

Kaiser Permanente Insurance Company (KPIC)

Point-of-Service (POS) Drug Formulary

This Drug Formulary was updated: January 1, 2026

NOTE: This drug formulary is updated often and is subject to change. Upon revision, all previous versions of the drug formulary are no longer in effect.

This document contains information regarding the drugs that are covered when you participate in the California Grandfathered Point of Service (POS) for Large Groups Health Insurance Plan(s) issued by Kaiser Permanente Insurance Company (KPIC) and fill your prescription at a MedImpact network pharmacy. If you belong to our POS plan and you intend to fill your prescriptions at a Kaiser Permanente pharmacy, please visit **kp.org/formulary** and **select the California Commercial HMO Formulary** for information on the drugs that are on the formulary of your HMO Tier benefit. Please note that this formulary does not have a specialty drug tier. If you are covered by a KPIC POS plan with a specialty drug tier, please see the Kaiser Permanente Insurance Company (KPIC) POS Formulary with Specialty Drug Tier.

Access to the most current version of the Formulary can be obtained by visiting: **kp.org/kpic-ca-rx-pos-gf**.

For help understanding your KPIC insurance plan benefits, including cost sharing for drugs under the prescription drug benefit and under the medical benefit, please call **1-800-788-0710 or 711 (TTY)**, Monday through Friday, 7a.m. to 7p.m.

For help with this Formulary, including the processes for submitting an exception request and requesting prior authorization and step therapy exceptions, please call MedImpact 24 hours a day, 7 days a week, at **1-800-788-2949 or 711 (TTY)**.

For information about your cost share for the outpatient prescription drug benefits in your specific plan, please visit: **kp.org/kpic-ca-rx-pos-gf**.

For help in your preferred language, please see the “Kaiser Permanente Insurance Company Notice of Language Assistance” in this document.

FORMULARY INFORMATION

Notice: The Formulary is updated with changes on a monthly basis. Updates will be effective on the first day of the month. During the policy year, the following types of changes may be made:

- Removal of a drug or dosage form of a drug from the Formulary;
- A change in tier placement of a drug that results in an increase or decrease in cost sharing; and
- Adding or changing utilization management procedures applicable to a drug.

How to Use This Document

This Formulary provides a list of the approved prescription medications covered under your Grandfathered POS Health Insurance Plan including both generic and brand name drugs. This document applies only to prescribed outpatient prescription drugs obtained through a retail pharmacy within the MedImpact network. This document does not apply to medications administered in the doctor's office or in the hospital which are covered under your medical benefit. For information on drugs covered under your medical benefit, please see the General Benefits section of your *Certificate of Insurance*.

The Formulary may be accessed using either the categorical list of drugs or the alphabetical index. The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB), a widely-accepted independent drug classification system.

A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the brand or generic name of the drug in the alphabetical index. A drug is listed alphabetically by the brand and generic name in the therapeutic category and class to which it belongs. The generic name for a brand name drug is included after the brand name in parentheses and all lowercase italicized letters. If a generic equivalent for a brand name drug is both available and covered, the generic drug will be listed separately from the brand name drug in all lowercase italicized letters. If a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized. If a generic equivalent for a brand name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

EXAMPLE of how drugs are listed on the Formulary:

Brand name drug. The brand name antibiotic drug "Moxatag" would be listed as follows:

Under the Prescription Drug Name Column, therapeutic category "ANTI-INFECTIVE AGENTS", drug class "AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS", the prescription brand name drug is listed in all capital letters, "MOXATAG" followed by the generic equivalent of the drug shown in parenthesis, all lower case italicized "(amoxicillin)".

ANTI-INFECTIVE AGENTS – DRUGS FOR INFECTIONS	
AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS	
MOXATAG ORAL TABLET, ER MULITPHASE 24 HR 775 MG (<i>amoxicillin</i>)	3

Generic drug. The generic antibiotic drug "amoxicillin" would be listed as follows:

Under the therapeutic category "ANTI-INFECTIVE AGENTS", drug class "AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS", the prescription generic drug is listed in lower case italics "*amoxicillin*".

ANTI-INFECTIVE AGENTS – DRUGS FOR INFECTIONS	
AMINOPENICILLIAN ANTIBIOTIC – ANTIBIOTICS	
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	1

Drug Tiers

Tier Benefit Design

The Formulary applies to a tier benefit design, where the insured shares the cost of prescription drug therapy based on the drug's tier and copay or coinsurance. In most instances, generically available drugs will be covered in a separate lower tier (lower copay), and branded drugs listed on the Formulary will be covered under a higher tier (higher copay).

Under your POS Plan, you will pay a different copay or coinsurance for preferred brand drugs and non-preferred brand drugs. Preferred drugs cost you less than non-preferred drugs. Please refer to the Tier Definition table below to see how to identify which drugs are preferred or non-preferred drugs.

If you request a brand-name drug when a generic drug is prescribed, you may be responsible for paying the brand-name copay plus the difference in cost between the generic drug and the brand-name drug. Please see your *Certificate of Insurance* for details.

For all drugs within the Drug Formulary table, the tier level is denoted throughout the document using the following symbols (*refer to table below*).

Tier Definition:

Symbol	Guideline	Description
T1	Tier 1	Preferred Generic Drugs
T2	Tier 2	Preferred Brand Name Drugs
T3	Tier 3	Non-Preferred Generic and Brand Name Drugs
PV	Preventive Drugs	Preventive-care benefits required under the Affordable Care Act (ACA). (Preventive Drugs covered at no cost if your group elected to include ACA preventive-care benefits under their grandfathered plan.) Tobacco cessation drugs listed on this formulary are covered at no cost on all plans.
DME	Other Pharmacy Items	Other pharmacy items and certain DME, such as test strips and lancets, available at the pharmacy and through your medical benefit.

Maintaining and Updating the Formulary

The MedImpact Healthcare Systems Pharmacy and Therapeutics (P&T) and Formulary Committees provide physicians and pharmacists with a method to evaluate the safety, efficacy and competitive prices for commercially available drug products. The MedImpact P&T and Formulary Committees meet quarterly and more often as warranted to ensure clinical relevancy of the Formulary.

The Formulary is updated by the MedImpact P&T and Formulary Committees using a structured approach to the drug selection process to ensure continuing patient access to rational drug therapies.

The MedImpact P&T and Formulary Committees use the following criteria in the evaluation of drug selection for the Formulary:

- Drug safety profile
- Drug efficacy
- Comparison of relevant therapeutic benefits to current Formulary agents of similar use, and to minimize therapeutic duplication where possible
- Lower costs relative to comparable therapies

What medications are covered?

Your prescription drug benefit will generally cover prescribed generic and brand-name drugs listed on the Formulary if the drug is medically necessary, the prescription is filled by a MedImpact network pharmacy provider, and other coverage rules are followed. Over-the-counter (OTC) medications are not generally covered, however, certain preventive OTC medications are covered when prescribed by a physician, such as over the counter FDA-approved female contraceptives, and some Durable Medical Equipment prescribed by a physician to treat diabetes, and inhaler spacers to assist with inhalation devices are also covered.

The Formulary lists the pharmacy benefits covered under your outpatient prescription drug benefit and obtained from a MedImpact network participating retail pharmacy. This Formulary does not apply to drugs and devices that are obtained through the medical benefit portion of your coverage: for example, medications provided or administered in the doctor's office or in the hospital or, unless specifically stated otherwise, devices covered under the Durable Medical Equipment benefit that are obtained at the doctor's office or through a Durable Medical Equipment vendor.

Diabetes medication and equipment. Your outpatient prescription drug coverage includes the following prescription items for the management and treatment of diabetes:

- Insulin
- Needles and syringes for injecting insulin
- Prescriptive medications for the treatment of diabetes
- Glucagon

Other pharmacy items. Some Durable Medical Equipment that is covered through your medical benefit is also available at the pharmacy: disposable blood glucose and ketone urine test strips; blood glucose monitors; lancets and lancet puncture devices; pen delivery systems for the administration of insulin; visual aids excluding eyewear to assist in insulin dosing; and peak flow meters.

Contraceptives. Your outpatient prescription drug coverage includes all prescribed FDA-approved contraceptive drugs, including over the counter FDA-approved female contraceptive methods when prescribed by a licensed health care professional authorized to prescribe drugs. All such medications require a prescription from your doctor.

Elective coverage of preventive drugs at no cost. If your plan covers preventive drugs at no cost (because your group **elected** to include preventive-care benefits required under the Affordable Care Act in their grandfathered plan), then the drugs identified in the Formulary with the "PV" symbol are covered at no cost share regardless of the drug tier indicated on the Formulary. All such medications require a prescription from your doctor. Additionally, some medications are only covered at no cost for patients who meet the criteria listed in the Formulary.

Note: The presence of a prescription drug on the Formulary does not guarantee that you will be prescribed that prescription drug by your prescribing provider for a particular medical condition.

Note: The total cost share for covered prescribed orally administered anti-cancer drugs shall not exceed \$200 for a 30-day supply.

What drugs are not covered?

- Self-administered injectable drugs.
- Over-the-counter (OTC) medications or their equivalents, except for those OTC medications included in this Formulary.
- Any drug product used for cosmetic purposes.
- Experimental drug products or any drug product used in an experimental manner. Refer to your *Certificate of Insurance* for additional information.
- Replacement of lost or stolen medication.
- Medications administered by a clinician unless otherwise specified in the Formulary listing.
- Foreign-sourced drugs or drugs not approved by the United States Food & Drug Administration, except in certain cases of drug shortage, when allowed under the individual's pharmacy benefit.
- Weight loss drugs
- Sexual dysfunction drugs

Non-formulary drugs

Non-formulary drugs are covered when medically necessary.

How do I request an exception for a drug that is not on the Formulary?

You, your designee, or your prescribing provider can request an exception to obtain coverage of a drug that is not on the Formulary by calling MedImpact at **1-800-788-2949**. Upon receipt of your exception request, MedImpact will notify you within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist, of the request approval or other outcome. (Urgent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health or ability to regain maximum function or when you are using a drug while undergoing a current course of treatment.) If a standard exception request is granted, coverage of the non-formulary drug will be granted for the duration of the prescription, including refills. If an exception based on urgent circumstances is granted, coverage of the non-formulary drug will be granted for the duration of the urgency. You may appeal the denial of an exception request. Please refer to your *Certificate of Insurance* for more information on appeal rights and procedures.

Are there any restrictions on the drugs covered on the Formulary?

Yes, for certain agents with the Formulary, a recommended prescribing guideline may apply. These are denoted throughout the document using the following symbols (*refer to table below*).

Guideline Symbol Table:

Symbol	Guidelines	Description
AGE	Age Edit	Coverage depends on patient age.
PA	Prior Authorization	Requires a prior authorization based on specific clinical criteria. See <i>“What is a Prior Authorization?”</i> below for additional information.
QL	Quantity Limit	Coverage is limited to specific quantities per prescription and/or time period. Prior authorization is required for quantities exceeding the restriction.
ST	Step Therapy	Coverage depends on previous use of another drug. Prior authorization may be required. See <i>“What is Step Therapy?”</i> below for additional information.
KP	Covered by KP Pharmacy	Covered under the HMO level of your POS plan through the KP pharmacy under a separate drug formulary (see kp.org/formulary)

What is a Prior Authorization?

A prior authorization (“PA”) is a technique that is used to encourage safe and competitively priced medication use. Many drugs have multiple indications, so PAs are placed on drugs to make sure the drug is appropriate and safe for the insured.

How does the program work? Drugs marked with a PA mean that your prescriber must first show that you have a medically necessary need for that particular drug. This means that to receive coverage your prescriber will need to work with MedImpact to receive pre-approval of the drug. Prior authorized drugs have specific clinical criteria that you must meet in order to obtain coverage. Refer to Requirements / Limits column in the Formulary for drugs that require a PA.

Upon receipt of your prior authorization request, MedImpact will notify the licensed prescribing provider within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist of the request approval or other outcome. If MedImpact fails to respond within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist from receipt of a request form from a licensed prescribing provider, the request shall be deemed to have been approved. If you are not satisfied with the outcome, you can request a waiver by calling MedImpact at **1-800-788-2949**.

What are Quantity Limits?

Coverage for certain drugs may be limited to specific quantities per prescription and/or time period. Prior authorization is required for quantities exceeding the quantity limit guideline.

What is Step Therapy?

Selected prescription drugs require step therapy. The step therapy program encourages safe and competitively priced medication use. Under this program, a “step” approach is required to receive coverage for certain high-cost medications. This means that to receive coverage you may need to first try a proven, lower cost medication before using a more costly treatment.

How does the program work? The step therapy program requires that you have a prescription history for a “first-line” medication before your benefit plan will cover a “second-line” medication. A first-line medication is recognized as safe and effective in treating a specific medical condition, as well as keeping costs down. A second-line medication is a less- preferred or sometimes more costly treatment option. Refer to Step Therapy Edits in the Index section at the end of the Formulary for a complete list of medications requiring step therapy and their criteria.

When possible, your doctor should prescribe a first-line medication appropriate for your condition. If your doctor determines that a first-line drug is not appropriate for you or is not effective for you, your prescription drug benefit will cover a second-line drug when certain conditions are met. Prior authorization may be required. Upon receipt of your request for a second-line drug, MedImpact will notify the licensed prescribing provider within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist of the request approval or other outcome. If you are not satisfied with the outcome, you can request a waiver by calling MedImpact at **1-800-788-2949**.

Note: If you have transitioned from a prior health insurance coverage to a new KPIC health insurance policy, any prescription drug that is currently being prescribed and considered safe and effective to treat a medical condition may not be subject to step therapy if, under your prior coverage:

- 1) The drug was not previously subject to step therapy; or
- 2) Step therapy was already obtained.

This does not apply if MedImpact’s P&T Committee and/or your provider determines that such drug is no longer safe or effective to treat your medical condition. Prior authorization may be required for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed under your prior coverage, and the prescribing provider is not precluded from prescribing another drug covered by the new policy that is medically appropriate for your condition.

The Pharmacy Network

This drug Formulary only applies to prescribed drugs, medicines and supplies purchased from a MedImpact network retail pharmacy. To fill your covered prescriptions, please visit a MedImpact network pharmacy. When visiting a MedImpact network pharmacy, please give the pharmacist your KPIC ID card with the MedImpact logo. The network of MedImpact pharmacies includes over 60,000 chain and independent pharmacies nationwide. To find a MedImpact network pharmacy near you, call **1-800-788-2949**.

What drugs are eligible to be mailed from the mail-order pharmacy?

There is no mail-order pharmacy coverage available with respect to this Formulary through MedImpact or through your KPIC POS coverage. Mail-order pharmacy coverage is provided under the HMO tier of the POS Plan through Kaiser Permanente mail-order pharmacy. Please see your *Evidence of Coverage* or visit **kp.org/formulary** for details of this benefit.

Benefit Coverage and Limitations

This printed Formulary does not provide information regarding the specific coverage and limitations you may be subject to specific benefit inclusions, exclusions, and out-of-pocket costs are not reflected in the Formulary.

The Formulary applies only to outpatient drugs provided to you and does not apply to medications used in an inpatient setting. For specific questions regarding your coverage, please call KPIC Customer Service at **1-800-788-0710**.

Definition of Terms

The following terms apply to your prescription drug coverage and the drug Formulary.

“Brand name drug” means a drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this Formulary in all CAPITAL letters.

“Coinsurance” means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

“Copayment” means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

“Deductible” means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

“Drug Tier” means a group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

“Exception request” means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

“Exigent circumstances” means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

“Formulary” or “prescription drug list” means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

“Generic drug” means a drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this Formulary in italicized lowercase letters.

“Medically Necessary” means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary. The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

“Non-formulary drug” means a prescription drug that is not listed on this Formulary.

“Out-of-pocket costs” means your expenses for health care benefits that aren’t reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

“Over-the-counter (OTC) drugs” are medicines sold directly to a consumer without requiring a prescription from a healthcare professional. For purposes of this Formulary, OTC drugs that are covered under your outpatient prescription drug benefit require a prescription from your doctor

“Prescribing provider” means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

“Prescription” means an oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.

“Prescription drug” means a drug that by law requires a prescription.

“Prior Authorization” means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this Formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

“Step therapy” means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this Formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

Kaiser Foundation Health Plan, Inc. (KFHP), underwrites the HMO tier of the Kaiser Permanente POS Plan and Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the participating and non-participating tiers of the Kaiser Permanente POS Plan.

Nondiscrimination Notice

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-788-0710** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

**KPIC Civil Rights Coordinator
P.O. Box 1809
Pleasanton, CA 94566
Phone: 1-800-788-0710**

You may also contact the California Department of Insurance regarding your complaint.

**By Phone:
California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4
TDD (1-800-482-4833)**

**By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013**

**Electronically:
www.insurance.ca.gov**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file the complaint electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>,

or by mail or phone at:

**U.S. Department of Health and Human Services,
200 Independence Avenue SW, Room 509F, HHH Building,
Washington, DC 20201
Phone: 1-800-368-1019, 1-800-537-7697 (TDD).**

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>.

Notice of Language Assistance

No Cost Language Services. You can get an interpreter and get documents read to you in your language. You may also request for materials to be translated into your language or alternative formats sent to you. For help, call us at the number listed on your ID card or 1-800-788-0710. For more help call the CA Dept. of Insurance at 1-800-927-4357. TTY users call 711. English

Servicios de idioma sin costo. Puede obtener servicios de un intérprete y que le lea documentos en su idioma. También puede solicitar que se traduzcan materiales a su idioma o que se le envíen en formatos alternativos. Si necesita ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-788-0710. Para obtener más información, llame al Departamento de Seguros de California al 1-800-927-4357. Los usuarios de TTY deben llamar al 711. Spanish

免費語言服務。 您可使用口譯員並請人使用您的語言將文件唸給您聽。您也可以要求將資料翻譯成您的語言或以替代格式寄給您。如需幫助，請致電您會員證上所列的電話號碼或致電1-800-788-0710與我們聯絡。如需進一步幫助，請致電1-800-927-4357與加州保險部聯絡。TTY使用者請致電711。Chinese

Bizaad bee áko t'áá íiyisí bá oolzinígíí. Díí bizaad bee naaltsoos nihá ályaaígíí t'áá íiyisí yíníłta'go bee hane' doo naaltsoos nihá níłtsá. Díí naaltsoos nihá bááqh yáhoot'éeł doo t'oh yáti'ígíí éí nihá bááqh yáhoot'éełígíí t'áá íiyisí bee ná'áłkidgo nihá dah naashá. Ákót'éego baa ahééh ná'idíłwo', doo bik'ehgo naaltsoos bee naaznilígíí bikáá' dah naashá ID béesh bee hane'gi t'áá ájít'éego bee hodiłłnih doo 1-800-788-0710 áłtsé. Díkwíí hóló holne'go, California Béeso Bee Hane' Áłchíní Bá Hooghan bee 1-800-927-4357 bibeeso biká anilyeed. TTY yáhoot'éeł nihá shikaad 711. Navajo

Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể được bố trí thông dịch viên và người đọc thông tin giấy tờ, tài liệu bằng ngôn ngữ quý vị dùng cho quý vị nghe. Quý vị cũng có thể yêu cầu dịch tài liệu sang ngôn ngữ của quý vị hoặc gửi đến quý vị các định dạng thay thế. Để được giúp đỡ, hãy gọi chúng tôi theo số điện thoại ghi trên thẻ Nhận Dạng (thẻ ID) của quý vị hoặc số 1-800-788-0710. Để được giúp đỡ thêm, vui lòng gọi Sở Bảo Hiểm CA theo số 1-800-927-4357. Người dùng TTY gọi số 711. Vietnamese

무료 언어 서비스. 통역사를 통해 사용하시는 언어로 서류를 읽어드립니다. 또한 사용하시는 언어로 자료를 번역해달라고 요청하거나 대체 형식으로 보내달라고 요청하셔도 됩니다. 도움이 필요한 경우, 회원 신분증에 적힌 번호나 1-800-788-0710 번으로 문의하십시오. 추가로 도움이 필요한 경우, 캘리포니아주 보험국 전화번호 1-800-927-4357번으로 문의하시기를 바랍니다. TTY 사용자는 711번으로 전화하십시오. Korean

Walang Gastos na Mga Serbisyo sa Wika. Maaari kayong kumuha ng interpreter at ipabasa ang mga dokumento sa inyong wika. Maaari rin kayong humiling na ang mga materyal ay isalin sa inyong wika o ipadala sa inyo sa mga alternatibong format. Para sa tulong, tawagan kami sa numero na nakalista sa inyong card ng pagkakakilanlan o sa 1-800-788-0710. Para sa higit pang tulong tumawag sa Departamento ng Insurance ng California sa 1-800-927-4357. Ang mga gumagamit ng TTY ay dapat tumawag sa 711. Tagalog

Անվճար լեզվական ծառայություններ: Դուք կարող եք բանավոր թարգմանիչ ստանալ, և փաստաթղթերը կարող են ընթերցել ձեզ համար ձեր լեզվով: Կարող եք նաև խնդրել, որ նյութերը թարգմանվեն ձեր լեզվով կամ ուղարկվեն ձեզ այլընտրանքային ձևաչափերով: Օգնության համար զանգահարեք մեզ ձեր նույնականացման քարտի վրա նշված համարով կամ 1-800-788-0710 հեռախոսահամարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի Ապահովագրության վարչություն 1-800-927-4357 հեռախոսահամարով: TTY-ից օգտվողները պետք է զանգահարեն 711: Armenian

Бесплатные услуги переводчика. Вы можете воспользоваться услугами переводчика, и документы будут прочтены для вас на вашем языке. Вы также можете подать запрос о переводе материалов на ваш язык или в альтернативные форматы. Если вам требуется помощь, звоните нам по телефону, указанному на вашей идентификационной карте, или по телефону 1-800-788-0710. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния по телефону 1-800-927-4357. Пользователям линии TTY следует звонить по телефону 711. Russian

無料の言語サービス。 通訳を手配し、書類をあなたの言語で読み上げてもらうことができます。また、ご希望があれば資料をあなたの言語に翻訳したり、別の形式でお届けすることも可能です。サポートが必要な場合は、身分証明カードに記載されている電話番号、または1-800-788-0710にお電話ください。さらにサポートが必要な場合は、カリフォルニア州保険局まで1-800-927-4357にご連絡ください。TTYユーザーの方は、711までお電話にてご連絡ください。Japanese

خدمات زبانی رایگان. می‌توانید یک مترجم شفاهی داشته باشید و ترتیبی بدهید تا اسناد به زبان خودتان برای شما خوانده شود. همچنین می‌توانید درخواست کنید که مطالب به زبان شما ترجمه شود یا در قالب‌های جایگزین برای شما ارسال گردد. برای دریافت کمک و راهنمایی، با شماره مندرج در کارت شناسایی یا 1-800-788-0710 با ما تماس بگیرید. برای دریافت راهنمایی بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. کاربران TTY می‌توانند با شماره 711 تماس بگیرند. Farsi

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਦੁਬਾਈ ਦੇ ਸਹਾਇਤਾ ਨਾਲ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹਵਾ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਮੱਗਰੀ ਦੇ ਅਨੁਵਾਦ ਜਾਂ ਵਿਕਲਪਿਕ ਫਾਰਮੇਟਾਂ ਦੀ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਸਹਾਇਤਾ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਜਾਂ 1-800-788-0710 'ਤੇ ਕਾਲ ਕਰੋ। ਹੋਰ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਬੀਮਾ ਵਿਭਾਗ ਨੂੰ 1-800-927-4357 'ਤੇ ਕਾਲ ਕਰੋ। TTY ਦੇ ਉਪਯੋਗਕਰਤਾ 711 'ਤੇ ਫੋਨ ਕਰੋ। ਪੰਜਾਬੀ Punjabi

សេវាភាសាភាគីភាគី។ អ្នកអាចទទួលបានអ្នកបកប្រែនិងទទួលបានឯកសារអានជូនអ្នក ក្នុងភាសារបស់អ្នក។ អ្នកក៏អាចស្នើសុំឯកសារដើម្បីបកប្រែក្នុងភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀត ត្រូវបានផ្ញើទៅអ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទមកលេខដែលមាននៅលើកាតសម្គាល់ខ្លួនរបស់អ្នក ឬទៅលេខ 1-800-788-0710។ សម្រាប់ជំនួយបន្ថែម សូមទូរសព្ទទៅនាយកដ្ឋានធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ាលេខ 1-800-927-4357។ អ្នកប្រើប្រាស់ TTY សូមហៅទៅលេខ 711។ Khmer

خدمات لغوية بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك بلغتك. يحق لك أيضاً طلب إرسال وثائق مترجمة بلغتك أو صيغ بديلة للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة الهوية الخاصة بك أو 1-866-213-3062. لمزيد من المساعدة اتصل بقسم التأمين في كاليفورنيا على الرقم 1-800-927-4357. TTY الاتصال على الرقم 711. العربية Arabic

Kev Pab Txhais Lus Dawb. Koj tuaj yeem txais ib tug kws txhais lus thiab txais kev nyeem cov ntaub ntawv ua koj hom lus. Koj tuaj kheev thov kom muab cov ntaub ntawv txhais mus ua koj hom lus los sis xa ua lwm hom ntawv tuaj rau koj huv si. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj uas sau nyob rau ntawm koj daim npav cim thawj los sis 1-800-788-0710. Rau kev pab ntxiv, hu rau CA Chaw Ua Hauj Lwm Tswj Kev Tuav Pov Hwm ntawm 1-800-927-4357. Cov neeg siv TTY hu rau 711. Hmong

बिना किसी लागत के भाषा सेवाएँ। आप एक दुभाषिया प्राप्त कर सकते हैं और दस्तावेज़ आपको आपकी भाषा में पढ़ कर सुनाए जा सकते हैं। आप सामग्रियों को अपनी भाषा या आपको भेजे जाने वाले वैकल्पिक प्रारूप में अनुवाद करवाने के लिए भी अनुरोध कर सकते हैं। सहायता के लिए, अपने आईडी कार्ड पर दिये नम्बर या 1-800-788-0710 पर हमें कॉल करें। अधिक सहायता के लिए कैलिफोर्निया डिपार्टमेंट ऑफ़ इंशोरेंस को 1-800-927-4357 पर कॉल करें। TTY प्रयोक्ता 711 पर कॉल करें। हिंदी: Hindi

บริการด้านภาษาที่ไม่คิดค่าบริการ คุณสามารถขอใช้บริการล่ามและบริการอ่านเอกสารให้ฟังเป็นภาษาของคุณได้ คุณอาจขอเอกสารที่แปลเป็นภาษาของคุณหรือในรูปแบบอื่นที่ส่งถึงคุณได้ หากต้องการความช่วยเหลือ โปรดติดต่อหมายเลขโทรศัพท์ที่ปรากฏบนบัตรประจำตัวของคุณหรือติดต่อหมายเลข 1-800-788-0710 หากต้องการความช่วยเหลือเพิ่มเติม โปรดติดต่อกรมการประกันภัยของรัฐบาลแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 ผู้ใช้เครื่อง TTY โปรดติดต่อหมายเลข 711 Thai

Table of Contents

Informational Section.....	1
Alternative Therapy - Vitamins And Minerals.....	1
Analgesic, Anti-Inflammatory Or Antipyretic.....	12
Analgesic, Anti-Inflammatory Or Antipyretic - Drugs For Pain And Fever.....	12
Anesthetics - Drugs For Pain And Fever.....	44
Anorectal Preparations - Rectal Preparations.....	46
Antidotes And Other Reversal Agents - Drugs For Overdose Or Poisoning.....	48
Anti-Infective Agents.....	51
Anti-Infective Agents - Drugs For Infections.....	51
Antineoplastics.....	84
Antineoplastics - Drugs For Cancer.....	85
Antiseptics And Disinfectants - Antiseptics And Disinfectants.....	102
Biologicals.....	104
Biologicals - Biological Agents.....	104
Cardiovascular Therapy Agents.....	118
Cardiovascular Therapy Agents - Drugs For The Heart.....	119
Central Nervous System Agents.....	156
Central Nervous System Agents - Drugs For The Nervous System.....	156
Chemical Dependency, Agents To Treat - Drugs For Addiction.....	236
Chemicals-Pharmaceutical Adjuvants.....	239
Cognitive Disorder Therapy.....	242
Cognitive Disorder Therapy - Drugs For The Nervous System.....	242
Contraceptives - Drugs For Women.....	245
Dermatological.....	262
Dermatological - Drugs For The Skin.....	263
Drugs To Treat Erectile Dysfunction - Drugs For The Urinary System.....	355
Electrolyte Balance-Nutritional Products.....	355
Electrolyte Balance-Nutritional Products - Drugs For Nutrition.....	355
Endocrine.....	425
Endocrine - Hormones.....	425
Fdb Class Obsolete-Not Used.....	465
Gastrointestinal Therapy Agents.....	466
Gastrointestinal Therapy Agents - Drugs For The Stomach.....	467
Genitourinary Therapy - Drugs For The Urinary System.....	512
Gout And Hyperuricemia Therapy - Drugs For Pain And Fever.....	523
Hematological Agents.....	525
Hematological Agents - Drugs For The Blood.....	525
Hepatobiliary System Treatment Agents.....	544
Hepatobiliary System Treatment Agents - Drugs For The Liver.....	545
Immunosuppressive Agents - Drugs For Organ Transplants.....	546
Locomotor System.....	548
Locomotor System - Drugs For Muscles, Ligaments, Tendons, And Bones.....	549
Medical Supplies And Durable Medical Equipment (Dme).....	555
Medical Supplies And Durable Medical Equipment (Dme) - Medical Supplies And Durable Medical Equipment.....	555
Medical Supply, Fdb Superset.....	698

Metabolic Disease Enzyme Replacement Agents - Drugs For Metabolic Disease	833
Metabolic Modifiers	834
Metabolic Modifiers - Drugs That Alter Metabolism	834
Mouth-Throat-Dental - Preparations - Drugs For The Mouth And Throat	838
Multiple Sclerosis Agents - Drugs For The Nervous System	843
Ophthalmic Agents	847
Ophthalmic Agents - Drugs For The Eye	847
Organ Preservation Solutions	868
Organ Preservation Solutions - Drugs For The Heart	868
Otic (Ear) - Drugs For The Ear	870
Respiratory Therapy Agents	871
Respiratory Therapy Agents - Drugs For The Lungs	871
Vaginal Products - Drugs For Women	894
Weight Loss/Gain Agents	897
Weight Loss/Gain Agents - Drugs For Eating Disorders	897

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alternative Therapy - Vitamins And Minerals		
Alternative Therapy - Androgenic Agents - Vitamins And Minerals		
DHEA ORAL TABLET 25 MG (prasterone (DHEA))	Tier 3	
<i>prasterone (dhea) oral capsule 25 mg</i>	Tier 3	
<i>prasterone (dhea) oral tablet 10 mg</i>	Tier 3	
<i>prasterone (dhea) oral tablet 25 mg</i>	Tier 3	
Alternative Therapy - Antiarthritics - Vitamins And Minerals		
<i>gluc-chon-msm-col-hy-bos-c-min oral tablet 750-551.5-50-30 mg</i>	Tier 3	
<i>glucosam su dip-chondroit-c-mn oral capsule 500-400-66-3 mg</i>	Tier 3	
<i>glucosam-chondr-msm-c-manganes oral capsule 375-300-75-15 mg</i>	Tier 3	
<i>glucosam-chondr-vit c-mn-boron oral tablet 750-600-30-1 mg</i>	Tier 3	
<i>glucosamine 2kcl-msm-chondroit oral tablet 500-166.6-400 mg</i>	Tier 3	
<i>glucosamine sulfate oral capsule 500 mg</i>	Tier 3	
<i>glucosamine sulfate oral tablet 1,000 mg</i>	Tier 3	
GLUCOSAMINE-CHONDR-D3 (C-MANG) ORAL CAPSULE 500-400-667 MG-MG-UNIT (glucosamine/chondr-collagen complex/vit D3/vit C/manganese)	Tier 3	
<i>glucosamine-chondroitin oral capsule 500-400 mg</i>	Tier 3	
<i>glucosamine-chondroitin oral tablet 250-200 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glucosamine-d3-boswellia serr oral tablet 1,500-400-100 mg-unit-mg</i>	Tier 3	
<i>glucosamine-d3-hyaluronic acid oral tablet 1,000 mg- 25 mcg-1.65 mg</i>	Tier 3	
<i>glucosamine-msm-chondr-d3-bosw oral tablet 25 mcg-937.5 mg</i>	Tier 3	
<i>glucosam-msm-chond-hrb149-hyal oral tablet 500-500-66.7 mg</i>	Tier 3	
MOVE FREE PLUS MSM-VIT D3 ORAL TABLET 750 MG-100 MG- 25 MCG (glucosamine/chondroitin/msm/D3/hyaluronic acid/cal borate)	Tier 3	
SUPERIOR JOINT SUPPORT ORAL TABLET 300-100-100-50 MG (glucosam/chondr/msm/collag/Boswell/turmeric/pancr/querc /brom)	Tier 3	
SYNOVX DJD ORAL CAPSULE 150 MG-150 MG- 250 MG-19 MG (glucosamin/chondroitin/msm/vit C/manganese/hyaluronic/mussel)	Tier 3	
SYNOVX RECOVERY ORAL CAPSULE 375-300-237.5 MG (glucosamine sulfate sodium/chondroitin sulfate sodium/msm)	Tier 3	
Alternative Therapy - Antidepressants - Vitamins And Minerals		
<i>st. john's wort oral capsule 300 mg</i>	Tier 3	
Alternative Therapy - Antioxidant - Vitamins And Minerals		
ADULT 50 PLUS EYE HEALTH ORAL CAPSULE 250-5-1 MG (vit C,E,copper,zinc 11/omega-3/dha/epa/fish/lutein/zeaxanth)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALAMAX CR ORAL TABLET EXTENDED RELEASE 600 MG- 450 MCG (alpha lipoic acid/biotin)	Tier 3	
ALAMAX PROTECT ORAL CAPSULE 125 MG-95 MCG-250 MG (alpha lipoic acid/biotin/berberine chloride)	Tier 3	
<i>alpha lipoic acid oral capsule 100 mg</i>	Tier 3	
<i>alpha lipoic acid oral capsule 200 mg</i>	Tier 3	
<i>alpha lipoic acid oral tablet 600 mg</i>	Tier 3	
<i>alpha lipoic acid oral tablet extended release 600 mg</i>	Tier 3	
<i>alpha lipoic acid-biotin oral capsule 300 mg- 333 mcg</i>	Tier 3	
ANTIOXIDANT FORMULA (SELENIUM) ORAL TABLET 8,333-167-133 UNIT-MG-UNIT (beta-carotene/ascorbic acid/vitE ac/selenium yeast)	Tier 3	
EYE HEALTH AREDS-2 ORAL CAPSULE 250-90-40-1 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
EYE HEALTH PLUS LUTEIN ORAL TABLET 300 MCG-200 MG-27 MG-2 MG (beta-carotene(A) w-C and E/lutein/minerals)	Tier 3	
EYE MULTIVITAMIN ORAL TABLET 2,148 MCG-113 MG-45 MG-17.4MG (beta-carotene/ascorbic acid/vitE ac/zinc oxide/cupric oxide)	Tier 3	
<i>glutathione (bulk) powder 100 %</i>	Tier 3	
HEALTHY EYES LUTEIN-ZEAXANTHIN ORAL CAPSULE 60 MG-13.5 MG- 15 MG-2 MG-6 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
HEALTHY EYES SUPERVISION2 ORAL CAPSULE 250-90-10-1 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
I-SIGHT ORAL CAPSULE 15 MG-100 MG-75 MG-50 MG (lutein/a-cysteine/ALA/quercet/zinc/taurine/bilberry/lycopene)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIVER PROTECT ORAL CAPSULE 200-200-262.5 MG (acetylcysteine/alpha lipoic/milk thistle/selenomethionine)	Tier 3	
<i>lutein oral capsule 20 mg</i>	Tier 3	
LUTEIN PLUS WITH ZEAXANTHIN ORAL TABLET 1,500 MCG-60 MG -20 MG-15 MG (betacarotene/vit C/vit E/zinc ox/cupric ox/lutein/zeaxanthin)	Tier 3	
<i>lutein-zeaxanthin oral capsule 25-5 mg</i>	Tier 3	
<i>lutein-zeaxanthin oral capsule 40-1,600 mg-mcg</i>	Tier 3	
<i>lutein-zeaxanthin oral tablet, chewable 10-2 mg</i>	Tier 3	
<i>lutein-zeaxanthin-bilberry ext oral capsule 20-1-2.2 mg</i>	Tier 3	
MITOPRIME ORAL CAPSULE 12.5 MG (ergothioneine)	Tier 3	
PRESERVISION AREDS 2 PLUS MV ORAL CAPSULE 200 MCG-15 MCG- 5 MG-1 MG (multivitamin-minerals/folic acid/vit K/lutein/zeaxanthin)	Tier 3	
PRESERVISION AREDS-2 ORAL CAPSULE 250-90-40-1 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
PRESERVISION AREDS-2 ORAL TABLET, CHEWABLE 250-90-40-1 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
PUREVITA ALPHA LIPOIC ACID ORAL DROPS 1 MG/2 ML (alpha lipoic acid)	Tier 3	
VISION HEALTH ORAL CAPSULE 250-90-40-2-5 MG (vit C/vit E acetate/zinc oxid/cupric oxide/lutein/zeaxanthin)	Tier 3	
VISION OPTIMIZER ORAL CAPSULE 66.6MG-3.33MCG-3.33 MG-0.66 MG (vitamin B complex/vit C/selenium/lutein/zeaxanthin/herb 253)	Tier 3	
VISTA ADVANCED AREDS2 ORAL CAPSULE 250-137.5-12.5 MG (vit C/vit E/zinc/copper/selen/lutein/zeaxanthin/glutathione)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alternative Therapy - Cough And Cold Agents - Vitamins And Minerals		
BABY COUGH ORAL SYRUP 4 GRAM-45 MG- 9 MG/3 ML (agave extract/thyme leaf extract/English ivy extract)	Tier 3	
BABY COUGH-MUCUS ORAL SYRUP 4 GRAM- 21 MG/3 ML (blue agave extract/English ivy extract)	Tier 3	
KINDERMED INFANTS COUGH PLUS ORAL SYRUP 4 GRAM- 21 MG/3 ML (blue agave extract/English ivy extract)	Tier 3	
KINDERMED INFANTS NIGHT COUGH ORAL LIQUID 4 GRAM-21 MG- 4 MG/3 ML (blue agave extract/English ivy extract/chamomile flower ext)	Tier 3	
Alternative Therapy - Laxatives And Cathartics - Vitamins And Minerals		
HERBAL COLON CLEANSER ORAL CAPSULE 500 MG (cascara/psyllium husk/bentonite/alfalfa/aloe/herbs)	Tier 3	
Alternative Therapy - Pineal Hormone Agents - Vitamins And Minerals		
<i>melatonin oral drops 1 mg/4 ml, 10 mg/ml, 3 mg/4 ml</i>	Tier 3	
<i>melatonin oral lozenge 5 mg</i>	Tier 3	
<i>melatonin oral tablet extended release 10 mg</i>	Tier 3	
Alternative Therapy - Sedative/Hypnotics - Vitamins And Minerals		
SLEEP TONITE VALERIAN ORAL TABLET 750-100-25 MG (valerian xt/passion flower/hops/chamomile flower/skullcap)	Tier 3	
SYNOVX CALM ORAL CAPSULE 100-30-15-40 MG (valerian rt/passion flower/hops/cherry/magnesium comb/potass)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alternative Therapy - Unclassified - Vitamins And Minerals		
ACAI BERRY DIET ORAL CAPSULE 250 MG-20 MCG- 80 MG-50 MG (acai berry extract/chromium/green tea/caffeine/enzymes)	Tier 3	
ADVANCED HERBALS GINGER ORAL TABLET,CHEWABLE 15 MG (ginger root extract)	Tier 3	
ALFA-MAX ALFALFA ORAL CAPSULE 525 MG (alfalfa)	Tier 3	
AM-PM MENOPAUSE FORMULA ORAL TABLETS, SEQUENTIAL 20-250-100(D)/ 20-200-100MG(N) (black cohosh/green tea/Panax ginseng/valerian/hops/theanine)	Tier 3	
ARTICHOKE PREMIUM EXTRACT ORAL CAPSULE 150-300 MG (milk thistle seed extract/artichoke leaf extract)	Tier 3	
<i>ashwagandha extract oral capsule 120 mg, 500 mg</i>	Tier 3	
<i>ashwagandha root extract oral capsule 500 mg</i>	Tier 3	
<i>ashwagandha root extract oral tablet 300 mg</i>	Tier 3	
ASHWAGANDHA ROOT LEAF EXTRACT ORAL TABLET,CHEWABLE 62.5 MG (ashwagandha extract)	Tier 3	
<i>astragalus root oral capsule 470 mg</i>	Tier 3	
ATRANTIL ORAL CAPSULE 275 MG (tannic acid/horse chestnut seed xt/peppermint leaf xt)	Tier 3	
AZO CRANBERRY PLUS PROBIOTIC ORAL TABLET 250-30-15 MG (cranberry fruit concentrate/ascorbic acid/Bacillus coagulans)	Tier 3	
AZO CRANBERRY PLUS VIT C ORAL CAPSULE 250-60 MG (cranberry fruit extract/ascorbic acid)	Tier 3	
BERGACOR ORAL TABLET 650 MG (bergamot extract)	Tier 3	
BERGACOR PLUS ORAL TABLET 400-250 MG (bergamot extract/Indian gooseberry extract)	Tier 3	
<i>bitter melon extract oral tablet 750 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>black cohosh oral capsule 540 mg</i>	Tier 3	
<i>black walnut hull oral capsule 450 mg</i>	Tier 3	
<i>boswellia serrata extract oral tablet 307 mg</i>	Tier 3	
BOWEL SUPPORT-IRRITABLE BOWEL ORAL CAPSULE,DELAYED RELEASE(DR/EC) (peppermint oil)	Tier 3	
BP MANAGER ORAL TABLET 519 MG (hawthorn extract/herbal drugs)	Tier 3	
BRONCHIAL SOOTHE ORAL SYRUP 43 MG/5 ML (English ivy extract)	Tier 3	
CALMAID ORAL CAPSULE 80 MG (lavender oil)	Tier 3	
CANDICIDAL ORAL CAPSULE 100 MG-150 MG- 50 MG-150 MG (turmeric/ginger/olive/oregano/sodium caprylate)	Tier 3	
<i>chamomile flower oral capsule 350 mg</i>	Tier 3	
<i>chaste tree fruit oral capsule 400 mg</i>	Tier 3	
<i>cinnamon bark extract oral tablet 500 mg</i>	Tier 3	
<i>cinnamon bark oral capsule 500 mg</i>	Tier 3	
CORTISOLV ORAL CAPSULE 150-250-50-50 MG (ashwagandha/magnolia brk/Phellod/banaba lf/maral rt/theanine)	Tier 3	
<i>cranberry conc-ascorbic acid oral capsule 300-100 mg, 4,200-20 mg</i>	Tier 3	
<i>cranberry extract oral capsule 500 mg</i>	Tier 3	
<i>cranberry extract oral tablet 500 mg</i>	Tier 3	
<i>cranberry fruit concentrate oral capsule 450 mg</i>	Tier 3	
<i>cranberry fruit concentrate oral tablet,disintegrating 125 mg</i>	Tier 3	
<i>cranberry fruit oral capsule 465 mg</i>	Tier 3	
CRANBERRY URINARY TRACT HEALTH ORAL TABLET 250-30-3.5 MG (cranberry fruit concentrate/ascorbic acid/Bacillus coagulans)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CURCUPLEX-95 ORAL CAPSULE 500 MG (turmeric root extract)	Tier 3	
<i>dandelion root oral capsule 525 mg</i>	Tier 3	
DIGESTIVE SUPPORT ORAL CAPSULE,DELAYED RELEASE(DR/EC) 100-21.5 MG (caraway seed extract/levomenthol)	Tier 3	
DRAMAMINE GINGER ORAL TABLET,CHEWABLE 15 MG (ginger root extract)	Tier 3	
DRAMAMINE NON-DROWSY ORAL CAPSULE 500 MG (ginger)	Tier 3	
<i>echinacea oral capsule 125 mg</i>	Tier 3	
<i>echinacea oral capsule 400 mg</i>	Tier 3	
<i>echinacea purp aerial part ext oral capsule 65 mg</i>	Tier 3	
EMERGEN-C APPLE CIDER VINEGAR ORAL TABLET,CHEWABLE 83.3 MG (ascorbic acid/multivitamin with minerals/herbal drugs)	Tier 3	
ESTROVEN CMPLT MENOPAUSE RLF ORAL TABLET 4 MG (rhubarb root extract)	Tier 3	
<i>evening primrose oil oral capsule 1,300 mg</i>	Tier 3	
<i>fenugreek seed oral capsule 610 mg</i>	Tier 3	
FLASHARREST ORAL CAPSULE 96.5 MG (hops extract/spruce fir extract)	Tier 3	
<i>flaxseed oil oral capsule 1,000 mg</i>	Tier 3	
<i>gamma-aminobutyric acid oral capsule 250 mg</i>	Tier 3	
<i>garlic extract oral capsule 500 mg</i>	Tier 3	
<i>garlic extract oral tablet 400 mg</i>	Tier 3	
<i>garlic oral capsule 1,000 mg</i>	Tier 3	
GARLICIN CARDIO ORAL TABLET 350 MG (garlic)	Tier 3	
GARLIX ORAL CAPSULE 650 MG (garlic extract)	Tier 3	
<i>gelatin oral capsule 650 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENNAMD ORAL CAPSULE 130 MG (cranberry fruit concentrate)	Tier 3	
<i>ginger (zingiber officinalis) oral capsule 550 mg</i>	Tier 3	
<i>ginger root-ginger root ext oral capsule 262.5 mg</i>	Tier 3	
<i>ginkgo biloba leaf extract oral capsule 120 mg, 125 mg</i>	Tier 3	
GINKGO BILOBA PLUS (BACOPA) ORAL CAPSULE 120-40 MG (ginkgo biloba leaf extract/bacopa leaf extract)	Tier 3	
GLUCOSA IMMUNE BOOSTER ORAL CAPSULE (herbal complex no.306)	Tier 3	
<i>goldenseal root oral capsule 333 mg</i>	Tier 3	
<i>grape seed extract oral capsule 100 mg</i>	Tier 3	
GREEN TEA-600 ORAL CAPSULE 600 MG (green tea leaf extract)	Tier 3	
HORMONE PROTECT ORAL CAPSULE 150-30 MG (diindolylmethane/broccoli seed extract)	Tier 3	
HORNY GOAT WEED PLUS ORAL CAPSULE 250-125 MG (barrenwort/maca extract/herbal drugs)	Tier 3	
JOINT COMFORT AND MOVEMENT ORAL CAPSULE 100-500 MG (Boswellia serrata extract/turmeric root extract)	Tier 3	
KOREAN GINSENG ORAL TABLET 1,000 MG (Panax ginseng root)	Tier 3	
<i>licorice root (g.glabra) oral capsule 450 mg</i>	Tier 3	
<i>maca oral capsule 525 mg</i>	Tier 3	
MEDCAPS MENOPAUSE ORAL CAPSULE (herbal complex no.321)	Tier 3	
<i>melatonin-pyridoxine (vit b6) oral tablet 5-1 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet extended release 5-10 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet, ir and er, biphasic 10-10 mg, 5-10 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MENOFEM ORAL CAPSULE (herbal complex no.323)	Tier 3	
<i>milk thistle oral capsule 500 mg</i>	Tier 3	
<i>milk thistle sd ext-blessed th oral capsule 175-120 mg</i>	Tier 3	
<i>milk thistle seed extract oral capsule 250 mg, 87.5 mg</i>	Tier 3	
MIND AND MEMORY ORAL CAPSULE 100-100 MG (coffee extract/phosphatidyl serine)	Tier 3	
<i>moringa oleifera oral capsule 500 mg</i>	Tier 3	
MYROSINASE ORAL CAPSULE 287.5 MG (mustard seed)	Tier 3	
NEURIVA ORIGINAL ORAL CAPSULE 100-100 MG (coffee extract/phosphatidyl serine)	Tier 3	
NEURIVA ORIGINAL ORAL TABLET,CHEWABLE 50-50 MG (coffee extract/phosphatidyl serine)	Tier 3	
NRF2 ACTIVATOR ORAL CAPSULE 200-200-50-30 MG (turmeric xt/green tea xt/pterostilbene/broccoli seed xt)	Tier 3	
NUMOISYN MUCOUS MEMBRANE LIQUID (flaxseed)	Tier 3	
ONCOPLEX ES ORAL CAPSULE 100 MG (broccoli seed extract)	Tier 3	
ONCOPLEX ORAL CAPSULE 30 MG (broccoli seed extract)	Tier 3	
ORAXINOL ORAL CAPSULE 500 MG (herbal complex no.319)	Tier 3	
<i>oregano oil-flaxseed oil oral capsule 50-25 mg</i>	Tier 3	
PMS SOOTHE ORAL CAPSULE (herbal complex no.327)	Tier 3	
<i>red beet oral capsule 500 mg</i>	Tier 3	
<i>red beet-sour cherry extract oral tablet,chewable 250-0.5 mg</i>	Tier 3	
<i>red yeast rice extract oral capsule 55 mg</i>	Tier 3	
<i>red yeast rice oral capsule 600 mg</i>	Tier 3	
REMIFEMIN MENOPAUSE ORAL TABLET 2.5 MG (black cohosh root extract)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SALOXICIN ORAL CAPSULE 60-25-20 MG (willow bark ext/Boswellia serrata ext/herbal complex no. 322)	Tier 3	
SAMBUCUS ELDERBERRY ORIGINAL ORAL SYRUP 50 MG/5 ML (elderberry fruit)	Tier 3	
<i>saw palmetto oral capsule 450 mg, 585 mg</i>	Tier 3	
<i>saw palmetto-zinc picolinate oral capsule 450-15 mg</i>	Tier 3	
<i>schisandra oral capsule 580 mg</i>	Tier 3	
SUPER ENERGY HERBAL COMPLEX ORAL TABLET 300-162.5-8 MG (guarana extract/Panax ginseng/alfalfa/herbal drugs)	Tier 3	
SYNOVX RELIEF ORAL CAPSULE 500 MG (Boswellia serrata extract/turmeric root extract)	Tier 3	
TESTOPLEX PLUS ORAL CAPSULE 250-100 MG (shilajit/Eurycoma longifolia extract)	Tier 3	
<i>turmeric root extract oral capsule 500 mg</i>	Tier 3	
<i>turmeric root extract oral tablet 500 mg</i>	Tier 3	
<i>turmeric root ext-sour cherry oral capsule 100-1,000 mg</i>	Tier 3	
<i>turmeric root-ginger root ext oral tablet, chewable 150-25 mg</i>	Tier 3	
<i>turmeric-ginger-black pepper oral tablet, chewable 125 mg-6 mg- 50 mcg</i>	Tier 3	
<i>turmeric-turmeric ext-pepper oral capsule 500-5 mg</i>	Tier 3	
<i>turmeric-turmeric root extract oral capsule 450-50 mg</i>	Tier 3	
<i>valerian oral capsule 530 mg</i>	Tier 3	
<i>valerian root oral capsule 450 mg, 500 mg</i>	Tier 3	
VIRAGRAPHIS ORAL CAPSULE 187.5-150-79.2 MG (Andrographis ext/Isatis root xt/licorice root xt)	Tier 3	
<i>vit c-echinacea purpurea xt oral tablet, chewable 75-3 mg</i>	Tier 3	
VITALVASC ORAL CAPSULE 75-250-125 MG (grape seed extract/hesperidin/olive extract)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Analgesic, Anti-Inflammatory Or Antipyretic		
Analgesic - Opioid Antagonists		
LOTREXONE ORAL CAPSULE 1.5 MG, 4.5 MG (naltrexone HCl)	Tier 3	
NALTREX ORAL CAPSULE 1.5 MG, 4.5 MG (naltrexone HCl)	Tier 3	
Analgesic - Selective Sodium Channel Blockers		
JOURNAVX ORAL TABLET 50 MG (suzetrigine)	Tier 3	PA
Anti-Inflammatory - Antimitotics		
LODOCO ORAL TABLET 0.5 MG (colchicine)	Tier 3	
Analgesic, Anti-Inflammatory Or Antipyretic - Drugs For Pain And Fever		
Analgesic - Central Alpha-2 Receptor Agonists - Arthritis And Pain Drugs		
<i>clonidine (pf) epidural solution 1,000 mcg/10 ml (100 mcg/ml), 5,000 mcg/10 ml</i>	Tier 1	KP
DURACLON (PF) EPIDURAL SOLUTION 1,000 MCG/10 ML (100 MCG/ML) (clonidine HCl/PF)	Tier 3	KP
Analgesic - Neuronal (N)-Type Calcium Channel Blockers (Nccbs) - Arthritis And Pain Drugs		
PRIALT INTRATHECAL SOLUTION 100 MCG/ML, 25 MCG/ML (ziconotide acetate)	Tier 3	KP
Analgesic Opioid Agonists - Arthritis And Pain Drugs		
<i>codeine sulfate oral tablet 15 mg, 30 mg</i>	Tier 1	QL (12 EA per 1 day); Age (Min 12 Years)
<i>codeine sulfate oral tablet 60 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEMEROL (PF) INJECTION SYRINGE 100 MG/ML, 25 MG/ML, 50 MG/ML, 75 MG/ML (meperidine HCl/PF)	Tier 3	KP
DEMEROL INJECTION SOLUTION 50 MG/ML (meperidine HCl)	Tier 3	KP
DILAUDID (PF) INJECTION SYRINGE 0.5 MG/0.5 ML, 1 MG/ML, 2 MG/ML, 4 MG/ML (hydromorphone HCl/PF)	Tier 3	KP
DILAUDID ORAL LIQUID 1 MG/ML (hydromorphone HCl)	Tier 3	
DILAUDID ORAL TABLET 2 MG, 4 MG, 8 MG (hydromorphone HCl)	Tier 3	
DISKETTS ORAL TABLET, SOLUBLE 40 MG (methadone HCl)	Tier 3	QL (1 EA per 1 day)
DSUVIA SUBLINGUAL TABLET IN APPLICATOR 30 MCG (sufentanil citrate)	Tier 3	
<i>fentanyl citrate (pf) intravenous patient control analgesia soln 1,500 mcg/30 ml (50 mcg/ml)</i>	Tier 1	KP
<i>fentanyl citrate (pf)-0.9% nacl intravenous pt controlled analgesia syring 1,000 mcg/50 ml (20 mcg/ml), 500 mcg/50 ml (10 mcg/ml)</i>	Tier 1	KP
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 200 mcg</i>	Tier 1	
<i>fentanyl citrate buccal tablet, effervescent 400 mcg, 600 mcg, 800 mcg</i>	Tier 3	
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour, 87.5 mcg/hour</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone bitartrate oral capsule, oral only, er 12hr 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>hydrocodone bitartrate oral tablet, oral only, ext. rel. 24 hr 100 mg, 120 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
<i>hydromorphone (pf) injection syringe 0.5 mg/0.5 ml, 1 mg/ml</i>	Tier 1	KP
<i>hydromorphone (pf)-0.9 % nacl intravenous pt controlled analgesia syring 30 mg/30 ml (1 mg/ml)</i>	Tier 1	KP
<i>hydromorphone oral liquid 1 mg/ml</i>	Tier 1	
<i>hydromorphone oral tablet 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>hydromorphone rectal suppository 3 mg</i>	Tier 1	
HYSINGLA ER ORAL TABLET, ORAL ONLY, EXT. REL. 24 HR 100 MG, 20 MG, 30 MG, 40 MG, 60 MG, 80 MG (hydrocodone bitartrate)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
<i>levorphanol tartrate oral tablet 2 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levorphanol tartrate oral tablet 3 mg</i>	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>meperidine (pf) injection solution 100 mg/ml, 50 mg/ml</i>	Tier 1	KP
<i>meperidine (pf) injection solution 25 mg/ml</i>	Tier 1	KP
<i>meperidine oral solution 50 mg/5 ml</i>	Tier 1	QL (30 ML per 1 day)
<i>meperidine oral tablet 50 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>methadone injection solution 10 mg/ml</i>	Tier 1	KP; QL (4 ML per 1 day)
methadone HCl (Methadone Intensol Oral Concentrate 10 Mg/ML)	Tier 1	QL (4 ML per 1 day)
<i>methadone oral concentrate 10 mg/ml</i>	Tier 1	QL (4 ML per 1 day)
<i>methadone oral solution 10 mg/5 ml</i>	Tier 1	QL (20 ML per 1 day)
<i>methadone oral solution 5 mg/5 ml</i>	Tier 1	QL (40 ML per 1 day)
<i>methadone oral tablet 10 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>methadone oral tablet 5 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>methadone oral tablet, soluble 40 mg</i>	Tier 1	QL (1 EA per 1 day)
METHADOSE ORAL CONCENTRATE 10 MG/ML (methadone HCl)	Tier 3	QL (4 ML per 1 day)
methadone HCl (Methadose Oral Tablet, Soluble 40 Mg)	Tier 1	QL (1 EA per 1 day)
<i>morphine (pf) intravenous syringe 1 mg/2 ml</i>	Tier 1	KP
<i>morphine concentrate oral solution 100 mg/5 ml (20 mg/ml)</i>	Tier 1	
<i>morphine in 0.9 % sodium chlor intravenous solution 1 mg/ml</i>	Tier 1	KP
<i>morphine in 0.9 % sodium chlor intravenous solution 5 mg/ml</i>	Tier 1	KP
<i>morphine intramuscular pen injector 10 mg/0.7 ml</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>morphine oral capsule, er multiphase 24 hr 120 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>morphine oral capsule, er multiphase 24 hr 30 mg, 45 mg, 60 mg, 75 mg, 90 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day)
<i>morphine oral capsule, extend.release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>morphine oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>morphine oral tablet 15 mg</i>	Tier 3	
<i>morphine oral tablet 30 mg</i>	Tier 2	
<i>morphine oral tablet extended release 100 mg, 15 mg, 200 mg, 30 mg, 60 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day)
<i>morphine rectal suppository 10 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 15 MG, 200 MG, 30 MG, 60 MG (morphine sulfate)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 150 MG, 200 MG, 250 MG, 50 MG (tapentadol HCl)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
NUCYNTA ORAL TABLET 100 MG, 50 MG, 75 MG (tapentadol HCl)	Tier 3	QL (6 EA per 1 day)
<i>oxycodone oral capsule 5 mg</i>	Tier 1	
<i>oxycodone oral concentrate 20 mg/ml</i>	Tier 1	
<i>oxycodone oral solution 5 mg/5 ml</i>	Tier 1	
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>oxycodone oral tablet, oral only 10 mg, 15 mg, 30 mg, 5 mg</i>	Tier 1	
<i>oxycodone oral tablet, oral only, ext. rel. 12 hr 10 mg, 20 mg, 40 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>oxycodone oral tablet, oral only, ext. rel. 12 hr 80 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)
OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG (oxycodone HCl)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
OXYCONTIN ORAL TABLET, ORAL ONLY, EXT. REL. 12 HR 80 MG (oxycodone HCl)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxymorphone oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>oxymorphone oral tablet extended release 12 hr 30 mg, 40 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)
QDOLO ORAL SOLUTION 5 MG/ML (tramadol HCl)	Tier 3	
ROXICODONE ORAL TABLET 15 MG, 30 MG (oxycodone HCl)	Tier 3	
ROXYBOND ORAL TABLET, ORAL ONLY 10 MG, 15 MG, 30 MG, 5 MG (oxycodone HCl)	Tier 3	
<i>tramadol oral capsule,er biphasic 24 hr 17-83 300 mg</i>	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral capsule,er biphasic 24 hr 25-75 100 mg, 200 mg</i>	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral solution 5 mg/ml</i>	Tier 1	
<i>tramadol oral tablet 100 mg</i>	Tier 3	QL (4 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet 25 mg, 75 mg</i>	Tier 3	
<i>tramadol oral tablet 50 mg</i>	Tier 1	QL (8 EA per 1 day); Age (Min 12 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tramadol oral tablet extended release 24 hr 100 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet extended release 24 hr 200 mg, 300 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet, er multiphase 24 hr 100 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (3 EA per 1 day); Age (Min 12 Years)
<i>tramadol oral tablet, er multiphase 24 hr 200 mg, 300 mg</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (1 EA per 1 day); Age (Min 12 Years)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 13.5 MG, 18 MG, 9 MG (oxycodone myristate)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 27 MG (oxycodone myristate)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XTAMPZA ER ORAL CAP,SPRINKL,ER12HR(DONT CRUSH) 36 MG (oxycodone myristate)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (8 EA per 1 day)
Analgesic Opioid Codeine Combinations - Arthritis And Pain Drugs		
<i>acetaminophen-codeine oral solution 120 mg-12 mg /5 ml (5 ml), 120-12 mg/5 ml</i>	Tier 1	QL (150 ML per 1 day); Age (Min 12 Years)
<i>acetaminophen-codeine oral solution 300 mg-30 mg /12.5 ml</i>	Tier 1	Age (Min 12 Years)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	Tier 1	QL (12 EA per 1 day); Age (Min 12 Years)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
codeine phosphate/butalbital/aspirin/caffeine (Ascomp With Codeine Oral Capsule 30-50-325-40 Mg)	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
<i>butalbital-acetaminop-caf-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
<i>codeine-butalbital-asa-caff oral capsule 30-50-325-40 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 12 Years)
FIORICET WITH CODEINE ORAL CAPSULE 50-300-40-30 MG (butalbital/acetaminophen/caffeine/codeine phosphate)	Tier 3	QL (6 EA per 1 day); Age (Min 12 Years)
Analgesic Opioid Dihydrocodeine Combinations - Arthritis And Pain Drugs		
<i>acetaminophen-caff-dihydrocod oral capsule 320.5-30-16 mg</i>	Tier 3	ST: Requires prior prescription for Acetaminophen/Codeine tablets within the past 120 days; QL (10 EA per 1 day); Age (Min 12 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Analgesic Opioid Dihydrocodeine, Non-Salicylate Analgesic, Xanthine - Arthritis And Pain Drugs		
<i>acetaminophen-caff-dihydrocod oral capsule 320.5-30-16 mg</i>	Tier 3	ST: Requires prior prescription for Acetaminophen/Codeine tablets within the past 120 days; QL (10 EA per 1 day); Age (Min 12 Years)
Analgesic Opioid Fentanyl Combinations - Arthritis And Pain Drugs		
<i>fentanyl (pf)-bupivacaine-nacl epidural prefilled pump reservoir 2 mcg/ml- 0.1 %, 2 mcg/ml- 0.125 %</i>	Tier 1	KP
<i>fentanyl (pf)-bupivacaine-nacl epidural syringe 2 mcg/ml- 0.125 %</i>	Tier 1	KP
<i>fentanyl-ropivacaine-nacl (pf) epidural prefilled pump reservoir 2-0.2 mcg/ml-%</i>	Tier 1	KP
<i>fentanyl-ropivacaine-nacl (pf) epidural solution 2-0.1 mcg/ml-%, 2-0.125 mcg/ml-%</i>	Tier 1	KP
<i>fentanyl-ropivacaine-nacl (pf) epidural syringe 100 mcg/50 ml (2 mcg/ml)-0.1%, 100 mcg/50 ml (2mcg/ml)-0.15%</i>	Tier 1	KP
Analgesic Opioid Hydrocodone And Non-Salicylate Combinations - Arthritis And Pain Drugs		
APADAZ ORAL TABLET 4.08-325 MG, 6.12-325 MG, 8.16-325 MG (benzhydrocodone HCl/acetaminophen)	Tier 3	ST: Requires prior prescription for generic Norco (Hydrocodone/Acetaminophen) tablets within the past 120 days; QL (12 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>benzhydrocodone-acetaminophen oral tablet 4.08-325 mg, 6.12-325 mg, 8.16-325 mg</i>	Tier 1	ST: Requires prior prescription for generic Norco (Hydrocodone/Acetaminophen) tablets within the past 120 days; QL (12 EA per 1 day)
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15 ml</i>	Tier 1	QL (200 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml</i>	Tier 3	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml)</i>	Tier 3	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 1	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier 1	QL (13 EA per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)
Analgesic Opioid Hydrocodone And Nsaid Combinations - Arthritis And Pain Drugs		
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	Tier 1	
Analgesic Opioid Hydrocodone Combinations - Arthritis And Pain Drugs		
<i>hydrocodone-acetaminophen oral solution 10-300 mg/15 ml</i>	Tier 1	QL (200 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml</i>	Tier 3	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 10-325 mg/15 ml(15 ml)</i>	Tier 3	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	Tier 1	QL (184 ML per 1 day)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier 1	QL (13 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	Tier 1	
Analgesic Opioid Oxycodone And Non-Salicylate Combinations - Arthritis And Pain Drugs		
oxycodone HCl/acetaminophen (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg)	Tier 1	QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Nalocet Oral Tablet 2.5-300 Mg)	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral solution 10-300 mg/5 ml</i>	Tier 3	QL (66 ML per 1 day)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5 ml</i>	Tier 1	QL (61 ML per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (13 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i>	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Percocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg)	Tier 1	QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Primlev Oral Tablet 10-300 Mg, 5-300 Mg, 7.5-300 Mg)	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (13 EA per 1 day)
oxycodone HCl/acetaminophen (Prolate Oral Solution 10-300 Mg/5 MI)	Tier 3	QL (66 ML per 1 day)
oxycodone HCl/acetaminophen (Prolate Oral Tablet 10-300 Mg, 5-300 Mg, 7.5-300 Mg)	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (13 EA per 1 day)
Analgesic Opioid Oxycodone Combinations - Arthritis And Pain Drugs		
oxycodone HCl/acetaminophen (Endocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg)	Tier 1	QL (12 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxycodone HCl/acetaminophen (Nalocet Oral Tablet 2.5-300 Mg)	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral solution 10-300 mg/5 ml</i>	Tier 3	QL (66 ML per 1 day)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5 ml</i>	Tier 1	QL (61 ML per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (13 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	Tier 1	QL (12 EA per 1 day)
<i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i>	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Percocet Oral Tablet 10-325 Mg, 2.5-325 Mg, 5-325 Mg, 7.5-325 Mg)	Tier 1	QL (12 EA per 1 day)
oxycodone HCl/acetaminophen (Primlev Oral Tablet 10-300 Mg, 5-300 Mg, 7.5-300 Mg)	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (13 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
oxycodone HCl/acetaminophen (Prolate Oral Solution 10-300 Mg/5 MI)	Tier 3	QL (66 ML per 1 day)
oxycodone HCl/acetaminophen (Prolate Oral Tablet 10-300 Mg, 5-300 Mg, 7.5-300 Mg)	Tier 3	ST: Requires prior prescriptions for generic Oxycodone IR and Oxycodone/Acetaminophen 325mg tablets within the past 365 days; QL (13 EA per 1 day)
Analgesic Opioid Partial-Mixed Agonists - Arthritis And Pain Drugs		
BELBUCA BUCCAL FILM 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG (buprenorphine HCl)	Tier 2	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (2 EA per 1 day)
<i>buprenorphine hcl injection solution 0.3 mg/ml</i>	Tier 1	KP; ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>buprenorphine hcl injection syringe 0.3 mg/ml</i>	Tier 1	KP; ST: Requires 7 consecutive days therapy of current short-acting opioid prescription
<i>buprenorphine transdermal patch weekly 10 mcg/hour, 15 mcg/hour, 20 mcg/hour, 5 mcg/hour, 7.5 mcg/hour</i>	Tier 1	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 28 days)
<i>butorphanol injection solution 1 mg/ml, 2 mg/ml</i>	Tier 1	KP
<i>butorphanol nasal spray, non-aerosol 10 mg/ml</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HOUR, 15 MCG/HOUR, 20 MCG/HOUR, 5 MCG/HOUR, 7.5 MCG/HOUR (buprenorphine)	Tier 3	ST: Requires 7 consecutive days therapy of current short-acting opioid prescription; QL (4 EA per 28 days)
<i>nalbuphine injection solution 10 mg/ml, 20 mg/ml</i>	Tier 1	KP
<i>pentazocine-naloxone oral tablet 50-0.5 mg</i>	Tier 1	
Analgesic Opioid Tramadol And Non-Salicylate Combinations - Arthritis And Pain Drugs		
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	Tier 1	QL (10 EA per 1 day); Age (Min 12 Years)
Analgesic Opioid Tramadol And Nsaid Combinations - Arthritis And Pain Drugs		
SEGLENTIS ORAL TABLET 44-56 MG (tramadol HCl/celecoxib)	Tier 3	
Analgesic Opioid Tramadol Combinations - Arthritis And Pain Drugs		
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	Tier 1	QL (10 EA per 1 day); Age (Min 12 Years)
Analgesic Or Antipyretic Non-Opioid/Sedative Combinations - Arthritis And Pain Drugs		
<i>butalbital-acetaminophen oral capsule 50-300 mg</i>	Tier 3	QL (6 EA per 1 day)
<i>butalbital-acetaminophen oral tablet 50-300 mg</i>	Tier 1	ST: Requires prior prescription for generic Butalbital/acetaminophen 50mg-325mg combination product within the past 120 days; QL (6 EA per 1 day)
<i>butalbital-acetaminophen oral tablet 50-325 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>butalbital-acetaminophen-caff oral capsule 50-300-40 mg, 50-325-40 mg</i>	Tier 1	
<i>butalbital-acetaminophen-caff oral solution 50-325-40 mg/15 ml</i>	Tier 3	
<i>butalbital-acetaminophen-caff oral tablet 50-325-40 mg</i>	Tier 1	
butalbital/acetaminophen/caffeine (Esgic Oral Tablet 50-325-40 Mg)	Tier 3	
butalbital/acetaminophen/caffeine (Fioricet Oral Capsule 50-300-40 Mg)	Tier 1	
butalbital/acetaminophen (Tencon Oral Tablet 50-325 Mg)	Tier 1	
Anti-Inflammatory - Complement (C5) Receptor Inhibitors - Arthritis And Pain Drugs		
TAVNEOS ORAL CAPSULE 10 MG (avacopan)	Tier 3	PA
Anti-Inflammatory - Interleukin-1 Receptor Antagonist - Arthritis And Pain Drugs		
ARCALYST SUBCUTANEOUS RECON SOLN 220 MG (rilonacept)	Tier 3	PA; KP
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Non-Selective - Arthritis And Pain Drugs		
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML) (etanercept)	Tier 3	PA; KP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML (etanercept)	Tier 3	PA; KP
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) (etanercept)	Tier 3	PA; KP
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML) (etanercept)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agnts,Tnf-Alpha Sel - Arthritis And Pain Drugs		
<i>adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml, 80 mg/0.8 ml</i>	Tier 3	PA; KP
<i>adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml, 20 mg/0.2 ml, 40 mg/0.4 ml</i>	Tier 3	PA; KP
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS) (certolizumab pegol)	Tier 3	PA; KP
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 3	PA; KP
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 3	PA; KP
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML (adalimumab)	Tier 3	PA; KP
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab-ryvk)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab-ryvk)	Tier 3	PA; KP
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML (golimumab)	Tier 2	KP
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA; KP
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA; KP
ZYMFENTRA SUBCUTANEOUS PEN INJECTOR KIT 120 MG/ML (infliximab-dyyb)	Tier 3	PA; KP
ZYMFENTRA SUBCUTANEOUS SYRINGE KIT 120 MG/ML (infliximab-dyyb)	Tier 3	PA; KP
Dmard - Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents - Arthritis And Pain Drugs		
<i>adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml, 80 mg/0.8 ml</i>	Tier 3	PA; KP
<i>adalimumab-adaz subcutaneous syringe 10 mg/0.1 ml, 20 mg/0.2 ml, 40 mg/0.4 ml</i>	Tier 3	PA; KP
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS) (certolizumab pegol)	Tier 3	PA; KP
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 3	PA; KP
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 3	PA; KP
ENBREL MINI SUBCUTANEOUS CARTRIDGE 50 MG/ML (1 ML) (etanercept)	Tier 3	PA; KP
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5 ML (etanercept)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) (etanercept)	Tier 3	PA; KP
ENBREL SURECLICK SUBCUTANEOUS PEN INJECTOR 50 MG/ML (1 ML) (etanercept)	Tier 3	PA; KP
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML (adalimumab)	Tier 3	PA; KP
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab-ryvk)	Tier 3	PA; KP
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab-ryvk)	Tier 3	PA; KP
SIMPONI ARIA INTRAVENOUS SOLUTION 12.5 MG/ML (golimumab)	Tier 2	KP
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA; KP
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML, 50 MG/0.5 ML (golimumab)	Tier 2	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dmard - Antimalarials - Arthritis And Pain Drugs		
<i>hydroxychloroquine oral tablet 100 mg</i>	Tier 1	QL (180 EA per 30 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	Tier 1	QL (100 EA per 30 days)
<i>hydroxychloroquine oral tablet 300 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>hydroxychloroquine oral tablet 400 mg</i>	Tier 1	QL (60 EA per 30 days)
PLAQUENIL ORAL TABLET 200 MG (hydroxychloroquine sulfate)	Tier 3	QL (100 EA per 30 days)
SOVUNA ORAL TABLET 200 MG (hydroxychloroquine sulfate)	Tier 2	QL (100 EA per 30 days)
SOVUNA ORAL TABLET 300 MG (hydroxychloroquine sulfate)	Tier 3	QL (60 EA per 30 days)
Dmard - Antimetabolites - Arthritis And Pain Drugs		
JYLAMVO ORAL SOLUTION 2 MG/ML (methotrexate)	Tier 3	PA
<i>methotrexate sodium (pf) injection solution 25 mg/ml</i>	Tier 1	KP
<i>methotrexate sodium injection solution 25 mg/ml</i>	Tier 1	KP
<i>methotrexate sodium oral tablet 2.5 mg</i>	Tier 1	
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML (methotrexate/PF)	Tier 2	KP; QL (0.8 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 12.5 MG/0.25 ML (methotrexate/PF)	Tier 2	KP; QL (1 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 15 MG/0.3 ML (methotrexate/PF)	Tier 2	KP; QL (1.2 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 17.5 MG/0.35 ML (methotrexate/PF)	Tier 2	KP; QL (1.4 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 20 MG/0.4 ML (methotrexate/PF)	Tier 2	KP; QL (1.6 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 22.5 MG/0.45 ML (methotrexate/PF)	Tier 2	KP; QL (1.8 ML per 28 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 25 MG/0.5 ML (methotrexate/PF)	Tier 2	KP; QL (2 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 30 MG/0.6 ML (methotrexate/PF)	Tier 2	KP; QL (2.4 ML per 28 days)
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 7.5 MG/0.15 ML (methotrexate/PF)	Tier 2	KP; QL (0.6 ML per 28 days)
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	Tier 2	
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	Tier 3	ST: Requires prior prescription for Methotrexate tablets or injection solution within the past 120 days if 12 years of age and older; QL (120 ML per 60 days)
Dmard - Antinflammatory, Select. Costimulation Modulator,T-Cell Inhib. - Arthritis And Pain Drugs		
ORENCIA CLICKJECT SUBCUTANEOUS AUTO-INJECTOR 125 MG/ML (abatacept)	Tier 3	PA; KP
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML, 50 MG/0.4 ML, 87.5 MG/0.7 ML (abatacept)	Tier 3	PA; KP
Dmard - Gold Compounds - Arthritis And Pain Drugs		
<i>auranofin oral capsule 3 mg</i>	Tier 1	
RIDAURA ORAL CAPSULE 3 MG (auranofin)	Tier 2	
Dmard - Immunosuppressives - Arthritis And Pain Drugs		
azathioprine (Azasan Oral Tablet 100 Mg, 75 Mg)	Tier 3	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CELLCEPT ORAL CAPSULE 250 MG (mycophenolate mofetil)	Tier 3	
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION 200 MG/ML (mycophenolate mofetil)	Tier 3	
CELLCEPT ORAL TABLET 500 MG (mycophenolate mofetil)	Tier 3	
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	Tier 1	
<i>cyclophosphamide oral tablet 25 mg, 50 mg</i>	Tier 1	
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	Tier 1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	Tier 1	
cyclosporine, modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	Tier 1	
cyclosporine, modified (Gengraf Oral Solution 100 Mg/ML)	Tier 1	
IMURAN ORAL TABLET 50 MG (azathioprine)	Tier 3	
<i>mycophenolate mofetil oral capsule 250 mg</i>	Tier 1	
<i>mycophenolate mofetil oral suspension for reconstitution 200 mg/ml</i>	Tier 1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	Tier 1	
NEORAL ORAL CAPSULE 100 MG, 25 MG (cyclosporine, modified)	Tier 3	
NEORAL ORAL SOLUTION 100 MG/ML (cyclosporine, modified)	Tier 3	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (cyclosporine)	Tier 3	
Dmard - Interleukin-1 Receptor Antagonist (IL-1Ra) - Arthritis And Pain Drugs		
KINERET SUBCUTANEOUS SYRINGE 100 MG/0.67 ML (anakinra)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dmard - Interleukin-6 (Il-6) Receptor Inhibitors, Monoclonal Antibody - Arthritis And Pain Drugs		
ACTEMRA ACTPEN SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML (tocilizumab)	Tier 3	PA; KP
ACTEMRA SUBCUTANEOUS SYRINGE 162 MG/0.9 ML (tocilizumab)	Tier 3	PA; KP
KEVZARA SUBCUTANEOUS PEN INJECTOR 150 MG/1.14 ML, 200 MG/1.14 ML (sarilumab)	Tier 3	PA; KP
KEVZARA SUBCUTANEOUS SYRINGE 150 MG/1.14 ML, 200 MG/1.14 ML (sarilumab)	Tier 3	PA; KP
TYENNE AUTOINJECTOR SUBCUTANEOUS PEN INJECTOR 162 MG/0.9 ML (tocilizumab-aazg)	Tier 3	KP
TYENNE SUBCUTANEOUS SYRINGE 162 MG/0.9 ML (tocilizumab-aazg)	Tier 3	KP
Dmard - Janus Kinase (Jak) Inhibitors - Arthritis And Pain Drugs		
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (baricitinib)	Tier 3	PA
RINVOQ LQ ORAL SOLUTION 1 MG/ML (upadacitinib)	Tier 3	PA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG (upadacitinib)	Tier 3	PA
XELJANZ ORAL SOLUTION 1 MG/ML (tofacitinib citrate)	Tier 3	PA
XELJANZ ORAL TABLET 5 MG (tofacitinib citrate)	Tier 3	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG (tofacitinib citrate)	Tier 3	PA
Dmard - Other - Arthritis And Pain Drugs		
AZULFIDINE EN-TABS ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG (sulfasalazine)	Tier 3	
AZULFIDINE ORAL TABLET 500 MG (sulfasalazine)	Tier 3	
CUPRIMINE ORAL CAPSULE 250 MG (penicillamine)	Tier 2	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPEN TITRATABS ORAL TABLET 250 MG (penicillamine)	Tier 2	PA
D-PENAMINE ORAL TABLET 125 MG (penicillamine)	Tier 3	PA
<i>minocycline oral capsule 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>minocycline oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>penicillamine oral capsule 250 mg</i>	Tier 1	PA
<i>penicillamine oral tablet 250 mg</i>	Tier 1	PA
<i>sulfasalazine oral tablet 500 mg</i>	Tier 1	
<i>sulfasalazine oral tablet, delayed release (drlec) 500 mg</i>	Tier 1	
Dmard - Phosphodiesterase-4 (Pde4) Inhibitors - Arthritis And Pain Drugs		
OTEZLA ORAL TABLET 20 MG, 30 MG (apremilast)	Tier 3	PA
OTEZLA STARTER ORAL TABLETS, DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47) (apremilast)	Tier 3	PA
Dmard - Pyrimidine Synthesis Inhibitors - Arthritis And Pain Drugs		
ARAVA ORAL TABLET 10 MG, 20 MG (leflunomide)	Tier 3	
LEFLUNICLO KIT, GEL AND TABLET 20 MG- 1 % (leflunomide/diclofenac sodium)	Tier 3	
<i>leflunomide oral tablet 10 mg, 20 mg</i>	Tier 1	
Immunomodulator - Rho Kinase Inhibitor - Arthritis And Pain Drugs		
REZUROCK ORAL TABLET 200 MG (belumosudil mesylate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Immunomodulator B-Lymphocyte Stimulator (Blys)-Specific Inhibitor Mcab - Arthritis And Pain Drugs		
BENLYSTA SUBCUTANEOUS AUTO-INJECTOR 200 MG/ML (belimumab)	Tier 3	PA; KP
BENLYSTA SUBCUTANEOUS SYRINGE 200 MG/ML (belimumab)	Tier 3	PA; KP
Nsaid Analgesic And Histamine H2 Receptor Antagonist Combinations - Arthritis And Pain Drugs		
<i>ibuprofen-famotidine oral tablet 800-26.6 mg</i>	Tier 3	ST: Requires prior prescription for generic prescription strength ibuprofen 400, 600, or 800mg within the past 120 days; QL (3 EA per 1 day)
Nsaid Analgesic And Non-Salicylate Analgesic Combination - Arthritis And Pain Drugs		
COMBOGESIC ORAL TABLET 97.5-325 MG (ibuprofen/acetaminophen)	Tier 3	
Nsaid Analgesic And Prostaglandin Analog Combinations - Arthritis And Pain Drugs		
ARTHROTEC 50 ORAL TABLET,IR,DELAYED REL,BIPHASIC 50-200 MG-MCG (diclofenac sodium/misoprostol)	Tier 3	
ARTHROTEC 75 ORAL TABLET,IR,DELAYED REL,BIPHASIC 75-200 MG-MCG (diclofenac sodium/misoprostol)	Tier 3	
<i>diclofenac-misoprostol oral tablet,ir,delayed rel,biphasic 50-200 mg-mcg, 75-200 mg-mcg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nsaid Analgesic And Proton Pump Inhibitor Combinations - Arthritis And Pain Drugs		
<i>naproxen-esomeprazole oral tablet,ir,delayed rel,biphasic 375-20 mg, 500-20 mg</i>	Tier 3	ST: Requires prior prescription for generic Naproxen within the past 120 days
Nsaid Analgesic And Topical Irritant Counter-Irritant Combinations - Arthritis And Pain Drugs		
INFLAMMACIN KIT 75 MG- 0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
INFLATHERM(DICLOFENAC-MENTHOL) KIT, GEL AND TABLET DELAY REL 75 MG-3 %- 3 % (diclofenac sodium/menthol/camphor)	Tier 3	
NAPROTIN KIT 500 MG- 0.025 % (naproxen/capsicum oleoresin)	Tier 3	
Nsaid Analgesic, Cyclooxygenase-2 (Cox-2) Selective Inhibitors - Arthritis And Pain Drugs		
CELEBREX ORAL CAPSULE 100 MG, 200 MG, 400 MG, 50 MG (celecoxib)	Tier 3	
<i>celecoxib oral capsule 100 mg, 200 mg, 400 mg, 50 mg</i>	Tier 1	
Nsaid Analgesics (Cox Non-Specific) - Anthranilic Acid Derivatives - Arthritis And Pain Drugs		
<i>meclofenamate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>mefenamic acid oral capsule 250 mg</i>	Tier 1	
Nsaid Analgesics (Cox Non-Specific) - Other - Arthritis And Pain Drugs		
<i>ketorolac injection solution 15 mg/ml, 30 mg/ml (1 ml)</i>	Tier 1	KP
<i>ketorolac injection solution 30 mg/ml</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ketorolac injection syringe 15 mg/ml, 30 mg/ml</i>	Tier 1	KP
<i>ketorolac intramuscular solution 60 mg/2 ml</i>	Tier 1	KP
<i>ketorolac intramuscular syringe 60 mg/2 ml</i>	Tier 1	KP
<i>ketorolac oral tablet 10 mg</i>	Tier 1	QL (20 EA per 5 days)
<i>nabumetone oral tablet 500 mg, 750 mg</i>	Tier 1	
RELAFEN DS ORAL TABLET 1,000 MG (nabumetone)	Tier 3	ST: Requires prior prescription for generic Nabumetone tablets within the past 120 days; QL (2 EA per 1 day); Age (Min 18 Years)
SPRIX NASAL SPRAY, NON-AEROSOL 15.75 MG/SPRAY (ketorolac tromethamine)	Tier 3	ST: Requires prior prescription for a generic nonsteroidal anti-inflammatory drug within the past 120 days; QL (5 EA per 30 days)
<i>sulindac oral tablet 150 mg, 200 mg</i>	Tier 1	
<i>tolmetin oral capsule 400 mg</i>	Tier 1	
<i>tolmetin oral tablet 600 mg</i>	Tier 1	
TORONOVA II SUIK KIT 30 MG/ML (ketorolac/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
TORONOVA SUIK KIT 30 MG/ML (ketorolac/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
Nsaid Analgesics (Cox Non-Specific) - Oxicam Derivatives - Arthritis And Pain Drugs		
FELDENE ORAL CAPSULE 20 MG (piroxicam)	Tier 3	
<i>meloxicam oral suspension 7.5 mg/5 ml</i>	Tier 1	
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>meloxicam submicronized oral capsule 10 mg, 5 mg</i>	Tier 3	ST: Requires prior prescriptions for generic Meloxicam and Diclofenac tablets within the past 365 days; QL (1 EA per 1 day)
<i>piroxicam oral capsule 10 mg, 20 mg</i>	Tier 1	
Nsaid Analgesics (Cox Non-Specific) - Phenylacetic Acid Derivatives - Arthritis And Pain Drugs		
<i>diclofenac potassium oral capsule 25 mg</i>	Tier 3	ST: Requires prior prescription for Diclofenac Sodium within the past 120 days; QL (4 EA per 1 day)
<i>diclofenac potassium oral powder in packet 50 mg</i>	Tier 3	
<i>diclofenac potassium oral tablet 25 mg</i>	Tier 3	QL (8 EA per 1 day)
<i>diclofenac potassium oral tablet 50 mg</i>	Tier 1	
<i>diclofenac sodium oral tablet extended release 24 hr 100 mg</i>	Tier 1	
<i>diclofenac sodium oral tablet, delayed release (drlec) 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>diclofenac submicronized oral capsule 35 mg</i>	Tier 3	ST: Requires prior prescription for Diclofenac Sodium within the past 120 days; QL (3 EA per 1 day)
diclofenac potassium (Lofena Oral Tablet 25 Mg)	Tier 3	QL (8 EA per 1 day)
TRESNI RECTAL SUPPOSITORY 100 MG (diclofenac sodium)	Tier 3	
ZORVOLEX ORAL CAPSULE 18 MG, 35 MG (diclofenac submicronized)	Tier 3	ST: Requires prior prescription for Diclofenac Sodium within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nsaid Analgesics (Cox Non-Specific) - Propionic Acid Derivatives - Arthritis And Pain Drugs		
ANAPROX DS ORAL TABLET 550 MG (naproxen sodium)	Tier 3	
COXANTO ORAL CAPSULE 300 MG (oxaprozin)	Tier 3	
DAYPRO ORAL TABLET 600 MG (oxaprozin)	Tier 3	
EC-NAPROSYN ORAL TABLET,DELAYED RELEASE (DR/EC) 375 MG, 500 MG (naproxen)	Tier 3	
EC-NAPROXEN ORAL TABLET,DELAYED RELEASE (DR/EC) 375 MG, 500 MG (naproxen)	Tier 1	
<i>fenoprofen oral capsule 200 mg, 400 mg</i>	Tier 3	
<i>fenoprofen oral tablet 600 mg</i>	Tier 3	
FENOPRON ORAL CAPSULE 300 MG (fenoprofen calcium)	Tier 3	
<i>flurbiprofen oral tablet 100 mg</i>	Tier 1	
ibuprofen (Ibu Oral Tablet 400 Mg, 600 Mg, 800 Mg)	Tier 1	
IBUPAK ORAL KIT 600 MG (ibuprofen/glycerin)	Tier 3	
<i>ibuprofen oral suspension 100 mg/5 ml</i>	Tier 1	
<i>ibuprofen oral tablet 300 mg</i>	Tier 3	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	Tier 1	
<i>ketoprofen oral capsule 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>ketoprofen oral capsule,ext rel. pellets 24 hr 200 mg</i>	Tier 1	
ketoprofen (Kiprofen Oral Capsule 25 Mg)	Tier 1	
flurbiprofen (Lurbipr Oral Tablet 100 Mg)	Tier 1	
flurbiprofen (Lurbiro Oral Tablet 100 Mg)	Tier 1	
NAPROSYN ORAL TABLET 500 MG (naproxen)	Tier 3	
<i>naproxen oral suspension 125 mg/5 ml</i>	Tier 3	
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>naproxen oral tablet, delayed release (drlec) 375 mg, 500 mg</i>	Tier 1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	Tier 1	
<i>naproxen sodium oral tablet, er multiphase 24 hr 375 mg, 500 mg, 750 mg</i>	Tier 3	
<i>oxaprozin oral capsule 300 mg</i>	Tier 3	
<i>oxaprozin oral tablet 600 mg</i>	Tier 1	
Nsaid Analgesics (Cyclooxygenase Inhibitors-Non-Selective) - Arthritis And Pain Drugs		
<i>diclofenac potassium oral powder in packet 50 mg</i>	Tier 3	
Nsaid Analgesics, (Cox Non-Specific) - Indole Acetic Acid Derivatives - Arthritis And Pain Drugs		
<i>etodolac oral capsule 200 mg, 300 mg</i>	Tier 1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	Tier 1	
<i>etodolac oral tablet extended release 24 hr 400 mg, 500 mg, 600 mg</i>	Tier 1	
<i>indomethacin oral capsule 25 mg, 50 mg</i>	Tier 1	
<i>indomethacin oral capsule, extended release 75 mg</i>	Tier 1	
<i>indomethacin oral suspension 25 mg/5 ml</i>	Tier 3	
<i>indomethacin rectal suppository 100 mg</i>	Tier 1	
<i>indomethacin rectal suppository 50 mg</i>	Tier 3	
<i>etodolac (Lodine Oral Tablet 400 Mg)</i>	Tier 3	
Salicylate Analgesic And Sedative Combinations - Arthritis And Pain Drugs		
<i>butalbital-aspirin-caffeine oral capsule 50-325-40 mg</i>	Tier 1	
<i>butalbital-aspirin-caffeine oral tablet 50-325-40 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Salicylate Analgesic Combinations - Arthritis And Pain Drugs		
<i>choline,magnesium salicylate oral liquid 500 mg/5 ml</i>	Tier 1	
Salicylate Analgesics - Arthritis And Pain Drugs		
ADULT ASPIRIN REGIMEN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
ADULT LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
ASPIRIN CHILDRENS ORAL TABLET,CHEWABLE 81 MG (aspirin)	PV	
<i>aspirin oral tablet 325 mg</i>	PV	
<i>aspirin oral tablet,chewable 81 mg</i>	PV	
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg</i>	PV	
BAYER ASPIRIN ORAL TABLET 325 MG (aspirin)	PV	
BAYER ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	PV	
BAYER LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
CHILDREN'S ASPIRIN ORAL TABLET,CHEWABLE 81 MG (aspirin)	PV	
<i>diflunisal oral tablet 500 mg</i>	Tier 1	
DISALCID ORAL TABLET 500 MG, 750 MG (salsalate)	Tier 3	
DOLOBID ORAL TABLET 250 MG, 375 MG (diflunisal)	Tier 3	
DURLAZA ORAL CAPSULE,EXTENDED RELEASE 24HR 162.5 MG (aspirin)	Tier 3	PA
ECOTRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	PV	
<i>salsalate oral tablet 500 mg, 750 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ST JOSEPH ASPIRIN ORAL TABLET,CHEWABLE 81 MG (aspirin)	PV	
ST. JOSEPH ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
Anesthetics - Drugs For Pain And Fever		
Anesthetic, Non-Parenteral-Benzodiazepine-Anti-Emetic Combinations - Drugs For Sedation		
MKO (MIDAZOLAM-KETAMINE-ONDAN) SUBLINGUAL TROCHE 3-25-2 MG (midazolam/ketamine HCl/ondansetron HCl)	Tier 1	
General Anesthetic - Inhalant Volatile - Drugs For Sedation		
<i>desflurane inhalation liquid 100 %</i>	Tier 1	
FORANE INHALATION LIQUID 99.9 % (isoflurane)	Tier 3	
<i>isoflurane inhalation liquid 99.9 %</i>	Tier 1	
<i>sevoflurane inhalation liquid 99.97 %</i>	Tier 1	
SUPRANE INHALATION LIQUID 100 % (desflurane)	Tier 3	
isoflurane (Terrell Inhalation Liquid 99.9 %)	Tier 1	
ULTANE INHALATION LIQUID 99.97 % (sevoflurane)	Tier 3	
General Anesthetic - Parenteral, Benzodiazepines - Drugs For Sedation		
<i>midazolam (pf) injection solution 5 mg/ml</i>	Tier 1	KP
<i>midazolam injection solution 5 mg/ml</i>	Tier 1	KP
General Anesthetic Adjuncts - Opioid - Drugs For Sedation		
<i>fentanyl citrate (pf) intravenous patient control.analgesia soln 1,500 mcg/30 ml (50 mcg/ml)</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Local Anesthetic - Amides - Drugs For Sedation		
ACCUCAINE KIT KIT 10 MG/ML (1 %) (lidocaine HCl/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
<i>bupivacaine in nacl(pf) epidural solution 0.125 % (1,250 mcg/ml)</i>	Tier 1	KP
<i>bupivacaine in nacl(pf) epidural syringe 25 mg/10 ml (2.5mg/ml)0.25%</i>	Tier 1	KP
<i>lidocaine hcl laryngotracheal solution 4 %</i>	Tier 1	
LIDOMARK 1-5 KIT 10 MG/ML (1 %) (lidocaine HCl/PF/adhesive bandage)	Tier 3	
LIDOMARK 2-5 KIT 20 MG/ML (2 %) (lidocaine HCl/PF/adhesive bandage)	Tier 3	
MARVONA SUIK (PF) KIT 0.5 % (5 MG/ML) (bupivacaine HCl/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
<i>ropivacaine (pf)-nacl,iso-osm epidural solution 0.2 % (2 mg/ml)</i>	Tier 1	KP
<i>ropivacaine(pf)-0.9 % sodchlor epidural prefilled pump reservoir 0.2 % (2 mg/ml)</i>	Tier 1	KP
<i>ropivacaine(pf)-0.9 % sodchlor epidural solution 0.1 %, 0.15 %, 0.2 %</i>	Tier 1	KP
<i>ropivacaine(pf)-0.9 % sodchlor epidural syringe 100 mg/50 ml (2 mg/ml) 0.2 %</i>	Tier 1	KP
XARACOLL IMPLANT IMPLANT 100 MG (bupivacaine HCl)	Tier 3	KP
Local Anesthetic - Esters - Drugs For Sedation		
CLOROTEKAL (PF) INTRATHECAL SOLUTION 10 MG/ML (1 %) (chlorprocaine HCl/PF)	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Local Anesthetic - Nsaid Combinations - Drugs For Sedation		
ZYNRELEF SURGICAL SITE INSTILLATION SOLUTION,EXTENDED RELEASE 200 MG-6 MG /7 ML, 400 MG-12 MG /14 ML (bupivacaine/meloxicam)	Tier 3	KP
Anorectal Preparations - Rectal Preparations		
Anal Fissure Pain/Treatment Agents - Nitrates - Rectal Preparations		
<i>nitroglycerin rectal ointment 0.4 % (w/w)</i>	Tier 1	
RECTIV RECTAL OINTMENT 0.4 % (W/W) (nitroglycerin)	Tier 3	
Anorectal - Glucocorticoids - Rectal Preparations		
ANUCORT-HC RECTAL SUPPOSITORY 25 MG (hydrocortisone acetate)	Tier 1	
ANUSOL-HC RECTAL SUPPOSITORY 25 MG (hydrocortisone acetate)	Tier 3	
hydrocortisone (Anusol-Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 3	
HEMMOREX-HC RECTAL SUPPOSITORY 25 MG, 30 MG (hydrocortisone acetate)	Tier 3	
<i>hydrocortisone acetate rectal suppository 25 mg, 30 mg</i>	Tier 1	
<i>hydrocortisone acetate topical cream with perineal applicator 2.5 %</i>	Tier 3	
<i>hydrocortisone topical cream with perineal applicator 1 %, 2.5 %</i>	Tier 1	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 % (hydrocortisone acetate)	Tier 3	
hydrocortisone acetate (Proctocort Rectal Suppository 30 Mg)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
hydrocortisone (Procto-Med Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Proctosol Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Proctozone-Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
Anorectal - Hemorrhoidal Rectal Glucocorticoid-Local Anesthetic Comb - Rectal Preparations		
hydrocortisone acetate/pramoxine HCl (Analpram-Hc Rectal Cream 1-1 %)	Tier 3	
ANALPRAM-HC RECTAL CREAM 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	
<i>hydrocortisone-pramoxine rectal cream 1-1 %, 2.5-1 %, 2.5-1 % (4g)</i>	Tier 1	
<i>hydrocortisone-pramoxine rectal suppository 25-18 mg</i>	Tier 3	
<i>lidocaine hcl-hydrocortison ac rectal cream 3-0.5 %</i>	Tier 1	
<i>lidocaine hcl-hydrocortison ac rectal gel 3 %-2.5 % (7 gram)</i>	Tier 1	
<i>lidocaine hcl-hydrocortison ac rectal kit 2 %-2 % (7 gram)</i>	Tier 3	
<i>lidocaine hcl-hydrocortison ac rectal kit 3-0.5 %, 3-1 % (7 gram), 3-2.5 % (7 gram)</i>	Tier 1	
<i>lidocaine-hydrocortisone-aloe rectal gel 2.8-0.55 %</i>	Tier 1	
PROCORT RECTAL CREAM 1.85-1.15 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	
PROCTOFOAM HC RECTAL FOAM 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
ZYPRAM RECTAL KIT, CREAM AND TOWELETTE 2.35-1 % (hydrocortisone acetate/pramoxine HCl/skin cleanser no.16)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidotes And Other Reversal Agents - Drugs For Overdose Or Poisoning		
Antidote - Acetaminophen Poisoning - Drugs For Overdose Or Poisoning		
<i>acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)</i>	Tier 1	
Antidote - Anticholinesterase Agents - Drugs For Overdose Or Poisoning		
<i>pyridostigmine bromide oral tablet extended release 105 mg</i>	Tier 3	
Antidote - Cholinesterase Reactivating Agent - Drugs For Overdose Or Poisoning		
<i>pralidoxime intramuscular pen injector 600 mg/2 ml</i>	Tier 3	KP
Antidote - Cholinesterase Reactivating Agent And Muscarinic Antagonist - Drugs For Overdose Or Poisoning		
DUODOTE INTRAMUSCULAR PEN INJECTOR 600-2.1 MG/2ML-MG/0.7ML (pralidoxime chloride/atropine sulfate)	Tier 3	KP
Antidote - Radioactive Agents - Drugs For Overdose Or Poisoning		
RADIOGARDASE ORAL CAPSULE 0.5 GRAM (prussian blue (insoluble))	Tier 3	
Antidote Others - Drugs For Overdose Or Poisoning		
GALZIN ORAL CAPSULE 25 MG (ZINC), 50 MG (ZINC) (zinc acetate)	Tier 3	
RADIOGARDASE ORAL CAPSULE 0.5 GRAM (prussian blue (insoluble))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Chelating Agents - Copper - Drugs For Overdose Or Poisoning		
CUPRIMINE ORAL CAPSULE 250 MG (penicillamine)	Tier 2	PA
CUVRIOR ORAL TABLET 300 MG (trientine tetrahydrochloride)	Tier 3	PA
DEPEN TITRATABS ORAL TABLET 250 MG (penicillamine)	Tier 2	PA
D-PENAMINE ORAL TABLET 125 MG (penicillamine)	Tier 3	PA
<i>penicillamine oral capsule 250 mg</i>	Tier 1	PA
<i>penicillamine oral tablet 250 mg</i>	Tier 1	PA
SYPRINE ORAL CAPSULE 250 MG (trientine HCl)	Tier 3	PA
<i>trientine oral capsule 250 mg</i>	Tier 3	PA
<i>trientine oral capsule 500 mg</i>	Tier 3	PA
Chelating Agents - Iron - Drugs For Overdose Or Poisoning		
<i>deferasirox oral granules in packet 180 mg, 360 mg, 90 mg</i>	Tier 3	PA
<i>deferasirox oral tablet 180 mg, 360 mg, 90 mg</i>	Tier 3	PA
<i>deferasirox oral tablet, dispersible 125 mg, 250 mg, 500 mg</i>	Tier 3	PA
<i>deferiprone oral tablet 1,000 mg, 500 mg</i>	Tier 3	PA
<i>deferoxamine injection recon soln 2 gram, 500 mg</i>	Tier 1	PA; KP
DESFERAL INJECTION RECON SOLN 500 MG (deferoxamine mesylate)	Tier 3	PA; KP
EXJADE ORAL TABLET, DISPERSIBLE 125 MG, 250 MG, 500 MG (deferasirox)	Tier 3	PA
FERRIPROX (2 TIMES A DAY) ORAL TABLET, MODIFIED RELEASE 1,000 MG (deferiprone)	Tier 3	PA
FERRIPROX ORAL SOLUTION 100 MG/ML (deferiprone)	Tier 3	PA
FERRIPROX ORAL TABLET 1,000 MG, 500 MG (deferiprone)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG (deferiasirox)	Tier 3	PA
JADENU SPRINKLE ORAL GRANULES IN PACKET 180 MG, 360 MG, 90 MG (deferiasirox)	Tier 3	PA
Chelating Agents - Lead Poisoning - Drugs For Overdose Or Poisoning		
CHEMET ORAL CAPSULE 100 MG (succimer)	Tier 3	
Mu-Opioid Receptor Antagonists, Peripherally-Acting - Drugs For Overdose Or Poisoning		
<i>alvimopan oral capsule 12 mg</i>	Tier 1	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (naloxegol oxalate)	Tier 2	QL (1 EA per 1 day)
RELISTOR ORAL TABLET 150 MG (methylnaltrexone bromide)	Tier 3	PA
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6 ML (methylnaltrexone bromide)	Tier 3	PA; KP
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML (methylnaltrexone bromide)	Tier 3	PA; KP
SYMPROIC ORAL TABLET 0.2 MG (naldemedine tosylate)	Tier 2	QL (1 EA per 1 day)
Opioid Reversal Agents - Opioid Antagonists - Drugs For Overdose Or Poisoning		
KLOXXADO NASAL SPRAY, NON-AEROSOL 8 MG/ACTUATION (naloxone HCl)	Tier 2	QL (4 EA per 30 days)
<i>naloxone injection syringe 0.4 mg/ml, 1 mg/ml</i>	Tier 1	KP
<i>naloxone nasal spray, non-aerosol 4 mg/actuation</i>	Tier 1	QL (4 EA per 30 days)
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION (naloxone HCl)	Tier 3	QL (4 EA per 30 days)
OPVEE NASAL SPRAY, NON-AEROSOL 2.7 MG/ACTUATION (nalmefene HCl)	Tier 3	QL (4 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REXTOVY NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION (naloxone HCl)	Tier 3	QL (4 EA per 30 days)
ZIMHI INJECTION SYRINGE 5 MG/0.5 ML (naloxone HCl)	Tier 3	KP; QL (2 ML per 30 days)
Anti-Infective Agents		
Antiretroviral - Capsid Inhibitors		
SUNLENCA ORAL TABLET 300 MG (lenacapavir sodium)	Tier 2	PA
SUNLENCA SUBCUTANEOUS SOLUTION 309 MG/ML (lenacapavir sodium)	Tier 2	PA; KP
YEZTUGO ORAL TABLET 300 MG (lenacapavir sodium)	PV	
YEZTUGO SUBCUTANEOUS SOLUTION 309 MG/ML (lenacapavir sodium)	PV	
Penem Antibiotic Combinations		
ORLYNVAH ORAL TABLET 500-500 MG (sulopenem etzadroxil/probenecid)	Tier 3	QL (2 EA per 1 day)
Anti-Infective Agents - Drugs For Infections		
Aminoglycoside Antibiotic - Antibiotics		
ARIKAYCE INHALATION SUSPENSION FOR NEBULIZATION 590 MG/8.4 ML (amikacin sulfate liposomal with nebulizer accessories)	Tier 3	
<i>neomycin oral tablet 500 mg</i>	Tier 1	
Aminomethylcycline Antibiotics - Antibiotics		
NUZYRA ORAL TABLET 150 MG (omadacycline tosylate)	Tier 3	
Aminopenicillin Antibiotic - Antibiotics		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>amoxicillin oral suspension for reconstitution 125 mg/5 ml, 200 mg/5 ml, 250 mg/5 ml, 400 mg/5 ml</i>	Tier 1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	Tier 1	
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ampicillin oral capsule 500 mg</i>	Tier 1	
MOXATAG ORAL TABLET, ER MULTIPHASE 24 HR 775 MG (amoxicillin)	Tier 3	
Aminopenicillin Antibiotic - Beta-Lactamase Inhibitor Combinations - Antibiotics		
<i>amoxicillin-pot clavulanate oral suspension for reconstitution 200-28.5 mg/5 ml, 250-62.5 mg/5 ml, 400-57 mg/5 ml, 600-42.9 mg/5 ml</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr 1,000-62.5 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet, chewable 200-28.5 mg, 400-57 mg</i>	Tier 1	
AUGMENTIN ES-600 ORAL SUSPENSION FOR RECONSTITUTION 600-42.9 MG/5 ML (amoxicillin/potassium clavulanate)	Tier 3	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML (amoxicillin/potassium clavulanate)	Tier 3	ST: Requires prior prescriptions for a different strength of Augmentin within the past 120 days; QL (150 ML per 30 days)
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 250-62.5 MG/5 ML (amoxicillin/potassium clavulanate)	Tier 3	
AUGMENTIN ORAL TABLET 500-125 MG (amoxicillin/potassium clavulanate)	Tier 3	
AUGMENTIN XR ORAL TABLET EXTENDED RELEASE 12 HR 1,000-62.5 MG (amoxicillin/potassium clavulanate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anthelmintic Agents - Benzimidazole Derivatives - Drugs For Parasites		
<i>albendazole oral tablet 200 mg</i>	Tier 1	
EMVERM ORAL TABLET,CHEWABLE 100 MG (mebendazole)	Tier 2	PA
Anthelmintic Agents - Macrocyclic Lactones - Drugs For Parasites		
<i>ivermectin oral tablet 3 mg, 6 mg</i>	Tier 1	
STROMEKTOL ORAL TABLET 3 MG (ivermectin)	Tier 3	
Anthelmintic Agents Other - Drugs For Parasites		
BILTRICIDE ORAL TABLET 600 MG (praziquantel)	Tier 3	
<i>praziquantel oral tablet 600 mg</i>	Tier 1	
Antibacterial Folate Antagonist - Other Combinations - Antibiotics		
BACTRIM DS ORAL TABLET 800-160 MG (sulfamethoxazole/trimethoprim)	Tier 3	
BACTRIM ORAL TABLET 400-80 MG (sulfamethoxazole/trimethoprim)	Tier 3	
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5 ml</i>	Tier 1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	Tier 1	
SULFATRIM ORAL SUSPENSION 200-40 MG/5 ML (sulfamethoxazole/trimethoprim)	Tier 1	
Antibacterial Folate Antagonist Others - Antibiotics		
PRIMSOL ORAL SOLUTION 50 MG/5 ML (trimethoprim)	Tier 2	
<i>trimethoprim oral tablet 100 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antibacterial Nitrofurantoin Derivatives - Antibiotics		
FURADANTIN ORAL SUSPENSION 25 MG/5 ML (nitrofurantoin)	Tier 3	PA
MACROBID ORAL CAPSULE 100 MG (nitrofurantoin monohydrate/macrocrystals)	Tier 3	
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>nitrofurantoin monohydrate-cryst oral capsule 100 mg</i>	Tier 1	
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	Tier 1	PA
<i>nitrofurantoin oral suspension 50 mg/5 ml</i>	Tier 3	
Antibacterial Other - Antibiotics		
<i>fosfomycin tromethamine oral packet 3 gram</i>	Tier 1	
MONUROL ORAL PACKET 3 GRAM (fosfomycin tromethamine)	Tier 3	
Antifungal - Allylamines - Drugs For Fungus		
<i>terbinafine hcl oral tablet 250 mg</i>	Tier 1	
Antifungal - Amphoteric Polyene Macrolides - Drugs For Fungus		
<i>nystatin oral tablet 500,000 unit</i>	Tier 1	
Antifungal - Fluorinated Pyrimidine-Type Agents - Drugs For Fungus		
ANCOBON ORAL CAPSULE 250 MG, 500 MG (flucytosine)	Tier 3	
<i>flucytosine oral capsule 250 mg, 500 mg</i>	Tier 1	
Antifungal - Glucan Synthesis Inhibitor, Triterpenoid - Antibiotics		
BREXAFEMME ORAL TABLET 150 MG (ibrexafungerp citrate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antifungal - Glucan Synthesis Inhibitors - Antibiotics		
BREXAFEMME ORAL TABLET 150 MG (ibrexafungerp citrate)	Tier 3	PA
Antifungal - Imidazoles - Drugs For Fungus		
<i>ketokonazole oral tablet 200 mg</i>	Tier 1	
ORAVIG BUCCAL MUCO-ADHESIVE BUCCAL TABLET 50 MG (miconazole)	Tier 3	
Antifungal - Tetrazoles - Drugs For Fungus		
VIVJOA ORAL CAPSULE 150 MG (oteseconazole)	Tier 3	PA
Antifungal - Triazoles - Drugs For Fungus		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (isavuconazonium sulfate)	Tier 3	PA
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML (fluconazole)	Tier 3	
DIFLUCAN ORAL TABLET 100 MG (fluconazole)	Tier 3	
<i>fluconazole oral suspension for reconstitution 10 mg/ml, 40 mg/ml</i>	Tier 1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Tier 1	
<i>itraconazole oral capsule 100 mg</i>	Tier 1	
<i>itraconazole oral solution 10 mg/ml</i>	Tier 1	
NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON 300 MG (posaconazole)	Tier 3	PA
NOXAFIL ORAL SUSPENSION 200 MG/5 ML (40 MG/ML) (posaconazole)	Tier 3	PA
NOXAFIL ORAL TABLET,DELAYED RELEASE (DR/EC) 100 MG (posaconazole)	Tier 3	PA
<i>posaconazole oral suspension 200 mg/5 ml (40 mg/ml)</i>	Tier 1	PA
<i>posaconazole oral tablet, delayed release (dr/ec) 100 mg</i>	Tier 1	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPORANOX ORAL CAPSULE 100 MG (itraconazole)	Tier 3	
SPORANOX ORAL SOLUTION 10 MG/ML (itraconazole)	Tier 3	
TOLSURA ORAL CAPSULE, SOLID DISPERSION 65 MG (itraconazole)	Tier 3	PA
VFEND ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML (40 MG/ML) (voriconazole)	Tier 3	
VFEND ORAL TABLET 50 MG (voriconazole)	Tier 3	
<i>voriconazole oral suspension for reconstitution 200 mg/5 ml (40 mg/ml)</i>	Tier 1	
<i>voriconazole oral tablet 200 mg, 50 mg</i>	Tier 1	
Antifungal Other - Drugs For Fungus		
griseofulvin ultramicrosize (Fulvicin P/G Oral Tablet 165 Mg)	Tier 3	
<i>griseofulvin microsize oral suspension 125 mg/5 ml</i>	Tier 1	
<i>griseofulvin microsize oral tablet 500 mg</i>	Tier 1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	Tier 1	
<i>griseofulvin ultramicrosize oral tablet 165 mg</i>	Tier 3	
Anti-Infective Immunologic Adjuvants - Interferons - Drugs For Infections		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5 ML (interferon gamma-1b, recomb.)	Tier 3	PA; KP
Antileprotic - Immunomodulators - Antibiotics		
THALOMID ORAL CAPSULE 100 MG, 50 MG (thalidomide)	Tier 2	PA
Antileprotic - Sulfone Agents - Antibiotics		
<i>dapsone oral tablet 100 mg, 25 mg</i>	Tier 1	
Antimalarial Combinations - Drugs For Parasites		
<i>atovaquone-proguanil oral tablet 250-100 mg, 62.5-25 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COARTEM ORAL TABLET 20-120 MG (artemether/lumefantrine)	Tier 3	
MALARONE ORAL TABLET 250-100 MG (atovaquone/proguanil HCl)	Tier 3	
MALARONE PEDIATRIC ORAL TABLET 62.5-25 MG (atovaquone/proguanil HCl)	Tier 3	
Antimalarials - Drugs For Parasites		
ARAKODA ORAL TABLET 100 MG (tafenoquine succinate)	Tier 3	
<i>chloroquine phosphate oral tablet 250 mg</i>	Tier 1	QL (36 EA per 16 days)
<i>chloroquine phosphate oral tablet 500 mg</i>	Tier 1	QL (18 EA per 16 days)
DARAPRIM ORAL TABLET 25 MG (pyrimethamine)	Tier 3	PA
<i>hydroxychloroquine oral tablet 100 mg</i>	Tier 1	QL (180 EA per 30 days)
<i>hydroxychloroquine oral tablet 200 mg</i>	Tier 1	QL (100 EA per 30 days)
<i>hydroxychloroquine oral tablet 300 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>hydroxychloroquine oral tablet 400 mg</i>	Tier 1	QL (60 EA per 30 days)
KRINTAFEL ORAL TABLET 150 MG (tafenoquine succinate)	Tier 2	QL (2 EA per 1 FILL)
<i>mefloquine oral tablet 250 mg</i>	Tier 1	
PLAQUENIL ORAL TABLET 200 MG (hydroxychloroquine sulfate)	Tier 3	QL (100 EA per 30 days)
<i>primaquine oral tablet 26.3 mg (15 mg base)</i>	Tier 2	
<i>pyrimethamine oral tablet 25 mg</i>	Tier 3	PA
QUALAQUIN ORAL CAPSULE 324 MG (quinine sulfate)	Tier 3	
<i>quinine sulfate oral capsule 324 mg</i>	Tier 1	
SOVUNA ORAL TABLET 200 MG (hydroxychloroquine sulfate)	Tier 2	QL (100 EA per 30 days)
SOVUNA ORAL TABLET 300 MG (hydroxychloroquine sulfate)	Tier 3	QL (60 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiprotozoal Agents - Nitrofuran Derivatives - Drugs For Parasites		
LAMPIT ORAL TABLET 120 MG, 30 MG (nifurtimox)	Tier 3	
Antiprotozoal Agents - Nitroimidazole Derivatives - Drugs For Parasites		
<i>benznidazole oral tablet 100 mg, 12.5 mg</i>	Tier 1	
Antiprotozoal Agents - Other - Drugs For Parasites		
<i>atovaquone oral suspension 750 mg/5 ml</i>	Tier 1	
IMPAVIDO ORAL CAPSULE 50 MG (miltefosine)	Tier 2	PA
MEPRON ORAL SUSPENSION 750 MG/5 ML (atovaquone)	Tier 3	
Antiprotozoal Agents (Antiparasitic) - 5-Nitrothiazolyl Derivatives - Drugs For Parasites		
ALINIA ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML (nitazoxanide)	Tier 3	QL (50 ML per 1 day)
ALINIA ORAL TABLET 500 MG (nitazoxanide)	Tier 3	QL (2 EA per 1 day)
<i>nitazoxanide oral tablet 500 mg</i>	Tier 1	QL (2 EA per 1 day)
Antiprotozoal-Antibacterial 1St Generation 2-Methyl-5-Nitroimidazole - Drugs For Infections		
LIKMEZ ORAL SUSPENSION 500 MG/5 ML (metronidazole)	Tier 3	
<i>metronidazole oral capsule 375 mg</i>	Tier 1	
<i>metronidazole oral tablet 125 mg</i>	Tier 3	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiprotozoal-Antibacterial 2Nd Generation 2-Methyl-5-Nitroimidazole - Drugs For Infections		
SOLOSEC ORAL GRANULES DEL RELEASE IN PACKET 2 GRAM (secnidazole)	Tier 3	ST: At least 2 prior prescriptions for Clindamycin, vaginal Clindamycin cream, oral Metronidazole, vaginal Metronidazole gel, or Tinidazole within the past 365 days; QL (1 EA per 30 days)
<i>tinidazole oral tablet 250 mg, 500 mg</i>	Tier 1	
Antiretroviral - Ccr5 Co-Receptor Antagonist - Drugs For Viral Infections		
<i>maraviroc oral tablet 150 mg, 300 mg</i>	Tier 1	
SELZENTRY ORAL SOLUTION 20 MG/ML (maraviroc)	Tier 2	
SELZENTRY ORAL TABLET 150 MG, 300 MG (maraviroc)	Tier 3	
Antiretroviral - Cd4 Attachment Inhibitors - Drugs For Viral Infections		
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HR 600 MG (fostemsavir tromethamine)	Tier 2	PA
Antiretroviral - Hiv-1 Fusion Inhibitors - Drugs For Viral Infections		
FUZEON SUBCUTANEOUS RECON SOLN 90 MG (enfuvirtide)	Tier 2	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretroviral - Hiv-1 Integrase Strand Transfer Inhibitors - Drugs For Viral Infections		
APRETUDE INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 600 MG/3 ML (200 MG/ML) (cabotegravir)	Tier 2	\$0 COPAY IF QUANTITY 0.15 IN 1 DAY, FILL OF 7 IN 365 DAYS, AND NO HISTORY OF ANTIRETROVIRAL MEDICATION IN 120 DAYS; Age (Min 12 Years)
ISENTRESS HD ORAL TABLET 600 MG (raltegravir potassium)	Tier 2	
ISENTRESS ORAL POWDER IN PACKET 100 MG (raltegravir potassium)	Tier 2	
ISENTRESS ORAL TABLET 400 MG (raltegravir potassium)	Tier 2	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG, 25 MG (raltegravir potassium)	Tier 2	
TIVICAY ORAL TABLET 50 MG (dolutegravir sodium)	Tier 2	
TIVICAY PD ORAL TABLET FOR SUSPENSION 5 MG (dolutegravir sodium)	Tier 2	
Antiretroviral - Integrase Inhibitor And Nrti Combinations - Drugs For Viral Infections		
JULUCA ORAL TABLET 50-25 MG (dolutegravir sodium/rilpivirine HCl)	Tier 2	
Antiretroviral - Integrase Inhibitor And Nrti Combinations - Drugs For Viral Infections		
DOVATO ORAL TABLET 50-300 MG (dolutegravir sodium/lamivudine)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretroviral - Non-Nucleoside Reverse Transcriptase Inhib (Nnrti) - Drugs For Viral Infections		
EDURANT ORAL TABLET 25 MG (rilpivirine HCl)	Tier 2	
EDURANT PED ORAL TABLET FOR SUSPENSION 2.5 MG (rilpivirine HCl)	Tier 2	
<i>efavirenz oral tablet 600 mg</i>	Tier 1	
<i>etravirine oral tablet 100 mg, 200 mg</i>	Tier 1	
INTELENCE ORAL TABLET 100 MG, 200 MG (etravirine)	Tier 3	
INTELENCE ORAL TABLET 25 MG (etravirine)	Tier 2	
<i>nevirapine oral suspension 50 mg/5 ml</i>	Tier 1	
<i>nevirapine oral tablet 200 mg</i>	Tier 1	
<i>nevirapine oral tablet extended release 24 hr 100 mg, 400 mg</i>	Tier 1	
PIFELTRO ORAL TABLET 100 MG (doravirine)	Tier 3	
Antiretroviral - Nucleoside And Nucleotide Analog Rtis Combinations - Drugs For Viral Infections		
CIMDUO ORAL TABLET 300-300 MG (lamivudine/tenofovir disoproxil fumarate)	Tier 2	
DESCOVY ORAL TABLET 120-15 MG (emtricitabine/tenofovir alafenamide fumarate)	Tier 2	
DESCOVY ORAL TABLET 200-25 MG (emtricitabine/tenofovir alafenamide fumarate)	Tier 2	\$0 COPAY IF QUANTITY 1 IN 1 DAY AND AND NO HISTORY OF ANTIRETROVIRAL MEDICATION IN 120 DAYS
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY AND AND NO HISTORY OF ANTIRETROVIRAL MEDICATION IN 120 DAYS
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG, 200-300 MG (emtricitabine/tenofovir disoproxil fumarate)	Tier 3	
Antiretroviral - Nucleoside Reverse Transcriptase Inhibitors (Nrti) - Drugs For Viral Infections		
<i>abacavir oral solution 20 mg/ml</i>	Tier 1	
<i>abacavir oral tablet 300 mg</i>	Tier 1	
<i>emtricitabine oral capsule 200 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY AND AND NO HISTORY OF ANTIRETROVIRAL MEDICATION IN 120 DAYS
EMTRIVA ORAL CAPSULE 200 MG (emtricitabine)	Tier 3	
EMTRIVA ORAL SOLUTION 10 MG/ML (emtricitabine)	Tier 2	
EPIVIR ORAL SOLUTION 10 MG/ML (lamivudine)	Tier 3	
EPIVIR ORAL TABLET 150 MG, 300 MG (lamivudine)	Tier 3	
<i>lamivudine oral solution 10 mg/ml</i>	Tier 1	
<i>lamivudine oral tablet 150 mg, 300 mg</i>	Tier 1	
RETROVIR ORAL CAPSULE 100 MG (zidovudine)	Tier 3	
RETROVIR ORAL SYRUP 10 MG/ML (zidovudine)	Tier 3	
<i>stavudine oral capsule 15 mg, 20 mg</i>	Tier 1	
ZIAGEN ORAL SOLUTION 20 MG/ML (abacavir sulfate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zidovudine oral capsule 100 mg</i>	Tier 1	
<i>zidovudine oral syrup 10 mg/ml</i>	Tier 1	
<i>zidovudine oral tablet 300 mg</i>	Tier 1	
Antiretroviral - Nucleotide Analog Reverse Transcriptase Inhibitors - Drugs For Viral Infections		
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY AND AND NO HISTORY OF ANTIRETROVIRAL MEDICATION IN 120 DAYS
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM) (tenofovir disoproxil fumarate)	Tier 2	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (tenofovir disoproxil fumarate)	Tier 2	
VIREAD ORAL TABLET 300 MG (tenofovir disoproxil fumarate)	Tier 3	
Antiretroviral Combinations - Protease Inhibitors - Drugs For Viral Infections		
EVOTAZ ORAL TABLET 300-150 MG (atazanavir sulfate/cobicistat)	Tier 2	
KALETRA ORAL SOLUTION 400-100 MG/5 ML (lopinavir/ritonavir)	Tier 3	
KALETRA ORAL TABLET 100-25 MG, 200-50 MG (lopinavir/ritonavir)	Tier 3	
<i>lopinavir-ritonavir oral tablet 100-25 mg, 200-50 mg</i>	Tier 1	
PREZCOBIX ORAL TABLET 675-150 MG (darunavir ethanolate/cobicistat)	Tier 3	QL (1 EA per 1 day)
PREZCOBIX ORAL TABLET 800-150 MG-MG (darunavir ethanolate/cobicistat)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretroviral- Nucleoside And Nucleotide Analogs, Protease Inhibitors - Drugs For Viral Infections		
SYMTUZA ORAL TABLET 800-150-200-10 MG (darunavir eth/cobicistat/emtricitabine/tenofovir alafenamide)	Tier 2	
Antiretroviral-Integrase Inhibitor, Nucleoside And Nucleotide Rti's Comb - Drugs For Viral Infections		
BIKTARVY ORAL TABLET 30-120-15 MG, 50-200-25 MG (bictegravir sodium/emtricitabine/tenofovir alafenamide fumar)	Tier 2	
GENVOYA ORAL TABLET 150-150-200-10 MG (elvitegravir/cobicistat/emtricitabine/tenofovir alafenamide)	Tier 2	
STRIBILD ORAL TABLET 150-150-200-300 MG (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil)	Tier 2	
Antiretroviral-Nucleoside Analogs And Integrase Inhibitor Combinations - Drugs For Viral Infections		
TRIUMEQ ORAL TABLET 600-50-300 MG (abacavir sulfate/dolutegravir sodium/lamivudine)	Tier 2	
TRIUMEQ PD ORAL TABLET FOR SUSPENSION 60-5-30 MG (abacavir sulfate/dolutegravir sodium/lamivudine)	Tier 2	
Antiretroviral-Nucleoside Reverse Transcriptase Inhibitors (Nrti) Comb - Drugs For Viral Infections		
<i>abacavir-lamivudine oral tablet 600-300 mg</i>	Tier 1	
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiretroviral-Nucleoside, Nucleotide Analogs And Non-Nucleoside Rti - Drugs For Viral Infections		
COMPLERA ORAL TABLET 200-25-300 MG (emtricitabine/rilpivirine HCl/tenofovir disoproxil fumarate)	Tier 3	
DELSTRIGO ORAL TABLET 100-300-300 MG (doravirine/lamivudine/tenofovir disoproxil fumarate)	Tier 3	
<i>efavirenz-emtricitabin-tenofov oral tablet 600-200-300 mg</i>	Tier 1	
<i>efavirenz-lamivu-tenofov disop oral tablet 400-300-300 mg, 600-300-300 mg</i>	Tier 1	
<i>emtricit-a-rilpivirine-tenof df oral tablet 200-25-300 mg</i>	Tier 1	
ODEFSEY ORAL TABLET 200-25-25 MG (emtricitabine/rilpivirine HCl/tenofovir alafenamide fumarate)	Tier 2	
SYMFI LO ORAL TABLET 400-300-300 MG (efavirenz/lamivudine/tenofovir disoproxil fumarate)	Tier 3	
SYMFI ORAL TABLET 600-300-300 MG (efavirenz/lamivudine/tenofovir disoproxil fumarate)	Tier 3	
Antitubercular - Aminobenzoic Acid Analogs - Antibiotics		
PASER ORAL GRANULES DR FOR SUSP IN PACKET 4 GRAM (aminosalicylic acid)	Tier 3	
Antitubercular - D-Alanine Analogs - Antibiotics		
<i>cycloserine oral capsule 250 mg</i>	Tier 1	
Antitubercular - Diarylquinoline Antibiotics - Antibiotics		
SIRTURO ORAL TABLET 100 MG, 20 MG (bedaquiline fumarate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antitubercular - Isonicotinic Acid Derivatives - Antibiotics		
<i>isoniazid oral solution 50 mg/5 ml</i>	Tier 1	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	Tier 1	
Antitubercular - Niacinamide Derivatives - Antibiotics		
<i>pyrazinamide oral tablet 500 mg</i>	Tier 1	
Antitubercular - Nitroimidazole Derivatives - Antibiotics		
<i>pretomanid oral tablet 200 mg</i>	Tier 3	QL (1 EA per 1 day)
Antitubercular - Rifamycin And Derivatives - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (rifapentine)	Tier 3	
<i>rifabutin oral capsule 150 mg</i>	Tier 1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	Tier 1	
Antitubercular Agents Other - Antibiotics		
<i>ethambutol oral tablet 100 mg, 400 mg</i>	Tier 1	
TRECATOR ORAL TABLET 250 MG (ethionamide)	Tier 3	
Cephalosporin Antibiotics - 1st Generation - Antibiotics		
<i>cefadroxil oral capsule 500 mg</i>	Tier 1	
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	Tier 1	
<i>cefadroxil oral tablet 1 gram</i>	Tier 1	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>cephalexin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cephalosporin Antibiotics - 2Nd Generation - Antibiotics		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml, 375 mg/5 ml</i>	Tier 1	
<i>cefaclor oral tablet extended release 12 hr 500 mg</i>	Tier 1	
<i>cefprozil oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>cefprozil oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	Tier 1	
Cephalosporin Antibiotics - 3Rd Generation - Antibiotics		
<i>cefdinir oral capsule 300 mg</i>	Tier 1	
<i>cefdinir oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>cefixime oral capsule 400 mg</i>	Tier 1	
<i>cefixime oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	Tier 1	
<i>cefpodoxime oral suspension for reconstitution 100 mg/5 ml, 50 mg/5 ml</i>	Tier 1	
<i>cefpodoxime oral tablet 100 mg, 200 mg</i>	Tier 1	
SPECTRACEF ORAL TABLET 400 MG (cefditoren pivoxil)	Tier 3	
SUPRAX ORAL CAPSULE 400 MG (cefixime)	Tier 3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML (cefixime)	Tier 3	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML (cefixime)	Tier 2	
SUPRAX ORAL TABLET,CHEWABLE 100 MG, 200 MG (cefixime)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cmv Antiviral Agent - Nucleoside Analogs - Drugs For Viral Infections		
VALCYTE ORAL RECON SOLN 50 MG/ML (valganciclovir HCl)	Tier 3	
VALCYTE ORAL TABLET 450 MG (valganciclovir HCl)	Tier 3	
<i>valganciclovir oral recon soln 50 mg/ml</i>	Tier 1	
<i>valganciclovir oral tablet 450 mg</i>	Tier 1	
Cmv Antiviral Agent - Protein Kinase Inhibitors - Drugs For Viral Infections		
LIVTENCITY ORAL TABLET 200 MG (maribavir)	Tier 3	PA
Cmv Antiviral Agent - Terminase Complex Inhibitors - Drugs For Viral Infections		
PREVYMIS ORAL PELLETS IN PACKET 120 MG, 20 MG (letermovir)	Tier 3	PA
PREVYMIS ORAL TABLET 240 MG, 480 MG (letermovir)	Tier 3	PA
Fluoroquinolone Antibiotics - Antibiotics		
BAXDELA ORAL TABLET 450 MG (delafloxacin meglumine)	Tier 3	
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON 250 MG/5 ML, 500 MG/5 ML (ciprofloxacin)	Tier 2	
CIPRO ORAL TABLET 250 MG, 500 MG (ciprofloxacin HCl)	Tier 3	
<i>ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>ciprofloxacin oral suspension,microcapsule recon 250 mg/5 ml, 500 mg/5 ml</i>	Tier 1	
<i>levofloxacin oral solution 250 mg/10 ml</i>	Tier 1	
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>moxifloxacin oral tablet 400 mg</i>	Tier 1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Glycopeptide Antibiotics - Antibiotics		
FIRVANQ ORAL RECON SOLN 25 MG/ML (vancomycin HCl)	Tier 3	QL (300 ML per 1 FILL)
FIRVANQ ORAL RECON SOLN 50 MG/ML (vancomycin HCl)	Tier 3	QL (600 ML per 1 FILL)
VANOCIN ORAL CAPSULE 125 MG (vancomycin HCl)	Tier 3	QL (56 EA per 1 FILL)
VANOCIN ORAL CAPSULE 250 MG (vancomycin HCl)	Tier 3	QL (112 EA per 1 FILL)
<i>vancomycin oral capsule 125 mg</i>	Tier 1	QL (56 EA per 1 FILL)
<i>vancomycin oral capsule 250 mg</i>	Tier 1	QL (112 EA per 1 FILL)
<i>vancomycin oral recon soln 25 mg/ml</i>	Tier 1	QL (300 ML per 1 FILL)
<i>vancomycin oral recon soln 50 mg/ml</i>	Tier 1	QL (600 ML per 1 FILL)
Hepatitis B Treatment- Nucleoside Analogs (Antiviral) - Drugs For Viral Infections		
BARACLUDE ORAL SOLUTION 0.05 MG/ML (entecavir)	Tier 2	QL (630 ML per 30 days)
BARACLUDE ORAL TABLET 0.5 MG, 1 MG (entecavir)	Tier 2	QL (1 EA per 1 day)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>lamivudine oral tablet 100 mg</i>	Tier 1	QL (1 EA per 1 day)
Hepatitis B Treatment- Nucleotide Analogs (Antiviral) - Drugs For Viral Infections		
<i>adefovir oral tablet 10 mg</i>	Tier 1	QL (1 EA per 1 day)
HEPSERA ORAL TABLET 10 MG (adefovir dipivoxil)	Tier 2	QL (1 EA per 1 day)
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY AND AND NO HISTORY OF ANTIRETROVIRAL MEDICATION IN 120 DAYS
VEMLIDY ORAL TABLET 25 MG (tenofovir alafenamide)	Tier 2	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIREAD ORAL POWDER 40 MG/SCOOP (40 MG/GRAM) (tenofovir disoproxil fumarate)	Tier 2	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (tenofovir disoproxil fumarate)	Tier 2	
VIREAD ORAL TABLET 300 MG (tenofovir disoproxil fumarate)	Tier 3	
Hepatitis C - Interferons - Drugs For Viral Infections		
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (peginterferon alfa-2a)	Tier 2	PA
PEGASYS SUBCUTANEOUS SYRINGE 180 MCG/0.5 ML (peginterferon alfa-2a)	Tier 2	PA
Hepatitis C - Ns5a Inhibitor And Ns3/4A Protease Inhibitor Combination - Drugs For Viral Infections		
MAVYRET ORAL PELLETS IN PACKET 50-20 MG (glecaprevir/pibrentasvir)	Tier 3	PA
MAVYRET ORAL TABLET 100-40 MG (glecaprevir/pibrentasvir)	Tier 3	PA
ZEPATIER ORAL TABLET 50-100 MG (elbasvir/grazoprevir)	Tier 3	PA
Hepatitis C - Ns5a, Ns3/4A Protease, Nucleo.Ns5b Polymerase Inhib Comb - Drugs For Viral Infections		
VOSEVI ORAL TABLET 400-100-100 MG (sofosbuvir/velpatasvir/voxilaprevir)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hepatitis C - Ns5b Polymerase And Ns5a Inhibitor Combinations - Drugs For Viral Infections		
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG (sofosbuvir/velpatasvir)	Tier 2	PA
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG (sofosbuvir/velpatasvir)	Tier 2	PA
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG (ledipasvir/sofosbuvir)	Tier 2	PA
HARVONI ORAL TABLET 45-200 MG, 90-400 MG (ledipasvir/sofosbuvir)	Tier 2	PA
Hepatitis C - Nucleos(T)ide Analog Ns5b Polymerase Inhibitors - Drugs For Viral Infections		
SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG (sofosbuvir)	Tier 3	PA
SOVALDI ORAL TABLET 200 MG, 400 MG (sofosbuvir)	Tier 3	PA
Hepatitis C - Nucleoside Analogs - Drugs For Viral Infections		
<i>ribavirin oral capsule 200 mg</i>	Tier 1	
<i>ribavirin oral tablet 200 mg</i>	Tier 1	
Hepatitis C- Ns5a, Ns3/4A Protease And Non-Nucleo.Ns5b Poly Inh. Comb - Drugs For Viral Infections		
VIEKIRA PAK ORAL TABLETS,DOSE PACK 12.5 MG-75 MG -50 MG/250 MG (ombitasvir/paritaprevir/ritonavir/dasabuvir sodium)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Herpes Antiviral Agent - Purine Analogs - Drugs For Viral Infections		
<i>acyclovir oral capsule 200 mg</i>	Tier 1	
<i>acyclovir oral suspension 200 mg/5 ml</i>	Tier 1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	Tier 1	
<i>valacyclovir oral tablet 1 gram, 500 mg</i>	Tier 1	
VALTREX ORAL TABLET 1 GRAM, 500 MG (valacyclovir HCl)	Tier 3	
ZOVIRAX ORAL SUSPENSION 200 MG/5 ML (acyclovir)	Tier 3	
Herpes Antiviral Agent - Thymidine Analogs - Drugs For Viral Infections		
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	Tier 1	
Influenza Antiviral Agents - Neuraminidase Inhibitors - Drugs For Viral Infections		
<i>oseltamivir oral capsule 30 mg</i>	Tier 1	QL (40 EA per 180 days)
<i>oseltamivir oral capsule 45 mg, 75 mg</i>	Tier 1	QL (20 EA per 180 days)
<i>oseltamivir oral suspension for reconstitution 6 mg/ml</i>	Tier 1	QL (360 ML per 180 days)
RELENZA DISKHALER INHALATION BLISTER WITH DEVICE 5 MG/ACTUATION (zanamivir)	Tier 3	QL (40 EA per 180 days)
TAMIFLU ORAL CAPSULE 30 MG (oseltamivir phosphate)	Tier 3	QL (40 EA per 180 days)
TAMIFLU ORAL CAPSULE 45 MG, 75 MG (oseltamivir phosphate)	Tier 3	QL (20 EA per 180 days)
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION 6 MG/ML (oseltamivir phosphate)	Tier 3	QL (360 ML per 180 days)
Influenza Antiviral Agents - Pa Endonuclease Inhibitor - Drugs For Viral Infections		
XOFLUZA ORAL TABLET 40 MG (baloxavir marboxil)	Tier 2	QL (4 EA per 180 days)
XOFLUZA ORAL TABLET 80 MG (baloxavir marboxil)	Tier 2	QL (2 EA per 180 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Influenza-A Antiviral Agents - Drugs For Viral Infections		
<i>rimantadine oral tablet 100 mg</i>	Tier 3	
Lincosamide Antibiotics - Antibiotics		
CLEOCIN HCL ORAL CAPSULE 150 MG, 300 MG, 75 MG (clindamycin HCl)	Tier 3	
clindamycin palmitate HCl (Cleocin Pediatric Oral Recon Soln 75 Mg/5 MI)	Tier 3	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	Tier 1	
<i>clindamycin palmitate hcl oral recon soln 75 mg/5 ml</i>	Tier 1	
clindamycin palmitate HCl (Clindamycin Pediatric Oral Recon Soln 75 Mg/5 MI)	Tier 1	
Macrolide Antibiotics - Antibiotics		
<i>azithromycin oral packet 1 gram</i>	Tier 1	
<i>azithromycin oral suspension for reconstitution 100 mg/5 ml, 200 mg/5 ml</i>	Tier 1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	Tier 1	
<i>clarithromycin oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>clarithromycin oral tablet extended release 24 hr 500 mg</i>	Tier 1	
DIFICID ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML (fidaxomicin)	Tier 2	QL (10 ML per 1 day)
DIFICID ORAL TABLET 200 MG (fidaxomicin)	Tier 1	QL (20 EA per 10 days)
erythromycin ethylsuccinate (E.E.S. 400 Oral Tablet 400 Mg)	Tier 1	
ERYPED 400 ORAL SUSPENSION FOR RECONSTITUTION 400 MG/5 ML (erythromycin ethylsuccinate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
erythromycin base (Ery-Tab Oral Tablet,Delayed Release (Dr/Ec) 250 Mg, 500 Mg)	Tier 1	
erythromycin base (Ery-Tab Oral Tablet,Delayed Release (Dr/Ec) 333 Mg)	Tier 3	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG (erythromycin stearate)	Tier 1	
<i>erythromycin ethylsuccinate oral suspension for reconstitution 200 mg/5 ml, 400 mg/5 ml</i>	Tier 1	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	Tier 1	
<i>erythromycin oral capsule, delayed release(dr/ec) 250 mg</i>	Tier 1	
<i>erythromycin oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>erythromycin oral tablet, delayed release (dr/ec) 250 mg, 333 mg, 500 mg</i>	Tier 1	
<i>fidaxomicin oral tablet 200 mg</i>	Tier 1	QL (20 EA per 10 days)
ZITHROMAX ORAL PACKET 1 GRAM (azithromycin)	Tier 3	
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML, 200 MG/5 ML (azithromycin)	Tier 3	
ZITHROMAX ORAL TABLET 250 MG, 500 MG (azithromycin)	Tier 3	
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (azithromycin)	Tier 3	
ZITHROMAX Z-PAK ORAL TABLET 250 MG (azithromycin)	Tier 3	
Misc Anti-Infective - Drugs For Infections		
<i>methenamine hippurate oral tablet 1 gram</i>	Tier 1	
<i>methenamine mandelate oral tablet 0.5 gram, 1 gram</i>	Tier 1	
NEBUPENT INHALATION RECON SOLN 300 MG (pentamidine isethionate)	Tier 3	
<i>pentamidine inhalation recon soln 300 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UROQID-ACID NO.2 ORAL TABLET 500-500 MG (methenamine mandelate/sodium phosphate,monobasic)	Tier 3	
Misc Anti-Infective Combinations - Drugs For Infections		
<i>methen-sod phos-meth blue-hyos oral tablet 81.6-40.8-0.12 mg</i>	Tier 1	
URELLE ORAL TABLET 81-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URETRON D-S ORAL TABLET 81.6-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 2	
URIBEL TABS ORAL TABLET 81.6-0.12-10.8 MG (methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin)	Tier 3	
URIMAR-T ORAL CAPSULE 120-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URIMAR-T ORAL TABLET 120-10.8-0.12 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URNEVA ORAL CAPSULE 120-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
UROGESIC-BLUE ORAL TABLET 81.6-40.8-0.12 MG (methenamine/sod phosph,monobasic/methylene blue/hyoscyamine)	Tier 1	
URO-MP ORAL CAPSULE 118-10-40.8-36 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URO-SP ORAL CAPSULE 118-10-40.8-36 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URL ORAL TABLET 81.6-40.8-0.12 MG (methenamine/sod phosph,monobasic/methylene blue/hyoscyamine)	Tier 3	
Oxazolidinone Antibiotics - Antibiotics		
<i>linezolid oral suspension for reconstitution 100 mg/5 ml</i>	Tier 1	
<i>linezolid oral tablet 600 mg</i>	Tier 1	
SIVEXTRO ORAL TABLET 200 MG (tedizolid phosphate)	Tier 2	
ZYVOX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML (linezolid)	Tier 3	
ZYVOX ORAL TABLET 600 MG (linezolid)	Tier 3	
Penicillin Antibiotic - Natural - Antibiotics		
<i>penicillin v potassium oral recon soln 125 mg/5 ml, 250 mg/5 ml</i>	Tier 1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	Tier 1	
Penicillin Antibiotic - Penicillinase-Resistant - Antibiotics		
<i>dicloxacillin oral capsule 250 mg, 500 mg</i>	Tier 1	
Pleuromutilin Antibiotics - Antibiotics		
XENLETA ORAL TABLET 600 MG (lefamulin acetate)	Tier 3	PA
Protease Inhibitors (Non-Peptidic) Antiretroviral - Drugs For Viral Infections		
APTIVUS ORAL CAPSULE 250 MG (tipranavir)	Tier 2	
<i>darunavir oral tablet 600 mg, 800 mg</i>	Tier 1	
PREZCOBIX ORAL TABLET 675-150 MG (darunavir ethanolate/cobicistat)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREZCOBIX ORAL TABLET 800-150 MG-MG (darunavir ethanolate/cobicistat)	Tier 3	
PREZISTA ORAL SUSPENSION 100 MG/ML (darunavir)	Tier 2	
PREZISTA ORAL TABLET 150 MG, 75 MG (darunavir)	Tier 2	
PREZISTA ORAL TABLET 600 MG, 800 MG (darunavir)	Tier 3	
Protease Inhibitors (Peptidic) Antiretroviral - Drugs For Viral Infections		
<i>atazanavir oral capsule 150 mg, 200 mg, 300 mg</i>	Tier 1	
EVOTAZ ORAL TABLET 300-150 MG (atazanavir sulfate/cobicistat)	Tier 2	
<i>fosamprenavir oral tablet 700 mg</i>	Tier 1	
NORVIR ORAL CAPSULE 100 MG (ritonavir)	Tier 2	
NORVIR ORAL POWDER IN PACKET 100 MG (ritonavir)	Tier 2	
NORVIR ORAL TABLET 100 MG (ritonavir)	Tier 3	
REYATAZ ORAL CAPSULE 200 MG, 300 MG (atazanavir sulfate)	Tier 3	
REYATAZ ORAL POWDER IN PACKET 50 MG (atazanavir sulfate)	Tier 2	
<i>ritonavir oral tablet 100 mg</i>	Tier 1	
VIRACEPT ORAL TABLET 250 MG, 625 MG (nelfinavir mesylate)	Tier 2	
Quaternary Protoberberine Alkaloids - Antibiotics		
<i>berberine chloride oral capsule 500 mg</i>	Tier 3	
BERBERINE ES-5 ORAL CAPSULE 200 MG (dihydroberberine)	Tier 3	
Respiratory Syncytial Virus (Rsv) Antiviral Agents - Drugs For Viral Infections		
<i>ribavirin inhalation recon soln 6 gram</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIRAZOLE INHALATION RECON SOLN 6 GRAM (ribavirin)	Tier 3	
Rifamycins And Related Derivative Antibiotics - Antibiotics		
PRIFTIN ORAL TABLET 150 MG (rifapentine)	Tier 3	
<i>rifabutin oral capsule 150 mg</i>	Tier 1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	Tier 1	
XIFAXAN ORAL TABLET 200 MG (rifaximin)	Tier 3	PA
XIFAXAN ORAL TABLET 550 MG (rifaximin)	Tier 2	PA
Sars-Cov-2 Antiviral Agent - Main Protease (Mpro) Inhibitors - Drugs For Infections		
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (10)-100 MG (10), 150 MG (6)- 100 MG (5) (nirmatrelvir/ritonavir)	PV	QL (20 EA per 28 days); Age (Min 12 Years)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG (nirmatrelvir/ritonavir)	PV	QL (30 EA per 28 days); Age (Min 12 Years)
Sars-Cov-2 Antiviral Agent - Rna Polymerase Inhibitors - Drugs For Viral Infections		
LAGEVRIO (EUA) ORAL CAPSULE 200 MG (molnupiravir)	PV	QL (40 EA per 29 days); Age (Min 18 Years)
Sulfonamide Antibiotic - Antibiotics		
<i>sulfadiazine oral tablet 500 mg</i>	Tier 1	
Tetracycline And Tetracycline Antibiotic Combinations - Antibiotics		
AVIDOXY DK KIT 100 MG-2 % -SPF 30 (doxycycline monohydrate/salicylic acid/octinoxate/zinc oxide)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 100mg capsules within the past 120 days; QL (1 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENZODOX 30 KIT, CLEANSER ER AND TABLET 100-4.4 MG-% (doxycycline monohydrate/benzoyl peroxide)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 100mg capsules within the past 120 days; QL (1 EA per 30 days)
BENZODOX 60 KIT, CLEANSER ER AND TABLET 100-4.4 MG-% (doxycycline monohydrate/benzoyl peroxide)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 100mg capsules within the past 120 days; QL (1 EA per 30 days)
Tetracycline Antibiotics - Antibiotics		
doxycycline monohydrate (Avidoxy Oral Tablet 100 Mg)	Tier 3	QL (2 EA per 1 day)
<i>demeclocycline oral tablet 150 mg, 300 mg</i>	Tier 1	
DORYX MPC ORAL TABLET,DELAYED RELEASE (DR/EC) 60 MG (doxycycline hyclate)	Tier 3	ST: Requires prior prescription for Doxycycline Hyclate/Monohydrate 50mg/100mg IR tablets/capsules within the past 120 days; QL (2 EA per 1 day)
DORYX ORAL TABLET,DELAYED RELEASE (DR/EC) 80 MG (doxycycline hyclate)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 75mg tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet 100 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline hyclate oral tablet 150 mg</i>	Tier 1	ST: Requires prior prescription for generic Doxycycline Monohydrate 150mg tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet 50 mg</i>	Tier 1	ST: Requires prior prescription for Doxycycline Hyclate 50mg capsules or Doxycycline Monohydrate 50mg capsules or tablets within the past 120 days; QL (4 EA per 1 day)
<i>doxycycline hyclate oral tablet 75 mg</i>	Tier 1	ST: Requires prior prescription for generic Doxycycline Monohydrate 75mg tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 100 mg</i>	Tier 3	ST: Requires prior prescription for Doxycycline Hyclate/Monohydrate 100mg capsule or tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 150 mg</i>	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 150mg tablets within the past 120 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 200 mg</i>	Tier 3	ST: Requires prior prescription for Doxycycline Hyclate/Monohydrate 100mg capsule or tablets within the past 120 days; QL (1 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 50 mg</i>	Tier 3	ST: Requires prior prescription for Doxycycline Hyclate 50mg tablets or Doxycycline Monohydrate 50mg capsules/tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline hyclate oral tablet, delayed release (dr/ec) 75 mg, 80 mg</i>	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 75mg tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline monohydrate oral capsule 150 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>doxycycline monohydrate oral capsule 75 mg</i>	Tier 1	ST: Requires prior prescription for generic Doxycycline Monohydrate 75mg tablets within the past 120 days; QL (2 EA per 1 day)
<i>doxycycline monohydrate oral capsule, ir - delay rel, biphasic 40 mg</i>	Tier 1	
<i>doxycycline monohydrate oral suspension for reconstitution 25 mg/5 ml</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 100 mg, 150 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>doxycycline monohydrate oral tablet 50 mg, 75 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMROSI ORAL CAPSULE,IR -EXTEND REL,BIPHASE 40 MG (minocycline HCl)	Tier 3	
<i>minocycline oral capsule 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>minocycline oral capsule,extended release 24hr 135 mg, 45 mg, 90 mg</i>	Tier 3	ST: Requires prior prescription for generic Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
<i>minocycline oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	Tier 3	ST: Requires prior prescription for generic Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
doxycycline monohydrate (Mondoxylene NI Oral Capsule 100 Mg)	Tier 1	
doxycycline monohydrate (Mondoxylene NI Oral Capsule 75 Mg)	Tier 1	ST: Requires prior prescription for generic Doxycycline Monohydrate 75mg tablets within the past 120 days; QL (2 EA per 1 day)
MORGIDOX 1X 50 KIT 50 MG (doxycycline hyclate/skin cleanser combination no.19)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 100mg capsules within the past 120 days; QL (1 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MORGIDOX 1X100 KIT 100 MG (doxycycline hyclate/skin cleanser combination no.19)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 100mg capsules within the past 120 days; QL (1 EA per 30 days)
MORGIDOX 2X100 KIT 100 MG (doxycycline hyclate/skin cleanser combination no.19)	Tier 3	ST: Requires prior prescription for generic Doxycycline Monohydrate 100mg capsules within the past 120 days; QL (1 EA per 30 days)
doxycycline hyclate (Morgidox Oral Capsule 50 Mg)	Tier 3	QL (2 EA per 1 day)
NUZYRA ORAL TABLET 150 MG (omadacycline tosylate)	Tier 3	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG (doxycycline monohydrate)	Tier 3	
SEYSARA ORAL TABLET 100 MG, 150 MG, 60 MG (sarecycline HCl)	Tier 3	ST: Requires prior prescription for generic Doxycycline or Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 9 Years)
doxycycline hyclate (Targadox Oral Tablet 50 Mg)	Tier 3	ST: Requires prior prescription for Doxycycline Hyclate 50mg capsules or Doxycycline Monohydrate 50mg capsules or tablets within the past 120 days; QL (4 EA per 1 day)
tetracycline oral capsule 250 mg, 500 mg	Tier 1	
tetracycline oral tablet 250 mg, 500 mg	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XIMINO ORAL CAPSULE,EXTENDED RELEASE 24HR 135 MG, 45 MG, 90 MG (minocycline HCl)	Tier 3	ST: Requires prior prescription for generic Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
Variola (Smallpox) Virus Antiviral Agents - Drugs For Viral Infections		
TEMBEXA ORAL SUSPENSION 10 MG/ML (brincidofovir)	Tier 2	
TEMBEXA ORAL TABLET 100 MG (brincidofovir)	Tier 2	
TPOXX (NATIONAL STOCKPILE) ORAL CAPSULE 200 MG (tecovirimat)	Tier 2	
Antineoplastics		
Antineoplastic - Akt (Protein Kinase B (Pkb)) Inhibitor		
TRUQAP ORAL TABLET 160 MG, 200 MG (capivasertib)	Tier 3	PA
Antineoplastic - Caseinolytic Protease P (Clpp) Activators		
MODEYSO ORAL CAPSULE 125 MG (dordaviprone HCl)	Tier 3	PA; QL (20 EA per 28 days)
Antineoplastic - Gamma-Secretase Inhibitor (Gsi)		
OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG (nirogacestat hydrobromide)	Tier 3	PA
Antineoplastic - Janus Kinase (Jak), Acvr1/Alk2 Inhibitors		
OJJAARA ORAL TABLET 100 MG, 150 MG, 200 MG (mometotinib dihydrochloride)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Menin Inhibitors		
REVUFORJ ORAL TABLET 110 MG, 160 MG, 25 MG (revumenib citrate)	Tier 3	PA
Antineoplastic - Ornithine Decarboxylase (Odc) Inhibitors		
IWILFIN ORAL TABLET 192 MG (eflornithine HCl)	Tier 3	PA
Antineoplastic - Parp Inhibitor And Antiandrogen Combinations		
AKEEGA ORAL TABLET 100-500 MG, 50-500 MG (niraparib tosylate/abiraterone acetate)	Tier 3	PA
Antineoplastic - Systemic Enzyme Inhibitors Combinations		
AVMAPKI-FAKZYNJA ORAL COMBO PACK 0.8-200 MG (avutometinib potassium/defactinib hydrochloride)	Tier 3	PA
Antineoplastic-Isocitrate Dehydrogenase-1 And -2 (Idh1 And Idh2) Inhib		
VORANIGO ORAL TABLET 10 MG, 40 MG (vorasidenib citrate)	Tier 3	PA
Antineoplastics - Drugs For Cancer		
Antineoplastic-Epiderm.Growth Factor-Egfr (ErbB1),Her-2 (ErbB2)R.Inhib - Drugs For Cancer		
<i>lapatinib oral tablet 250 mg</i>	Tier 1	PA
TYKERB ORAL TABLET 250 MG (lapatinib ditosylate)	Tier 3	PA
Antineoplastic - Cyp17 (17 Alpha-Hydroxylase/C17,20-Lyase) Inhibitor - Drugs For Cancer		
<i>abiraterone oral tablet 250 mg, 500 mg</i>	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
abiraterone acetate (Abitrega Oral Tablet 250 Mg)	Tier 3	PA
YONSA ORAL TABLET 125 MG (abiraterone acetate, submicronized)	Tier 2	PA
ZYTIGA ORAL TABLET 250 MG, 500 MG (abiraterone acetate)	Tier 3	PA
Antineoplastic - 1St Generation Egfr Tyrosine Kinase Inhibitor - Drugs For Cancer		
<i>erlotinib oral tablet 100 mg, 150 mg, 25 mg</i>	Tier 1	PA
<i>gefitinib oral tablet 250 mg</i>	Tier 3	PA
IRESSA ORAL TABLET 250 MG (gefitinib)	Tier 3	PA
TARCEVA ORAL TABLET 100 MG (erlotinib HCl)	Tier 3	PA
Antineoplastic - 2Nd Generation Egfr Tyrosine Kinase Inhibitor - Drugs For Cancer		
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG (afatinib dimaleate)	Tier 3	PA
NERLYNX ORAL TABLET 40 MG (neratinib maleate)	Tier 3	PA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG (dacomitinib)	Tier 3	PA
Antineoplastic - 3Rd Generation Egfr Tyrosine Kinase Inhibitor - Drugs For Cancer		
LAZCLUZE ORAL TABLET 240 MG, 80 MG (lazertinib mesylate)	Tier 3	PA
TAGRISSO ORAL TABLET 40 MG, 80 MG (osimertinib mesylate)	Tier 3	PA
Antineoplastic - Alkylating Agent - Alkyl Sulfonates - Drugs For Cancer		
MYLERAN ORAL TABLET 2 MG (busulfan)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Alkylating Agent - Methylhydrazines - Drugs For Cancer		
MATULANE ORAL CAPSULE 50 MG (procarbazine HCl)	Tier 3	
Antineoplastic - Alkylating Agent - Nitrogen Mustards - Drugs For Cancer		
ALKERAN ORAL TABLET 2 MG (melphalan)	Tier 3	
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	Tier 1	
<i>cyclophosphamide oral tablet 25 mg, 50 mg</i>	Tier 1	
HEPZATO (50 MM CATHETER) INTRA-ARTERIAL RECON SOLN 50 MG (melphalan HCl)	Tier 3	
HEPZATO (62 MM CATHETER) INTRA-ARTERIAL RECON SOLN 50 MG (melphalan HCl)	Tier 3	
LEUKERAN ORAL TABLET 2 MG (chlorambucil)	Tier 2	
Antineoplastic - Alkylating Agent - Nitrosoureas - Drugs For Cancer		
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (lomustine)	Tier 2	
GLIADEL WAFER IMPLANT WAFER 7.7 MG (carmustine in polifeprosan 20)	Tier 3	KP
Antineoplastic - Alkylating Agent - Triazenes - Drugs For Cancer		
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	Tier 2	
Antineoplastic - Anaplastic Lymphoma Kinase (Alk) Inhibitors - Drugs For Cancer		
ALECENSA ORAL CAPSULE 150 MG (alectinib HCl)	Tier 3	PA
ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG (brigatinib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALUNBRIG ORAL TABLETS,DOSE PACK 90 MG (7)- 180 MG (23) (brigatinib)	Tier 3	PA
ENSACOVE ORAL CAPSULE 100 MG, 25 MG (ensartinib hydrochloride)	Tier 3	PA
LORBRENA ORAL TABLET 100 MG, 25 MG (lorlatinib)	Tier 3	PA
XALKORI ORAL CAPSULE 200 MG, 250 MG (crizotinib)	Tier 3	PA
XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG (crizotinib)	Tier 3	PA
ZYKADIA ORAL TABLET 150 MG (ceritinib)	Tier 3	PA
Antineoplastic - Antiadrenals - Drugs For Cancer		
LYSODREN ORAL TABLET 500 MG (mitotane)	Tier 2	
Antineoplastic - Antiandrogens - Drugs For Cancer		
<i>abiraterone oral tablet 250 mg, 500 mg</i>	Tier 3	PA
abiraterone acetate (Abitrega Oral Tablet 250 Mg)	Tier 3	PA
<i>bicalutamide oral tablet 50 mg</i>	Tier 1	
CASODEX ORAL TABLET 50 MG (bicalutamide)	Tier 3	
ERLEADA ORAL TABLET 240 MG, 60 MG (apalutamide)	Tier 3	PA
NILANDRON ORAL TABLET 150 MG (nilutamide)	Tier 2	
<i>nilutamide oral tablet 150 mg</i>	Tier 1	
NUBEQA ORAL TABLET 300 MG (darolutamide)	Tier 3	PA
XTANDI ORAL CAPSULE 40 MG (enzalutamide)	Tier 3	PA
XTANDI ORAL TABLET 40 MG, 80 MG (enzalutamide)	Tier 3	PA
YONSA ORAL TABLET 125 MG (abiraterone acetate, submicronized)	Tier 2	PA
ZYTIGA ORAL TABLET 250 MG, 500 MG (abiraterone acetate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Antimetabolite - Folic Acid Analogs - Drugs For Cancer		
JYLAMVO ORAL SOLUTION 2 MG/ML (methotrexate)	Tier 3	PA
<i>methotrexate sodium (pf) injection recon soln 1 gram</i>	Tier 1	KP
<i>methotrexate sodium (pf) injection solution 25 mg/ml</i>	Tier 1	KP
<i>methotrexate sodium injection solution 25 mg/ml</i>	Tier 1	KP
<i>methotrexate sodium oral tablet 2.5 mg</i>	Tier 1	
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (methotrexate sodium)	Tier 2	
XATMEP ORAL SOLUTION 2.5 MG/ML (methotrexate)	Tier 3	ST: Requires prior prescription for Methotrexate tablets or injection solution within the past 120 days if 12 years of age and older; QL (120 ML per 60 days)
Antineoplastic - Antimetabolite - Purine Analogs - Drugs For Cancer		
<i>mercaptopurine oral suspension 20 mg/ml</i>	Tier 3	ST: Requires prior prescription for Mercaptopurine tablets within the past 120 days
<i>mercaptopurine oral tablet 50 mg</i>	Tier 1	
PURIXAN ORAL SUSPENSION 20 MG/ML (mercaptopurine)	Tier 3	ST: Requires prior prescription for Mercaptopurine tablets within the past 120 days
TABLOID ORAL TABLET 40 MG (thioguanine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Antimetabolite - Pyrimidine Analogs - Drugs For Cancer		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	Tier 1	PA
ONUREG ORAL TABLET 200 MG, 300 MG (azacitidine)	Tier 3	PA
XELODA ORAL TABLET 150 MG, 500 MG (capecitabine)	Tier 2	PA
Antineoplastic - Antimetabolite - Urea Derivatives - Drugs For Cancer		
HYDREA ORAL CAPSULE 500 MG (hydroxyurea)	Tier 3	
<i>hydroxyurea oral capsule 500 mg</i>	Tier 1	
Antineoplastic - Antimetabolites - Pyrimidine Analog Combinations - Drugs For Cancer		
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG (trifluridine/tipiracil HCl)	Tier 3	PA
Antineoplastic - Aromatase Inhibitors - Drugs For Cancer		
<i>anastrozole oral tablet 1 mg</i>	PV	\$0 COPAY IF QUANTITY 1 IN 1 DAY
ARIMIDEX ORAL TABLET 1 MG (anastrozole)	PV	
AROMASIN ORAL TABLET 25 MG (exemestane)	PV	
<i>exemestane oral tablet 25 mg</i>	PV	\$0 COPAY IF QUANTITY 1 IN 1 DAY
FEMARA ORAL TABLET 2.5 MG (letrozole)	Tier 3	
<i>letrozole oral tablet 2.5 mg</i>	Tier 1	
Antineoplastic - Asparaginase Enzyme Therapy Agents - Drugs For Cancer		
RYLAZE INTRAMUSCULAR SOLUTION 10 MG/0.5 ML (asparaginase Erwinia chrysanthemi (recombinant)-rywn)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - B-Cell Lymphoma-2 (Bcl-2) Inhibitors - Drugs For Cancer		
VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG (venetoclax)	Tier 3	PA
VENCLEXTA STARTING PACK ORAL TABLETS,DOSE PACK 10 MG-50 MG- 100 MG (venetoclax)	Tier 3	PA
Antineoplastic - Braf Kinase Inhibitors - Drugs For Cancer		
BRAFTOVI ORAL CAPSULE 75 MG (encorafenib)	Tier 3	PA
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION 25 MG/ML (tovorafenib)	Tier 3	PA
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4), 500 MG/WEEK (100 MG X 5), 600 MG/WEEK (100 MG X 6) (tovorafenib)	Tier 3	PA
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (dabrafenib mesylate)	Tier 3	PA
TAFINLAR ORAL TABLET FOR SUSPENSION 10 MG (dabrafenib mesylate)	Tier 3	PA
ZELBORAF ORAL TABLET 240 MG (vemurafenib)	Tier 3	PA
Antineoplastic - Bruton's Tyrosine Kinase (Btk) Inhibitor - Drugs For Cancer		
BRUKINSA ORAL CAPSULE 80 MG (zanubrutinib)	Tier 3	PA
BRUKINSA ORAL TABLET 160 MG (zanubrutinib)	Tier 3	PA
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET 100 MG (acalabrutinib maleate)	Tier 3	PA
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG (ibrutinib)	Tier 3	PA
IMBRUVICA ORAL SUSPENSION 70 MG/ML (ibrutinib)	Tier 3	PA
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG (ibrutinib)	Tier 3	PA
JAYPIRCA ORAL TABLET 100 MG, 50 MG (pirtobrutinib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Cyclin-Dependent Kinase (Cdk) 4/6 Inhibitors - Drugs For Cancer		
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (palbociclib)	Tier 3	PA
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (palbociclib)	Tier 3	PA
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3) (ribociclib succinate)	Tier 3	PA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (abemaciclib)	Tier 3	PA
Antineoplastic - Epidermal Growth Factor Receptor-2 (Her2) Inhibitor - Drugs For Cancer		
HERNEXEOS ORAL TABLET 60 MG (zongertinib)	Tier 3	PA; QL (3 EA per 1 day)
TUKYSA ORAL TABLET 150 MG, 50 MG (tucatinib)	Tier 3	PA
Antineoplastic - Epipodophyllotoxins - Drugs For Cancer		
<i>etoposide oral capsule 50 mg</i>	Tier 1	
Antineoplastic - Exportin-1 (Xpo1) Inhibitors - Drugs For Cancer		
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK) (selinexor)	Tier 3	PA
Antineoplastic - Ezh2 Histone Methyltransferase (Hmt) Inhibitor - Drugs For Cancer		
TAZVERIK ORAL TABLET 200 MG (tazemetostat hydrobromide)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Fibroblast Growth Factor Receptor (Fgfr) Kinase Inhib - Drugs For Cancer		
BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG (erdafitinib)	Tier 3	PA
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5) (futibatinib)	Tier 3	PA
PEMAZYRE ORAL TABLET 13.5 MG, 4.5 MG, 9 MG (pemigatinib)	Tier 3	PA
Antineoplastic - Fms-Like Tyrosine Kinase 3 (Flt3) Inhibitors - Drugs For Cancer		
VANFLYTA ORAL TABLET 17.7 MG, 26.5 MG (quizartinib dihydrochloride)	Tier 3	PA
XOSPATA ORAL TABLET 40 MG (gilteritinib fumarate)	Tier 3	PA
Antineoplastic - Hedgehog Pathway Inhibitor - Drugs For Cancer		
DAURISMO ORAL TABLET 100 MG, 25 MG (glasdegib maleate)	Tier 3	PA
ERIVEDGE ORAL CAPSULE 150 MG (vismodegib)	Tier 3	PA
ODOMZO ORAL CAPSULE 200 MG (sonidegib phosphate)	Tier 3	PA
Antineoplastic - Histone Deacetylase (Hdac) Inhibitors - Drugs For Cancer		
ZOLINZA ORAL CAPSULE 100 MG (vorinostat)	Tier 3	
Antineoplastic - Hypoxia Inducible Factor (Hif) Inhibitors - Drugs For Cancer		
WELIREG ORAL TABLET 40 MG (belzutifan)	Tier 3	PA
Antineoplastic - Interferons - Drugs For Cancer		
BESREMI SUBCUTANEOUS SYRINGE 500 MCG/ML (ropeginterferon alfa-2b-njft)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Janus Kinase (Jak) Inhibitors - Drugs For Cancer		
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (ruxolitinib phosphate)	Tier 3	PA; QL (2 EA per 1 day)
Antineoplastic - Janus Kinase(Jak),Fms-Like Tyrosine Kinase(Flt) Inhib - Drugs For Cancer		
INREBIC ORAL CAPSULE 100 MG (fedratinib dihydrochloride)	Tier 3	PA; QL (4 EA per 1 day)
VONJO ORAL CAPSULE 100 MG (pacritinib citrate)	Tier 3	PA; QL (4 EA per 1 day)
Antineoplastic - Kirsten Rat Sarcoma (Kras) Protein Inhibitor - Drugs For Cancer		
KRAZATI ORAL TABLET 200 MG (adagrasib)	Tier 3	PA
LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG (sotorasib)	Tier 3	PA
Antineoplastic - Lhrh (Gnrh) Agonist Analog Pituitary Suppressants - Drugs For Cancer		
ELIGARD (4 MONTH) SUBCUTANEOUS SYRINGE 30 MG (leuprolide acetate)	Tier 3	PA; KP
ELIGARD SUBCUTANEOUS SYRINGE 7.5 MG (1 MONTH) (leuprolide acetate)	Tier 3	PA; KP
<i>leuprolide subcutaneous kit 1 mg/0.2 ml</i>	Tier 1	PA; KP
Antineoplastic - Lhrh (Gnrh) Antagonist Pituitary Suppressants - Drugs For Cancer		
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG (degarelix acetate)	Tier 3	KP; QL (2 EA per 365 days)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG (degarelix acetate)	Tier 3	KP; QL (1 EA per 30 days)
ORGOVYX ORAL TABLET 120 MG (relugolix)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Mast Cell Stabilizers - Drugs For Cancer		
<i>cromolyn oral concentrate 100 mg/5 ml</i>	Tier 1	
GASTROCROM ORAL CONCENTRATE 100 MG/5 ML (cromolyn sodium)	Tier 3	
Antineoplastic - Mek Kinase Inhibitors - Drugs For Cancer		
COTELLIC ORAL TABLET 20 MG (cobimetinib fumarate)	Tier 3	PA
GOMEKLI ORAL CAPSULE 1 MG, 2 MG (mirdametinib)	Tier 3	PA
GOMEKLI ORAL TABLET FOR SUSPENSION 1 MG (mirdametinib)	Tier 3	PA
KOSELUGO ORAL CAPSULE 10 MG, 25 MG (selumetinib sulfate)	Tier 3	PA
MEKINIST ORAL RECON SOLN 0.05 MG/ML (trametinib dimethyl sulfoxide)	Tier 3	PA
MEKINIST ORAL TABLET 0.5 MG, 2 MG (trametinib dimethyl sulfoxide)	Tier 3	PA
MEKTOVI ORAL TABLET 15 MG (binimetinib)	Tier 3	PA
Antineoplastic - Mtor Kinase Inhibitors - Drugs For Cancer		
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 3 MG, 5 MG (everolimus)	Tier 2	PA
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG (everolimus)	Tier 2	PA
<i>everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	Tier 1	PA
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg</i>	Tier 1	PA
everolimus (Torpenz Oral Tablet 10 Mg, 2.5 Mg, 5 Mg, 7.5 Mg)	Tier 1	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Multikinase Inhibitors - Drugs For Cancer		
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (cabozantinib s-malate)	Tier 3	PA
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY) (cabozantinib s-malate)	Tier 3	PA
ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG (ponatinib HCl)	Tier 3	PA
NEXAVAR ORAL TABLET 200 MG (sorafenib tosylate)	Tier 3	PA
<i>sorafenib oral tablet 200 mg</i>	Tier 3	PA
STIVARGA ORAL TABLET 40 MG (regorafenib)	Tier 3	PA
Antineoplastic - Mutant Isocitrate Dehydrogenase 1 (Mdh1) Inhibitors - Drugs For Cancer		
REZLIDHIA ORAL CAPSULE 150 MG (olutasidenib)	Tier 3	PA
TIBSOVO ORAL TABLET 250 MG (ivosidenib)	Tier 3	PA
Antineoplastic - Mutant Isocitrate Dehydrogenase 2 (Mdh2) Inhibitors - Drugs For Cancer		
IDHIFA ORAL TABLET 100 MG, 50 MG (enasidenib mesylate)	Tier 3	PA
Antineoplastic - Phosphatidylinositol 3-Kinase (Pi3k) Inhibitors - Drugs For Cancer		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (duvelisib)	Tier 3	PA
ZYDELIG ORAL TABLET 100 MG, 150 MG (idelalisib)	Tier 3	PA
Antineoplastic - Pi3k-Alpha Inhibitors - Drugs For Cancer		
ITOVEBI ORAL TABLET 3 MG, 9 MG (inavolisib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2) (alpelisib)	Tier 3	PA
Antineoplastic - Pi3k-Delta And Gamma Inhibitors - Drugs For Cancer		
COPIKTRA ORAL CAPSULE 15 MG, 25 MG (duvelisib)	Tier 3	PA
Antineoplastic - Pi3k-Delta Inhibitors - Drugs For Cancer		
ZYDELIG ORAL TABLET 100 MG, 150 MG (idelalisib)	Tier 3	PA
Antineoplastic - Poly (Adp-Ribose) Polymerase (Parp) Inhibitors - Drugs For Cancer		
LYNPARZA ORAL TABLET 100 MG, 150 MG (olaparib)	Tier 3	PA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG (rucaparib camsylate)	Tier 3	PA
TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG (talazoparib tosylate)	Tier 3	PA
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (niraparib tosylate)	Tier 3	PA
Antineoplastic - Progestins - Drugs For Cancer		
<i>megestrol oral tablet 20 mg, 40 mg</i>	Tier 1	
Antineoplastic - Proteasome Enzyme Inhibitors - Drugs For Cancer		
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG (ixazomib citrate)	Tier 3	PA
Antineoplastic - Protein-Tyrosine Kinase Inhibitors - Drugs For Cancer		
AUGTYRO ORAL CAPSULE 160 MG, 40 MG (repotrectinib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG (avapritinib)	Tier 3	PA
BOSULIF ORAL CAPSULE 100 MG, 50 MG (bosutinib)	Tier 3	PA
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG (bosutinib)	Tier 3	PA
BRUKINSA ORAL CAPSULE 80 MG (zanubrutinib)	Tier 3	PA
BRUKINSA ORAL TABLET 160 MG (zanubrutinib)	Tier 3	PA
CALQUENCE (ACALABRUTINIB MAL) ORAL TABLET 100 MG (acalabrutinib maleate)	Tier 3	PA
CAPRELSA ORAL TABLET 100 MG, 300 MG (vandetanib)	Tier 3	PA
DANZITEN ORAL TABLET 71 MG, 95 MG (nilotinib tartrate)	Tier 3	PA
<i>dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg</i>	Tier 3	PA
FOTIVDA ORAL CAPSULE 0.89 MG, 1.34 MG (tivozanib HCl)	Tier 3	PA
FRUZAQLA ORAL CAPSULE 1 MG, 5 MG (fruquintinib)	Tier 3	PA
GLEEVEC ORAL TABLET 100 MG, 400 MG (imatinib mesylate)	Tier 3	PA
IBTROZI ORAL CAPSULE 200 MG (taletrectinib adipate)	Tier 3	PA
<i>imatinib oral tablet 100 mg, 400 mg</i>	Tier 1	PA
IMBRUVICA ORAL CAPSULE 140 MG, 70 MG (ibrutinib)	Tier 3	PA
IMBRUVICA ORAL SUSPENSION 70 MG/ML (ibrutinib)	Tier 3	PA
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG (ibrutinib)	Tier 3	PA
IMKELDI ORAL SOLUTION 80 MG/ML (imatinib mesylate)	Tier 3	PA
INLYTA ORAL TABLET 1 MG, 5 MG (axitinib)	Tier 3	PA
JAYPIRCA ORAL TABLET 100 MG, 50 MG (pirtobrutinib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2) (lenvatinib mesylate)	Tier 3	PA
<i>nilotinib hcl oral capsule 150 mg, 200 mg, 50 mg</i>	Tier 3	PA
OFEV ORAL CAPSULE 100 MG, 150 MG (nintedanib esylate)	Tier 3	PA
<i>pazopanib oral tablet 200 mg</i>	Tier 3	PA
QINLOCK ORAL TABLET 50 MG (ripretinib)	Tier 3	PA
ROMVIMZA ORAL CAPSULE 14 MG, 20 MG, 30 MG (vimseltinib)	Tier 3	PA
ROZLYTREK ORAL CAPSULE 100 MG, 200 MG (entrectinib)	Tier 3	PA
ROZLYTREK ORAL PELLETS IN PACKET 50 MG (entrectinib)	Tier 3	PA
RYDAPT ORAL CAPSULE 25 MG (midostaurin)	Tier 3	PA
SCSEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG (asciminib hydrochloride)	Tier 3	PA
SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG (dasatinib)	Tier 3	PA
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Tier 3	PA
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG (sunitinib malate)	Tier 3	PA
TABRECTA ORAL TABLET 150 MG, 200 MG (capmatinib hydrochloride)	Tier 3	PA
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG (nilotinib HCl)	Tier 3	PA
TEPMETKO ORAL TABLET 225 MG (tepotinib HCl)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TURALIO ORAL CAPSULE 125 MG (pexidartinib hydrochloride)	Tier 3	PA
VOTRIENT ORAL TABLET 200 MG (pazopanib HCl)	Tier 3	PA
Antineoplastic - Retinoids - Drugs For Cancer		
<i>tretinoin (antineoplastic) oral capsule 10 mg</i>	Tier 1	
Antineoplastic - Selective Estrogen Receptor Degradors (Serds) - Drugs For Cancer		
ORSERDU ORAL TABLET 345 MG, 86 MG (elacestrant HCl)	Tier 3	PA
Antineoplastic - Selective Estrogen Receptor Modulators (Serms) - Drugs For Cancer		
FARESTON ORAL TABLET 60 MG (toremifene citrate)	Tier 3	
SOLTAMOX ORAL SOLUTION 20 MG/10 ML (tamoxifen citrate)	Tier 2	
<i>tamoxifen oral tablet 10 mg, 20 mg</i>	PV	\$0 COPAY IF QUANTITY 1 IN 1 DAY
<i>toremifene oral tablet 60 mg</i>	Tier 1	
Antineoplastic - Selective Inhibitors Of Nuclear Export (Sine) - Drugs For Cancer		
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (10 MG X 4), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK) (selinexor)	Tier 3	PA
Antineoplastic - Selective Ret Kinase Inhibitor - Drugs For Cancer		
GAVRETO ORAL CAPSULE 100 MG (pralsetinib)	Tier 3	PA
RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG (selpercatinib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic - Selective Retinoid X Receptor Agonists - Drugs For Cancer		
<i>bexarotene oral capsule 75 mg</i>	Tier 1	PA
TARGRETIN ORAL CAPSULE 75 MG (bexarotene)	Tier 2	PA
Antineoplastic - Thalidomide Analogs - Drugs For Cancer		
<i>lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg</i>	Tier 3	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (pomalidomide)	Tier 3	PA
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG (lenalidomide)	Tier 3	PA
THALOMID ORAL CAPSULE 100 MG, 50 MG (thalidomide)	Tier 2	PA
Antineoplastic - Topoisomerase I Inhibitors - Drugs For Cancer		
HYCAMTIN ORAL CAPSULE 0.25 MG, 1 MG (topotecan HCl)	Tier 3	
Antineoplastic - Tropomyosin Receptor Kinase (Trk) Inhibitor - Drugs For Cancer		
VITRAKVI ORAL CAPSULE 100 MG, 25 MG (larotrectinib sulfate)	Tier 3	PA
VITRAKVI ORAL SOLUTION 20 MG/ML (larotrectinib sulfate)	Tier 3	PA
Antineoplastic Antibiotic - Others - Drugs For Cancer		
JELMYTO INTRA-PYELOCALYCEAL KIT 40 MG X 2 (mitomycin)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antineoplastic-Pyrimidine Analog And Cytidine Deaminase Inhibitor Comb - Drugs For Cancer		
INQOVI ORAL TABLET 35-100 MG (decitabine/cedazuridine)	Tier 3	PA
Fluorouracil And Related Rescue Agents - Drugs For Cancer		
VISTOGARD ORAL GRANULES IN PACKET 10 GRAM (uridine triacetate)	Tier 3	QL (24 EA per 14 days)
Methotrexate Rescue Agents - Drugs For Cancer		
<i>leucovorin calcium oral tablet 10 mg, 15 mg</i>	Tier 1	
<i>leucovorin calcium oral tablet 25 mg, 5 mg</i>	Tier 1	
Methotrexate Rescue Agents - Folic Acid Antagonist Type - Drugs For Cancer		
<i>leucovorin calcium oral tablet 10 mg, 15 mg</i>	Tier 1	
<i>leucovorin calcium oral tablet 25 mg, 5 mg</i>	Tier 1	
Urinary Tract Protective Agents Used In Conjunction With Chemotherapy - Drugs For Cancer		
<i>mesna oral tablet 400 mg</i>	Tier 1	
MESNEX ORAL TABLET 400 MG (mesna)	Tier 3	
Antiseptics And Disinfectants - Antiseptics And Disinfectants		
Antiseptic - Chlorine Releasing - Antiseptics And Disinfectants		
ATRAPRO DERMAL SPRAY TOPICAL SPRAY, NON-AEROSOL 0.003-0.004 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DELUO TOPICAL SPRAY, NON-AEROSOL 0.018 %-0.004 % -0.06 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
HYCLODEX TOPICAL SPRAY, NON-AEROSOL 0.012 %-0.002 % -0.046 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
HYPOCYN ANTIPRURITIC TOPICAL SPRAY GEL 0.012 % (hypochlorous acid/sodhypochlor/sod chlor/sodmagfluo/e.water)	Tier 3	
HYPOCYN DERMAL TOPICAL SPRAY, NON-AEROSOL 0.012 %-0.002 % -0.046 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
MICROCYN TOPICAL SPRAY, NON-AEROSOL 0.003 %-0.004 % -0.023 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
RENOVAR IRRIGATION IRRIGATION SOLUTION (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
RENOVAR TOPICAL SOLUTION (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
Antiseptic - Iodine/Iodophores - Antiseptics And Disinfectants		
IODOFLEX TOPICAL PADS, MEDICATED 0.9 % (cadexomer iodine)	Tier 3	
IODOSORB TOPICAL GEL 0.9 % (cadexomer iodine)	Tier 3	
LUGOLS TOPICAL SOLUTION 5-10 % (iodine/potassium iodide)	Tier 1	
STRONG IODINE TOPICAL SOLUTION 5-10 % (iodine/potassium iodide)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiseptic - Others - Antiseptics And Disinfectants		
<i>glutaraldehyde solution 25 %</i>	Tier 3	
Antiseptic - Oxidizing Agents - Antiseptics And Disinfectants		
<i>hydrogen peroxide (bulk) solution 30 %</i>	Tier 3	
Antiseptic - Phenol Derivatives - Antiseptics And Disinfectants		
<i>phenol liquid</i>	Tier 3	
Biologicals		
Vaccine Viral - Respiratory Syncytial Virus (Rsv)		
ABRYSVO (PF) INTRAMUSCULAR RECON SOLN 120 MCG/0.5 ML (respiratory syncytial virus vaccine, preF A and B/PF)	Tier 3	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
AREXVY (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 120 MCG/0.5 ML (respiratory syncytial virus vacc. antigen/AS01E adjuvant/PF)	Tier 3	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
MRESVIA (PF) INTRAMUSCULAR SYRINGE 50 MCG/0.5 ML (respiratory syncytial virus vaccine, preF protein, mRNA/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Biologicals - Biological Agents		
Allergenic Extracts - Grass Pollen - Biological Agents		
GRASTEK SUBLINGUAL TABLET 2,800 BAU (allergenic extract,grass pollen-timothy,standard)	Tier 2	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY (grass pollen-orchard/sweet vernal/rye/Kentucky/timothy, std.)	Tier 2	PA
Allergenic Extracts - Mite Extracts - Biological Agents		
ODACTRA SUBLINGUAL TABLET 12 SQ-HDM (allergenic extract, mite-D.farinae-D.pteronysinus,standard)	Tier 2	PA
Allergenic Extracts - Weed Pollen - Biological Agents		
RAGWITEK SUBLINGUAL TABLET 12 AMB A 1 UNIT (allergenic extract-weed pollen-short ragweed)	Tier 2	PA
Antivenoms - Scorpion Antivenoms - Biological Agents		
ANASCORP INTRAVENOUS RECON SOLN 120 MG (centruroides (scorpion) polyvalent antivenom)	Tier 3	KP
Antiviral Monoclonal Antibodies - Respiratory Syncytial Virus (Rsv) - Drugs For Viral Infections		
BEYFORTUS INTRAMUSCULAR SYRINGE 100 MG/ML, 50 MG/0.5 ML (nirsevimab-alip)	Tier 3	KP
Chemicals, Foods, Irritant/Allergenic - Biological Agents		
T.R.U.E. TEST ALLERGEN TOPICAL ADHESIVE PATCH,MEDICATED (chemical allergens)	Tier 3	
Hepatitis A And Hepatitis B Vaccine Combinations - Vaccines		
TWINRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT- 20 MCG/ML (hepatitis A virus and hepatitis B virus vaccine/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hepatitis A Vaccine - Single Agents - Vaccines		
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML (hepatitis A virus vaccine/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML (hepatitis A virus vaccine/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML (hepatitis A virus vaccine/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Hepatitis B Vaccines - Single Agents - Vaccines		
ENGRIX-B (PF) INTRAMUSCULAR SUSPENSION 20 MCG/ML (hepatitis B virus vaccine recombinant/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
ENGRIX-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/ML (hepatitis B virus vaccine recombinant/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
HEPLISAV-B (PF) INTRAMUSCULAR SYRINGE 20 MCG/0.5 ML (hepatitis B vaccine recombinant/vaccine adjuvant CpG 1018/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML (hepatitis B virus vaccine recombinant/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML (hepatitis B virus vaccine recombinant/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Immune Globulin - Gamma Globulin (Igg), Human - Biological Agents		
CUTAQUIG SUBCUTANEOUS SOLUTION 16.5 % (immune globulin,gamma(IgG)-hipp human/maltose)	Tier 3	PA; KP
CUVITRU SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %), 8 GRAM/40 ML (20 %) (immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL)	Tier 3	PA; KP
GAMMAGARD LIQUID INJECTION SOLUTION 10 % (immune globulin,gamm(IgG)/glycine/IgA greater than 50 mcg/mL)	Tier 3	PA; KP
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 20 GRAM/200 ML (10 %), 5 GRAM/50 ML (10 %) (immune globulin,gamma(IgG)/glycine/IgA average 46 mcg/mL)	Tier 3	PA; KP
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %) (immune globulin,gamma(IgG)/glycine/IgA average 46 mcg/mL)	Tier 3	PA; KP
HIZENTRA SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) (immune globulin,gamma (IgG)/proline/IgA 0 to 50 mcg/mL)	Tier 3	PA; KP
HIZENTRA SUBCUTANEOUS SYRINGE 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) (immune globulin,gamma (IgG)/proline/IgA 0 to 50 mcg/mL)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYQVIA SUBCUTANEOUS SOLUTION 10 GRAM /100 ML (10 %), 2.5 GRAM /25 ML (10 %), 20 GRAM /200 ML (10 %), 30 GRAM /300 ML (10 %), 5 GRAM /50 ML (10 %) (immune globulin,gamma(IgG) human/hyaluronidase, human recomb)	Tier 3	PA; KP
XEMBIFY SUBCUTANEOUS SOLUTION 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) (immune globulin,gamma (IgG)-klhw human)	Tier 3	PA; KP
Live Vaccine And Live Virus Formulations - Vaccines		
FLUMIST 2025-2026 NASAL NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML (influenza vaccine trivalent live 2025-2026 (2 yrs-49 yrs))	Tier 2	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUMIST HOME 2025-2026 NASAL (HOME ADMIN) NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML (influenza vaccine trivalent live 2025-2026 (2 yrs-49 yrs))	Tier 2	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
ROTARIX ORAL SUSPENSION 10EXP6 CCID50 /1.5 ML (rotavirus vaccine, live oral attenuated,89-12 strain, G1P(8))	Tier 3	
ROTATEQ VACCINE ORAL SOLUTION 2 ML (rotavirus vaccine, live oral pentavalent)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML (varicella virus vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
VAXCHORA VACCINE ORAL SUSPENSION FOR RECONSTITUTION 4X10EXP8 TO 2X 10EXP9 CF UNIT (cholera vaccine, live)	Tier 3	
VIVOTIF ORAL CAPSULE, DELAYED RELEASE (DR/EC) 2 BILLION UNIT (typhoid vacc, live, attenuated)	Tier 3	
Peanut Desensitization Agents - Biological Agents		
PALFORZIA (LEVEL 0) ORAL CAPSULE, SPRINKLE 1 MG (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 1) ORAL CAPSULE, SPRINKLE 3 MG (1 MG X 3) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 2) ORAL CAPSULE, SPRINKLE 6 MG (1 MG X 6) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 3) ORAL CAPSULE, SPRINKLE 12 MG (1 MG X 2, 10 MG X 1) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 4) ORAL CAPSULE, SPRINKLE 20 MG (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 5) ORAL CAPSULE, SPRINKLE 40 MG (20 MG X 2) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 6) ORAL CAPSULE, SPRINKLE 80 MG (20 MG X 4) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 7) ORAL CAPSULE, SPRINKLE 120 MG (20 MG X 1, 100 MG X 1) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 8) ORAL CAPSULE, SPRINKLE 160 MG (20 MG X 3, 100 MG X 1) (peanut allergen powder-dnfp)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PALFORZIA (LEVEL 9) ORAL CAPSULE, SPRINKLE 200 MG (100 MG X 2) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 10) ORAL CAPSULE, SPRINKLE 240 MG (20 MG X 2, 100 MG X 2) (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA (LEVEL 11 UP-DOSE) ORAL POWDER IN PACKET 300 MG (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA INITIAL (1-3 YRS) ORAL CAPSULE, SPRINKLE 0.5/1/1.5/3 MG (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA INITIAL (4-17 YRS) ORAL CAPSULE, SPRINKLE 0.5/1/1.5/3/6 MG (peanut allergen powder-dnfp)	Tier 3	PA
PALFORZIA LEVEL 11 MAINTENANCE ORAL POWDER IN PACKET 300 MG (peanut allergen powder-dnfp)	Tier 3	PA
Toxoid Vaccine Combinations - Vaccines		
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SUSPENSION 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML (diphtheria,pertussis(acellular),tetanus vaccine/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
ADACEL(TDAP ADOLESN/ADULT)(PF) INTRAMUSCULAR SYRINGE 2 LF-(2.5-5-3-5 MCG)-5LF/0.5 ML (diphtheria,pertussis(acellular),tetanus vaccine/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE 2.5-8-5 LF-MCG-LF/0.5ML (diphtheria,pertussis(acellular),tetanus vaccine)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
TENIVAC (PF) INTRAMUSCULAR SUSPENSION 5 LF UNIT- 2 LF UNIT/0.5ML (tetanus and diphtheria toxoids, adsorbed, adult/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TENIVAC (PF) INTRAMUSCULAR SYRINGE 5-2 LF UNIT/0.5 ML (tetanus and diphtheria toxoids, adsorbed, adult/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Bacterial - Gram Negative Bacilli (Non-Enteric) - Vaccines		
VIVOTIF ORAL CAPSULE, DELAYED RELEASE (DR/EC) 2 BILLION UNIT (typhoid vacc, live, attenuated)	Tier 3	
Vaccine Bacterial - Gram Negative Cocci - Vaccines		
MENQUADFI (PF) INTRAMUSCULAR SOLUTION 10 MCG/0.5 ML (meningococcal vaccine A,C,Y and W-135, conj tetanus toxoid/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT 10-5 MCG/0.5 ML (meningococcal vaccine A,C,Y,W-135, diphtheria toxoid conj/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR SOLUTION 10-5 MCG/0.5 ML (meningococcal vaccine A,C,Y,W-135, diphtheria toxoid conj/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PENBRAYA (PF) INTRAMUSCULAR KIT 5-120 MCG/0.5 ML (meningococ A,C,Y,W-135, TT comp/N. mening B, fHBP rec comp/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Bacterial - Gram Positive Cocci - Vaccines		
CAPVAXIVE INTRAMUSCULAR SYRINGE 0.5 ML (pneumococcal 21-valent conjugate vaccine (Diphtheria crm)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PNEUMOVAX-23 INJECTION SYRINGE 25 MCG/0.5 ML (pneumococcal 23-valent polysaccharide vaccine)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PREVNAR 20 (PF) INTRAMUSCULAR SYRINGE 0.5 ML (pneumococcal 20-valent conjugate vaccine (Diphtheria crm)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
VAXNEUVANCE (PF) INTRAMUSCULAR SYRINGE 0.5 ML (pneumococcal 15-valent conjugate vaccine (Diphtheria crm)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Bacterial - Meningococcal Group B Vaccines - Vaccines		
BEXSERO INTRAMUSCULAR SYRINGE 50-50-50-25 MCG/0.5 ML (meningococcal group B vaccine, 4-component)	Tier 3	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
TRUMENBA INTRAMUSCULAR SYRINGE 120 MCG/0.5 ML (Neisseria meningitidis group B, lipidated fHBP recombinant)	Tier 3	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Bacterial - Toxin-Producing Bacilli - Vaccines		
VAXCHORA VACCINE ORAL SUSPENSION FOR RECONSTITUTION 4X10EXP8 TO 2X 10EXP9 CF UNIT (cholera vaccine, live)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaccine Viral - Covid-19 (Sars-Cov-2) - Vaccines		
COMIRNATY 2025-2026(5-11Y)(PF) INTRAMUSCULAR SUSPENSION 10 MCG/0.3 ML (COVID vacc 2025-2026 (5-11 years) (Pfizer)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
COMIRNATY 2025-26 (12Y UP)(PF) INTRAMUSCULAR SYRINGE 30 MCG/0.3 ML (COVID vaccine 2025-2026 (12 yrs up) (Pfizer)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
MNEXSPIKE 2025-2026 (PF) INTRAMUSCULAR SYRINGE 10 MCG/0.2 ML (COVID vaccine 2025-2026 (12 years up) (Moderna)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
MODERNA COVID 24-25(6M-11Y)PF INTRAMUSCULAR SYRINGE 25 MCG/0.25 ML (COVID vaccine 2024-2025 (6 months-11 years)(Moderna)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
NOVAVAX COVID 2024-25(PF)(EUA) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML (COVID vaccine 2024-2025 (12 yrs up)/adjuvant-Matrix/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
NUVAXOVID 2025-2026 (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML (COVID vaccine 2025-2026 (12 yrs up)/adjuvant-Matrix/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
SPIKEVAX 2024-2025(12Y UP)(PF) INTRAMUSCULAR SYRINGE 50 MCG/0.5 ML (COVID vaccine 2024-2025 (12 yrs up) (Moderna)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SPIKEVAX 2025-2026(12Y UP)(PF) INTRAMUSCULAR SYRINGE 50 MCG/0.5 ML (COVID vaccine 2025-2026 (12 years up) (Moderna)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
SPIKEVAX 2025-26 (6M-11Y) (PF) INTRAMUSCULAR SYRINGE 25 MCG/0.25 ML (COVID vaccine 2025-2026 (6 months-11 years)(Moderna)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral - Human Papillomavirus (Hpv) Vaccines - Vaccines		
GARDASIL 9 (PF) INTRAMUSCULAR SUSPENSION 0.5 ML (human papillomavirus vaccine, 9-valent/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
GARDASIL 9 (PF) INTRAMUSCULAR SYRINGE 0.5 ML (human papillomavirus vaccine, 9-valent/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral - Influenza A And B - Vaccines		
AFLURIA 2025-2026 (3YR UP)(PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML (influenza virus vaccine trival split 2025-26 (36 mos up)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
AFLURIA 2025-2026 (6MO UP) INTRAMUSCULAR SUSPENSION 45 MCG (15 MCG X 3)/0.5 ML (influenza virus vaccine trivalent 2025-26 (6 mos and older))	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUAD 2025-2026 (65 YR UP)(PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML (influenza vaccine tvs 2025-26 (65 yr up)/adjuvant MF59C.1/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUARIX 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML (influenza virus vaccine tvs 2025-2026(6 months and older)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUBLOK 2025-2026 (PF) INTRAMUSCULAR SYRINGE 135 MCG (45 MCG X 3)/0.5 ML (influenza virus vaccine tv 2025-26(9 yrs and older)rcmb/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUCELVAX 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML (flu vaccine tri 2025-2026(6 month and older)cell derived/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUCELVAX 2025-2026 INTRAMUSCULAR SUSPENSION 45 MCG (15 MCG X 3)/0.5 ML (flu vaccine triv 2025-2026(6 month and older)cell derived)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLULAVAL 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML (influenza virus vaccine tvs 2025-2026(6 months and older)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUMIST 2025-2026 NASAL NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML (influenza vaccine trivalent live 2025-2026 (2 yrs-49 yrs))	Tier 2	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUMIST HOME 2025-2026 NASAL (HOME ADMIN) NASAL SPRAY SYRINGE 10EXP6.5-7.5 FF UNIT/0.2 ML (influenza vaccine trivalent live 2025-2026 (2 yrs-49 yrs))	Tier 2	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUZONE 2025-2026 (PF) INTRAMUSCULAR SYRINGE 45 MCG (15 MCG X 3)/0.5 ML (influenza virus vaccine tvs 2025-2026(6 months and older)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUZONE 2025-2026 INTRAMUSCULAR SUSPENSION 45 MCG (15 MCG X 3)/0.5 ML (influenza virus vaccine trivalent 2025-26 (6 mos and older))	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
FLUZONE HIGH-DOSE 2025-26 (PF) INTRAMUSCULAR SYRINGE 180 MCG/0.5 ML (influenza virus vaccine trival split 2025-2026(65 yr up)/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral - Measles - Vaccines		
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral - Mumps And Related - Vaccines		
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral - Poliomyelitis - Vaccines		
IPOL INJECTION SUSPENSION 40-8-32 UNIT/0.5 ML (poliomyelitis vaccine, killed)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaccine Viral - Rotavirus - Vaccines		
ROTARIX ORAL SUSPENSION 10EXP6 CCID50 /1.5 ML (rotavirus vaccine, live oral attenuated,89-12 strain, G1P(8))	Tier 3	
ROTATEQ VACCINE ORAL SOLUTION 2 ML (rotavirus vaccine, live oral pentavalent)	Tier 3	
Vaccine Viral - Rubella - Vaccines		
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral - Varicella - Vaccines		
SHINGRIX (PF) INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 50 MCG/0.5 ML (varicella-zoster virus glycoprotein E,rec/AS01B adjuvant/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
VARIVAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 1,350 UNIT/0.5 ML (varicella virus vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
Vaccine Viral Combinations - Vaccines		
M-M-R II (PF) SUBCUTANEOUS RECON SOLN 1,000-12,500 TCID50/0.5 ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE
PRIORIX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10EXP3.4-4.2- 3.3CCID50/0.5ML (measles, mumps, and rubella vaccine live/PF)	PV	\$0 COPAY WITH RESTRICTIONS THAT APPLY ACCORDING TO CDC GUIDANCE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cardiovascular Therapy Agents		
Antihyperlipidemic - Apolipoprotein C-III Synthesis Inhibitors		
TRYNGOLZA SUBCUTANEOUS AUTO-INJECTOR 80 MG/0.8 ML (olezarsen sodium)	Tier 3	PA; KP
Endothelin Receptor Antagonists		
TRYVIO ORAL TABLET 12.5 MG (aprocitentan)	Tier 3	PA
VANRAFIA ORAL TABLET 0.75 MG (atrasentan hydrochloride)	Tier 3	PA
Endothelin-Angiotensin Receptor Antagonist		
FILSPARI ORAL TABLET 200 MG, 400 MG (sparsentan)	Tier 3	PA
Factor XII Inhibitors		
ANDEMBRY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 200 MG/1.2 ML (garadacimab-gxii)	Tier 3	PA; KP
Pah-Endothelin Receptor Antagonist-Selective Cgmp Pde5 Inhibitor Comb		
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG (macitentan/tadalafil)	Tier 3	PA
Plasma Kallikrein Inhibitor Agents, Antisense Oligonucleotide (Aso)		
DAWNZERA SUBCUTANEOUS AUTO-INJECTOR 80 MG/0.8 ML (donidalorsen sodium)	Tier 3	PA; KP; QL (0.8 ML per 28 days)
Pulmonary Antihypertensive Agent - Activin Receptor IIA-Fc (Actriia)		
WINREVAIR SUBCUTANEOUS KIT 120 MG (60 MG X 2), 45 MG, 60 MG, 90 MG (45 MG X 2) (sotatercept-csrk)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cardiovascular Therapy Agents - Drugs For The Heart		
Ace Inhibitor And Calcium Channel Blocker Combinations - Drugs For High Blood Pressure		
<i>amlodipine-benazepril oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	Tier 1	
amlodipine besylate/benazepril HCl (Lotrel Oral Capsule 10-20 Mg)	Tier 3	
LOTREL ORAL CAPSULE 10-40 MG, 5-10 MG, 5-20 MG (amlodipine besylate/benazepril HCl)	Tier 3	
PRESTALIA ORAL TABLET 14-10 MG, 3.5-2.5 MG, 7-5 MG (perindopril arginine/amlodipine besylate)	Tier 3	ST: Requires prior prescriptions for Amlodipine and an ACE Inhibitor within the past 365 days; QL (1 EA per 1 day)
<i>trandolapril-verapamil oral tablet, ir - er, biphasic 24hr 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	Tier 1	
Ace Inhibitor And Diuretic Combinations - Drugs For High Blood Pressure		
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (quinapril HCl/hydrochlorothiazide)	Tier 3	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	Tier 1	
<i>captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg</i>	Tier 1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	Tier 1	
<i>fosinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg</i>	Tier 1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (benazepril HCl/hydrochlorothiazide)	Tier 3	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Tier 1	
VASERETIC ORAL TABLET 10-25 MG (enalapril maleate/hydrochlorothiazide)	Tier 3	
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (lisinopril/hydrochlorothiazide)	Tier 3	
Ace Inhibitors - Drugs For High Blood Pressure		
ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (quinapril HCl)	Tier 3	
ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG (ramipril)	Tier 3	
<i>benazepril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>enalapril maleate oral solution 1 mg/ml</i>	Tier 1	PA
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	
EPANED ORAL SOLUTION 1 MG/ML (enalapril maleate)	Tier 3	PA
<i>fosinopril oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	Tier 1	
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (benazepril HCl)	Tier 3	
<i>moexipril oral tablet 15 mg, 7.5 mg</i>	Tier 1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	Tier 1	
QBRELIS ORAL SOLUTION 1 MG/ML (lisinopril)	Tier 3	PA
<i>quinapril oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VASOTEC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (enalapril maleate)	Tier 3	
ZESTRIL ORAL TABLET 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG (lisinopril)	Tier 3	
Aldosterone Receptor Antagonists - Drugs For High Blood Pressure		
ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (spironolactone)	Tier 3	
CAROSPIR ORAL SUSPENSION 25 MG/5 ML (spironolactone)	Tier 3	PA
<i>eplerenone oral tablet 25 mg, 50 mg</i>	Tier 1	
INSPRA ORAL TABLET 25 MG, 50 MG (eplerenone)	Tier 3	
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG (finerenone)	Tier 3	PA
<i>spironolactone oral suspension 25 mg/5 ml</i>	Tier 1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
Alpha-Beta Blockers - Drugs For High Blood Pressure		
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	Tier 1	
<i>carvedilol phosphate oral capsule, er multiphase 24 hr 10 mg, 20 mg, 40 mg, 80 mg</i>	Tier 1	QL (1 EA per 1 day)
COREG CR ORAL CAPSULE, ER MULTIPHASE 24 HR 10 MG, 20 MG, 40 MG, 80 MG (carvedilol phosphate)	Tier 3	QL (1 EA per 1 day)
COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (carvedilol)	Tier 3	
<i>labetalol oral tablet 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>labetalol oral tablet 400 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Angiotensin II Receptor Blocker (Arb)-Calcium Channel Blocker Comb. - Drugs For High Blood Pressure		
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	Tier 1	
<i>amlodipine-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	Tier 1	
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG (amlodipine besylate/olmesartan medoxomil)	Tier 3	
EXFORGE ORAL TABLET 10-160 MG, 10-320 MG, 5-160 MG, 5-320 MG (amlodipine besylate/valsartan)	Tier 3	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	Tier 1	
Angiotensin II Receptor Blocker (Arb)-Calcium Channel Blocker-Diuretic - Drugs For High Blood Pressure		
<i>amlodipine-valsartan-hcthiiazid oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg</i>	Tier 1	
EXFORGE HCT ORAL TABLET 10-160-12.5 MG, 10-160-25 MG, 10-320-25 MG, 5-160-12.5 MG, 5-160-25 MG (amlodipine besylate/valsartan/hydrochlorothiazide)	Tier 3	
<i>olmesartan-amlodipin-hcthiiazid oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg</i>	Tier 1	
TRIBENZOR ORAL TABLET 20-5-12.5 MG, 40-10-12.5 MG, 40-10-25 MG, 40-5-12.5 MG, 40-5-25 MG (olmesartan medoxomil/amlodipine besylate/hydrochlorothiazide)	Tier 3	
Angiotensin II Receptor Blocker (Arb)-Diuretic Combinations - Drugs For High Blood Pressure		
ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (candesartan cilexetil/hydrochlorothiazide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (irbesartan/hydrochlorothiazide)	Tier 3	
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG (olmesartan medoxomil/hydrochlorothiazide)	Tier 3	
<i>candesartan-hydrochlorothiazid oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	Tier 1	
DIOVAN HCT ORAL TABLET 160-12.5 MG, 160-25 MG, 320-12.5 MG, 320-25 MG, 80-12.5 MG (valsartan/hydrochlorothiazide)	Tier 3	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (azilsartan medoxomil/chlorthalidone)	Tier 3	ST: Requires prior prescription for an ACE inhibitor, ACE inhibitor combination, ARB, or ARB combination within the past 120 days
HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (losartan potassium/hydrochlorothiazide)	Tier 3	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	Tier 1	
<i>losartan-hydrochlorothiazide oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	Tier 1	
MICARDIS HCT ORAL TABLET 40-12.5 MG, 80-12.5 MG, 80-25 MG (telmisartan/hydrochlorothiazide)	Tier 3	
<i>olmesartan-hydrochlorothiazide oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	Tier 1	
<i>telmisartan-hydrochlorothiazid oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	Tier 1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Angiotensin II Receptor Blocker-Neprilysin Inhibitor Comb. (Arni) - Drugs For High Blood Pressure		
ENTRESTO ORAL TABLET 24-26 MG (sacubitril/valsartan)	Tier 2	QL (6 EA per 1 day)
ENTRESTO ORAL TABLET 49-51 MG, 97-103 MG (sacubitril/valsartan)	Tier 2	QL (2 EA per 1 day)
ENTRESTO SPRINKLE ORAL PELLETS 15-16 MG, 6-6 MG (sacubitril/valsartan)	Tier 3	QL (8 EA per 1 day)
<i>sacubitril-valsartan oral tablet 24-26 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>sacubitril-valsartan oral tablet 49-51 mg, 97-103 mg</i>	Tier 1	QL (2 EA per 1 day)
Angiotensin II Receptor Blockers (Arbs) - Drugs For High Blood Pressure		
ARBLI ORAL SUSPENSION 10 MG/ML (losartan potassium)	Tier 3	PA
ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (candesartan cilexetil)	Tier 3	
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG (irbesartan)	Tier 3	
BENICAR ORAL TABLET 20 MG, 40 MG, 5 MG (olmesartan medoxomil)	Tier 3	
<i>candesartan oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Tier 1	
COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG (losartan potassium)	Tier 3	
DIOVAN ORAL TABLET 160 MG, 320 MG, 40 MG, 80 MG (valsartan)	Tier 3	
EDARBI ORAL TABLET 40 MG, 80 MG (azilsartan medoxomil)	Tier 3	ST: Requires prior prescription for an ACE inhibitor, ACE inhibitor combination, ARB, or ARB combination within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eprosartan oral tablet 600 mg</i>	Tier 1	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	Tier 1	
<i>losartan oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
MICARDIS ORAL TABLET 20 MG, 40 MG, 80 MG (telmisartan)	Tier 3	
<i>olmesartan oral tablet 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>valsartan oral solution 4 mg/ml</i>	Tier 3	ST: Requires prior prescription for Valsartan tablets within the past 120 days
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	Tier 1	
Antianginal - Coronary Vasodilators (Nitrates) - Drugs For Angina		
GONITRO SUBLINGUAL POWDER IN PACKET 400 MCG (nitroglycerin)	Tier 3	ST: Requires prior prescriptions for two generic sublingual Nitroglycerin products within the past 365 days
ISORDIL ORAL TABLET 40 MG (isosorbide dinitrate)	Tier 3	
ISORDIL TITRADOSE ORAL TABLET 5 MG (isosorbide dinitrate)	Tier 3	
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	Tier 1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>isosorbide mononitrate oral tablet extended release 24 hr 120 mg, 30 mg, 60 mg</i>	Tier 1	
nitroglycerin (Nitro-Bid Transdermal Ointment 2 %)	Tier 2	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.1 MG/HR, 0.2 MG/HR, 0.4 MG/HR, 0.6 MG/HR (nitroglycerin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (nitroglycerin)	Tier 2	
<i>nitroglycerin sublingual tablet 0.3 mg, 0.4 mg, 0.6 mg</i>	Tier 1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	Tier 1	
<i>nitroglycerin translingual spray, non-aerosol 400 mcg/spray</i>	Tier 1	
NITROLINGUAL TRANSLINGUAL SPRAY, NON-AEROSOL 400 MCG/SPRAY (nitroglycerin)	Tier 3	
NITROMIST TRANSLINGUAL AEROSOL, SPRAY 400 MCG/SPRAY (nitroglycerin)	Tier 3	
NITROSTAT SUBLINGUAL TABLET 0.3 MG, 0.4 MG, 0.6 MG (nitroglycerin)	Tier 3	
NITRO-TIME ORAL CAPSULE, EXTENDED RELEASE 2.5 MG, 6.5 MG, 9 MG (nitroglycerin)	Tier 1	
Antianginal And Anti-Ischemic Agents - Drugs For Angina		
VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG (vericiguat)	Tier 3	PA
Antianginal And Anti-Ischemic Agents, Non-Hemodynamic - Drugs For Angina		
ASPRUZYO SPRINKLE ORAL EXTEND RELEASE GRANULES, PACKET 1,000 MG, 500 MG (ranolazine)	Tier 3	PA
<i>ranolazine oral tablet extended release 12 hr 1,000 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>ranolazine oral tablet extended release 12 hr 500 mg</i>	Tier 1	QL (120 EA per 30 days)
Antiarrhythmic - Class Ia - Drugs For Abnormal Heart Rhythms		
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	Tier 1	
NORPACE CR ORAL CAPSULE, EXTENDED RELEASE 100 MG, 150 MG (disopyramide phosphate)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NORPACE ORAL CAPSULE 100 MG, 150 MG (disopyramide phosphate)	Tier 3	
<i>quinidine gluconate oral tablet extended release 324 mg</i>	Tier 1	
<i>quinidine sulfate oral tablet 200 mg, 300 mg</i>	Tier 1	
Antiarrhythmic - Class Ib - Drugs For Abnormal Heart Rhythms		
<i>mexiletine oral capsule 150 mg, 200 mg, 250 mg</i>	Tier 1	
Antiarrhythmic - Class Ic - Drugs For Abnormal Heart Rhythms		
<i>flecainide oral tablet 100 mg, 150 mg, 50 mg</i>	Tier 1	
<i>propafenone oral capsule, extended release 12 hr 225 mg, 325 mg, 425 mg</i>	Tier 1	
<i>propafenone oral tablet 150 mg, 225 mg, 300 mg</i>	Tier 1	
Antiarrhythmic - Class II - Drugs For Abnormal Heart Rhythms		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol HCl)	Tier 3	
BETAPACE ORAL TABLET 120 MG, 160 MG, 240 MG, 80 MG (sotalol HCl)	Tier 3	
sotalol HCl (Sotalol Af Oral Tablet 120 Mg, 160 Mg, 80 Mg)	Tier 1	
<i>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	Tier 1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (sotalol HCl)	Tier 3	QL: 8 BOTTLES IN 30 DAYS; ST: Requires prior prescription for Sotalol tablets within the past 120 days
Antiarrhythmic - Class III - Drugs For Abnormal Heart Rhythms		
<i>amiodarone oral tablet 100 mg, 200 mg, 400 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	Tier 1	
MULTAQ ORAL TABLET 400 MG (dronedarone HCl)	Tier 2	
amiodarone HCl (Pacerone Oral Tablet 100 Mg, 200 Mg, 400 Mg)	Tier 1	
TIKOSYN ORAL CAPSULE 125 MCG, 250 MCG, 500 MCG (dofetilide)	Tier 3	
Antiarrhythmic - Class Iv - Drugs For Abnormal Heart Rhythms		
<i>verapamil oral tablet 120 mg, 40 mg, 80 mg</i>	Tier 1	
Antihyperlipidemic - Apolipoprotein Inhibitors - Drugs For Cholesterol		
TRYNGOLZA SUBCUTANEOUS AUTO-INJECTOR 80 MG/0.8 ML (olezarsen sodium)	Tier 3	PA; KP
Antihyperlipidemic - Atp-Citrate Lyase (Acly) Inhibitor - Drugs For Cholesterol		
NEXLETOL ORAL TABLET 180 MG (bempedoic acid)	Tier 2	ST: Requires prior prescription for generic statin within the past 120 days
Antihyperlipidemic - Bile Acid Sequestrants - Drugs For Cholesterol		
<i>cholestyramine (with sugar) oral powder 4 gram</i>	Tier 1	
<i>cholestyramine (with sugar) oral powder in packet 4 gram</i>	Tier 1	
cholestyramine (Cholestyramine Light Oral Powder 4 Gram)	Tier 1	
cholestyramine (Cholestyramine Light Oral Powder In Packet 4 Gram)	Tier 1	
<i>colesevelam oral powder in packet 3.75 gram</i>	Tier 1	
<i>colesevelam oral tablet 625 mg</i>	Tier 1	
COLESTID ORAL GRANULES 5 GRAM (colestipol HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COLESTID ORAL TABLET 1 GRAM (colestipol HCl)	Tier 3	
<i>colestipol oral granules 5 gram</i>	Tier 1	
<i>colestipol oral packet 5 gram</i>	Tier 1	
<i>colestipol oral tablet 1 gram</i>	Tier 1	
cholestyramine (Prevalite Oral Powder 4 Gram)	Tier 1	
cholestyramine (Prevalite Oral Powder In Packet 4 Gram)	Tier 1	
cholestyramine (Questran Light Oral Powder 4 Gram)	Tier 3	
cholestyramine (with sugar) (Questran Oral Powder 4 Gram)	Tier 3	
cholestyramine (with sugar) (Questran Oral Powder In Packet 4 Gram)	Tier 3	
WELCHOL ORAL POWDER IN PACKET 3.75 GRAM (colesevelam HCl)	Tier 3	
WELCHOL ORAL TABLET 625 MG (colesevelam HCl)	Tier 3	
Antihyperlipidemic - Fibric Acid Derivatives - Drugs For Cholesterol		
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	Tier 1	
<i>fenofibrate micronized oral capsule 90 mg</i>	Tier 3	
<i>fenofibrate nanocrystallized oral tablet 145 mg, 48 mg</i>	Tier 1	
<i>fenofibrate oral capsule 150 mg, 50 mg</i>	Tier 1	
<i>fenofibrate oral tablet 120 mg, 160 mg, 40 mg, 54 mg</i>	Tier 1	
<i>fenofibric acid (choline) oral capsule, delayed release(dr/ec) 135 mg, 45 mg</i>	Tier 1	
<i>fenofibric acid oral tablet 105 mg, 35 mg</i>	Tier 1	
FENOGLIDE ORAL TABLET 120 MG, 40 MG (fenofibrate)	Tier 3	ST: Requires prior prescription for generic Fenofibrate or Gemfibrozil within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIBRICOR ORAL TABLET 105 MG, 35 MG (fenofibric acid)	Tier 3	
<i>gemfibrozil oral tablet 600 mg</i>	Tier 1	
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (fenofibrate)	Tier 3	ST: Requires prior prescription for generic Fenofibrate or Gemfibrozil within the past 120 days
LOPID ORAL TABLET 600 MG (gemfibrozil)	Tier 3	
TRICOR ORAL TABLET 145 MG, 48 MG (fenofibrate nanocrystallized)	Tier 3	
Antihyperlipidemic - Hmg Coa Reductase Inhibitors (Statins) - Drugs For Cholesterol		
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR 20 MG, 40 MG, 60 MG (lovastatin)	Tier 3	ST: At least 2 prior prescriptions for Atorvastatin, Lovastatin, Pravastatin, or Simvastatin within the past 365 days; QL (1 EA per 1 day)
ATORVALIQ ORAL SUSPENSION 20 MG/5 ML (4 MG/ML) (atorvastatin calcium)	Tier 3	PA
<i>atorvastatin oral tablet 10 mg, 20 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>atorvastatin oral tablet 40 mg, 80 mg</i>	Tier 1	QL (1 EA per 1 day)
CRESTOR ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (rosuvastatin calcium)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EZALLOR SPRINKLE ORAL CAPSULE, SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (rosuvastatin calcium)	Tier 3	ST: Requires prior prescription for generic Rosuvastatin within the past 120 days; QL (1 EA per 1 day)
FLOLIPID ORAL SUSPENSION 20 MG/5 ML (4 MG/ML), 40 MG/5 ML (8 MG/ML) (simvastatin)	Tier 3	PA
<i>fluvastatin oral capsule 20 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Atorvastatin, Lovastatin, Pravastatin, or Simvastatin within the past 365 days; \$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (2 EA per 1 day)
<i>fluvastatin oral capsule 40 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Atorvastatin, Lovastatin, Pravastatin, or Simvastatin within the past 365 days; \$0 COPAY IF QUANTITY 2 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluvastatin oral tablet extended release 24 hr 80 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Atorvastatin, Lovastatin, Pravastatin, or Simvastatin within the past 365 days; \$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
LIPITOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG (atorvastatin calcium)	Tier 3	QL (1 EA per 1 day)
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (pitavastatin calcium)	Tier 3	QL (1 EA per 1 day)
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (2 EA per 1 day)
<i>pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pravastatin oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>rosuvastatin oral tablet 10 mg, 5 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>rosuvastatin oral tablet 20 mg, 40 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 1 IN 1 DAY, 40-75 YEARS OF AGE, AND NO HISTORY OF CARDIOVASCULAR DISEASE PREVENTION MEDICATIONS IN 120 DAYS; QL (1 EA per 1 day)
<i>simvastatin oral tablet 80 mg</i>	Tier 1	PA; QL (1 EA per 1 day)
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG (simvastatin)	Tier 3	QL (1 EA per 1 day)
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (pitavastatin magnesium)	Tier 3	ST: Requires prior prescription for Livalo within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperlipidemic - Nicotinic Acid Derivatives - Drugs For Cholesterol		
<i>niacin oral tablet 500 mg</i>	Tier 3	
<i>niacin oral tablet extended release 24 hr 1,000 mg, 500 mg, 750 mg</i>	Tier 1	
niacin (Niacor Oral Tablet 500 Mg)	Tier 1	
Antihyperlipidemic - Omega-3 Fatty Acid Type - Drugs For Cholesterol		
<i>icosapent ethyl oral capsule 0.5 gram</i>	Tier 1	QL (8 EA per 1 day)
<i>icosapent ethyl oral capsule 1 gram</i>	Tier 1	QL (4 EA per 1 day)
omega-3 acid ethyl esters (Lovaza Oral Capsule 1 Gram)	Tier 3	ST: Requires prior prescription for generic Fenofibrate within the past 120 days; QL (4 EA per 1 day)
<i>omega-3 acid ethyl esters oral capsule 1 gram</i>	Tier 1	ST: Requires prior prescription for generic Fenofibrate within the past 120 days; QL (4 EA per 1 day)
VASCEPA ORAL CAPSULE 0.5 GRAM (icosapent ethyl)	Tier 3	QL (8 EA per 1 day)
VASCEPA ORAL CAPSULE 1 GRAM (icosapent ethyl)	Tier 3	QL (4 EA per 1 day)
Antihyperlipidemic - Pcsk9 Inhibitor, Monoclonal Antibody (Mab) - Drugs For Cholesterol		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML (alirocumab)	Tier 3	KP; ST: Requires prior prescription for Repatha within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML (evolocumab)	Tier 2	KP; ST: Requires prior prescription for generic statin within the past 120 days
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML (evolocumab)	Tier 2	KP; ST: Requires prior prescription for generic statin within the past 120 days
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML (evolocumab)	Tier 2	KP; ST: Requires prior prescription for generic statin within the past 120 days
Antihyperlipidemic - Pcsk9 Inhibitors - Drugs For Cholesterol		
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML, 75 MG/ML (alirocumab)	Tier 3	KP; ST: Requires prior prescription for Repatha within the past 120 days
REPATHA PUSHTRONEX SUBCUTANEOUS WEARABLE INJECTOR 420 MG/3.5 ML (evolocumab)	Tier 2	KP; ST: Requires prior prescription for generic statin within the past 120 days
REPATHA SURECLICK SUBCUTANEOUS PEN INJECTOR 140 MG/ML (evolocumab)	Tier 2	KP; ST: Requires prior prescription for generic statin within the past 120 days
REPATHA SYRINGE SUBCUTANEOUS SYRINGE 140 MG/ML (evolocumab)	Tier 2	KP; ST: Requires prior prescription for generic statin within the past 120 days
Antihyperlipidemic - Selective Cholesterol Absorption Inhibitor - Drugs For Cholesterol		
<i>ezetimibe oral tablet 10 mg</i>	Tier 1	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZETIA ORAL TABLET 10 MG (ezetimibe)	Tier 3	QL (1 EA per 1 day)
Antihyperlipidemic Agents - Dietary Source - Drugs For Cholesterol		
<i>choline bitartrate oral tablet 500 mg</i>	Tier 3	
<i>lecithin, soy oral capsule 1,200 mg</i>	Tier 3	
PHOSPHALINE ORAL CAPSULE 900 MG (phosphatidylcholine)	Tier 3	
PHOSPHALINE ORAL LIQUID 3 GRAM/5 ML (phosphatidylcholine)	Tier 3	
Antihyperlipidemic Agents - Dietary Source Combinations - Drugs For Cholesterol		
COQMAX OMEGA ORAL CAPSULE 174-50-115-250 MG, 348-500-100 MG (omega-3 fatty acids/dha/epa/fish oil/coenzyme Q-10)	Tier 3	
FISH OIL ORAL CAPSULE 1,000 (120-180) MG, 1,200 (144-216) MG, 300-1,000 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
FISH OIL ORAL CAPSULE 300-500 MG, 360-1,200 MG (omega-3 fatty acids/fish oil)	Tier 3	
FISH OIL ORAL CAPSULE, DELAYED RELEASE (DR/EC) 300-1,000 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
<i>inositol-choline bitartrate oral capsule 250-250 mg</i>	Tier 3	
<i>krill-om-3-dha-epa-phospho-ast oral capsule 350-90-24-50 mg, 500-115-30-64 mg</i>	Tier 3	
LIPOCHOL PLUS ORAL TABLET 0.5 MG (methionine/inositol/choline/folic acid)	Tier 3	
MEGARED ADV TOTAL BODY REFRESH ORAL CAPSULE 375-350-500-30 MG (omega-3 fatty acids/dha/epa/fish oil/krill/lutein/zeaxanth)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEGARED ADVANCED 4-IN-1 ORAL CAPSULE 339 MG-314 MG- 500 MG, 700 MG-600 MG- 900 MG (omega-3 fatty acids/dha/epa/fish oil/krill oil)	Tier 3	
MEGARED ADVANCED TOTAL BODY ORAL CAPSULE 339-314-500-24 MG (omega-3 fatty acids/dha/epa/fish oil/krill/lutein/zeaxanth)	Tier 3	
MEGARED OMEGA-3 KRILL OIL ORAL CAPSULE 1,000-230-60 MG, 350-90-24-50 MG, 500-115-30-64 MG (krill oil/omega-3 fatty acids/dha/epa/phospholipids/astaxan)	Tier 3	
<i>omega 3-dha-epa-fish oil oral capsule 1,000 (120-180) mg, 200-300-1,000 mg, 300-1,000 mg, 60-90-500 mg</i>	Tier 3	
<i>omega 3-dha-epa-fish oil oral capsule 100-400-1,000 mg, 300 mg (120 mg- 180mg)-1,000 mg, 415-670 mg</i>	Tier 3	
<i>omega 3-dha-epa-fish oil oral capsule, delayed release(dr/ec) 300 mg (120 mg- 180mg)-1,000 mg, 450 mg (128 mg- 322 mg)-650 mg</i>	Tier 3	
OMEGA MONOPURE DHA EC ORAL CAPSULE, DELAYED RELEASE(DR/EC) 790 MG-675 MG-118 MG-1,300 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGA MONOPURE EPA EC ORAL CAPSULE, DELAYED RELEASE(DR/EC) 910-1,300 MG (omega-3 fatty acids/eicosapentaenoic acid (epa)/fish oil)	Tier 3	
OMEGA MONOPURE ORAL CAPSULE, DELAYED RELEASE(DR/EC) 430-130-650 MG, 860-260-1,300 MG (omega-3 fatty acids/dha/epa/dpa/fish oil)	Tier 3	
<i>omega-3 fatty acids-fish oil oral capsule 300-1,000 mg</i>	Tier 3	
<i>omega-3 fatty acids-fish oil oral capsule 360-1,200 mg</i>	Tier 3	
OMEGA-3 KRILL OIL ORAL CAPSULE 350-90-24-50 MG (krill oil/omega-3 fatty acids/dha/epa/phospholipids/astaxan)	Tier 3	
<i>omega-3s-dha-epa-fish oil oral capsule 360-600 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMEGAPURE 900-TG ORAL CAPSULE 964-257-643 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE PRM ORAL CAPSULE 590-195-245-800 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE-600 EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 650 MG-240 MG- 360 MG-1,000 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE-780 EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 910 MG-330 MG- 450 MG-1,400 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE-820 ORAL CAPSULE 937.5 MG-320 MG - 500 MG-1,250MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OMEGAPURE-900 EC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 967 MG-385 MG- 515 MG-1,290 MG (omega-3 fatty acids/docosahexaenoic acid/epa/fish oil)	Tier 3	
OVEGA-3 ORAL CAPSULE 250-140-47.5 MG (omega-3 fatty acids/dha/epa/Schizochytrium algal oil)	Tier 3	
OVEGA-3 ORAL CAPSULE 500-270-135 MG (omega-3 fatty acids/docosahexaenoic acid/epa)	Tier 3	
SUPERIOR OMEGA3 WITH VIT D ORAL CAPSULE 1,250 MG-1,375 MG-25 MCG (omega-3/dha/epa/other omega-3s/fish oil/vitamin D3)	Tier 3	
TRIPLE OMEGA 3-6-9 ORAL CAPSULE 400-400-400 MG (fish oil/borage oil/flaxseed oil/omega 3,6,9 combination no1)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperlipidemic- Atp-Citrate Lyase And Cholesterol Absorption Inhib - Drugs For Cholesterol		
NEXLIZET ORAL TABLET 180-10 MG (bempedoic acid/ezetimibe)	Tier 2	ST: Requires prior prescription for generic statin within the past 120 days
Antihyperlipidemic Hmg Coa Reduct Inhib And Calcium Channel Blocker - Drugs For Cholesterol		
<i>amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg</i>	Tier 1	QL (1 EA per 1 day)
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG (amlodipine besylate/atorvastatin calcium)	Tier 3	QL (1 EA per 1 day)
Antihyperlipidemic-Hmg Coa Reduct Inhib And Cholesterol Absorp Inhibit - Drugs For Cholesterol		
<i>ezetimibe-rosuvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-5 mg</i>	Tier 3	ST: Requires prior prescriptions for Atorvastatin and Rosuvastatin tablets within the past 365 days; QL (1 EA per 1 day)
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>ezetimibe-simvastatin oral tablet 10-80 mg</i>	Tier 1	PA; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSZET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-5 MG (ezetimibe/rosuvastatin calcium)	Tier 3	ST: Requires prior prescriptions for Atorvastatin and Rosuvastatin tablets within the past 365 days; QL (1 EA per 1 day)
VYTORIN 10-10 ORAL TABLET 10-10 MG (ezetimibe/simvastatin)	Tier 3	QL (1 EA per 1 day)
VYTORIN 10-20 ORAL TABLET 10-20 MG (ezetimibe/simvastatin)	Tier 3	QL (1 EA per 1 day)
VYTORIN 10-40 ORAL TABLET 10-40 MG (ezetimibe/simvastatin)	Tier 3	QL (1 EA per 1 day)
VYTORIN 10-80 ORAL TABLET 10-80 MG (ezetimibe/simvastatin)	Tier 3	PA; QL (1 EA per 1 day)
Antihyperlipidemic-Microsomal Triglyceride Transfer Protein (Mtp)Inhib - Drugs For Cholesterol		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG (lomitapide mesylate)	Tier 3	PA
Beta Blockers Cardiac Selective - Drugs For High Blood Pressure		
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>betaxolol oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>bisoprolol fumarate oral tablet 2.5 mg</i>	Tier 1	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (nebivolol HCl)	Tier 3	
KAPSPARGO SPRINKLE ORAL CAPSULE,SPRINKLE,ER 24HR 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOPRESSOR ORAL SOLUTION 10 MG/ML (metoprolol tartrate)	Tier 3	PA
LOPRESSOR ORAL TABLET 100 MG, 50 MG (metoprolol tartrate)	Tier 3	
<i>metoprolol succinate oral tablet extended release 24 hr 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>metoprolol tartrate oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>metoprolol tartrate oral tablet 25 mg, 37.5 mg, 75 mg</i>	Tier 1	
<i>nebivolol oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG (atenolol)	Tier 3	
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 200 MG, 25 MG, 50 MG (metoprolol succinate)	Tier 3	
Beta Blockers Cardiac Selective, Intrinsic Sympathomimetic Activity - Drugs For High Blood Pressure		
<i>acebutolol oral capsule 200 mg, 400 mg</i>	Tier 1	
Beta Blockers Non-Cardiac Select., Intrinsic Sympathomimetic Activity - Drugs For High Blood Pressure		
<i>pindolol oral tablet 10 mg, 5 mg</i>	Tier 1	
Beta Blockers Non-Cardiac Selective - Drugs For High Blood Pressure		
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (sotalol HCl)	Tier 3	
BETAPACE ORAL TABLET 120 MG, 160 MG, 240 MG, 80 MG (sotalol HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (propranolol HCl)	Tier 3	ST: Requires prior prescription for generic Propranolol oral solution within the past 120 days if 1 year of age and older; QL (360 ML per 30 days)
INDERAL LA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 160 MG, 60 MG, 80 MG (propranolol HCl)	Tier 3	
INDERAL XL ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 80 MG (propranolol HCl)	Tier 3	ST: Requires prior prescription for Inderal LA within the past 120 days
INNOPRAN XL ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 80 MG (propranolol HCl)	Tier 3	ST: Requires prior prescription for Inderal LA within the past 120 days
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>propranolol oral capsule,extended release 24 hr 120 mg, 160 mg, 60 mg, 80 mg</i>	Tier 1	
<i>propranolol oral solution 20 mg/5 ml (4 mg/ml), 40 mg/5 ml (8 mg/ml)</i>	Tier 1	
<i>propranolol oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
sotalol HCl (Sotalol Af Oral Tablet 120 Mg, 160 Mg, 80 Mg)	Tier 1	
<i>sotalol oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	Tier 1	
SOTYLIZE ORAL SOLUTION 5 MG/ML (sotalol HCl)	Tier 3	QL: 8 BOTTLES IN 30 DAYS; ST: Requires prior prescription for Sotalol tablets within the past 120 days
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bradykinin B2 Receptor Antagonists - Drugs For The Heart		
FIRAZYR SUBCUTANEOUS SYRINGE 30 MG/3 ML (icatibant acetate)	Tier 3	PA; KP
<i>icatibant subcutaneous syringe 30 mg/3 ml</i>	Tier 3	PA; KP
icatibant acetate (Sajazir Subcutaneous Syringe 30 Mg/3 MI)	Tier 3	PA; KP
Calcium Channel Blocker - Nsaid, Cox-2 Selective Inhibitor Combination - Drugs For High Blood Pressure		
CONSENSI ORAL TABLET 10-200 MG, 2.5-200 MG, 5-200 MG (amlodipine besylate/celecoxib)	Tier 3	
Calcium Channel Blockers - Benzothiazepines - Drugs For High Blood Pressure		
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG (diltiazem HCl)	Tier 3	
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem HCl)	Tier 3	
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG (diltiazem HCl)	Tier 3	
diltiazem HCl (Cartia Xt Oral Capsule,Extended Release 24Hr 120 Mg, 180 Mg, 240 Mg, 300 Mg)	Tier 1	
<i>diltiazem hcl oral capsule,ext.rel 24h degradable 120 mg, 180 mg, 240 mg</i>	Tier 1	
<i>diltiazem hcl oral capsule,extended release 12 hr 120 mg, 60 mg, 90 mg</i>	Tier 1	
<i>diltiazem hcl oral capsule,extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	Tier 1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>diltiazem hcl oral tablet extended release 24 hr 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 1	
DILT-XR ORAL CAPSULE,EXT.REL 24H DEGRADABLE 120 MG, 180 MG, 240 MG (diltiazem HCl)	Tier 1	
diltiazem HCl (Matzim La Oral Tablet Extended Release 24 Hr 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Tier 1	
diltiazem HCl (Tiadylt Er Oral Capsule,Extended Release 24 Hr 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Tier 1	
TIAZAC ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (diltiazem HCl)	Tier 3	
Calcium Channel Blockers - Dihydropyridines - Cerebrovascular Specific - Drugs For High Blood Pressure		
<i>nimodipine oral capsule 30 mg</i>	Tier 1	
<i>nimodipine oral solution 60 mg/20 ml</i>	Tier 3	PA
NYMALIZE ORAL SOLUTION 60 MG/10 ML (nimodipine)	Tier 3	PA
NYMALIZE ORAL SYRINGE 30 MG/5 ML, 60 MG/10 ML (nimodipine)	Tier 3	PA
Calcium Channel Blockers - Dihydropyridines - Drugs For High Blood Pressure		
<i>amlodipine oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
CONJUPRI ORAL TABLET 2.5 MG, 5 MG (levamlodipine maleate)	Tier 3	PA
<i>felodipine oral tablet extended release 24 hr 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KATERZIA ORAL SUSPENSION 1 MG/ML (amlodipine benzoate)	Tier 3	PA
<i>levamlodipine oral tablet 2.5 mg, 5 mg</i>	Tier 1	PA
<i>nicardipine oral capsule 20 mg, 30 mg</i>	Tier 1	
<i>nifedipine oral capsule 10 mg, 20 mg</i>	Tier 1	
<i>nifedipine oral tablet extended release 24hr 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>nifedipine oral tablet extended release 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>nisoldipine oral tablet extended release 24 hr 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	Tier 1	
NORLIQVA ORAL SOLUTION 1 MG/ML (amlodipine besylate)	Tier 3	PA
NORVASC ORAL TABLET 10 MG, 2.5 MG, 5 MG (amlodipine besylate)	Tier 3	
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24HR 30 MG, 60 MG, 90 MG (nifedipine)	Tier 3	
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG (nisoldipine)	Tier 3	
Calcium Channel Blockers - Phenylalkylamines - Drugs For High Blood Pressure		
<i>verapamil oral capsule, 24 hr er pellet ct 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>verapamil oral capsule, ext rel. pellets 24 hr 120 mg, 180 mg, 240 mg, 360 mg</i>	Tier 1	
<i>verapamil oral tablet 120 mg, 40 mg, 80 mg</i>	Tier 1	
<i>verapamil oral tablet extended release 120 mg, 180 mg, 240 mg</i>	Tier 1	
Cardiac Myosin Inhibitor - Drugs For The Heart		
CAMZYOS ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (mavacamten)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb. - Drugs For High Blood Pressure		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	Tier 1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	Tier 1	
<i>metoprolol ta-hydrochlorothiaz oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	Tier 1	
TENORETIC 100 ORAL TABLET 100-25 MG (atenolol/chlorthalidone)	Tier 3	
TENORETIC 50 ORAL TABLET 50-25 MG (atenolol/chlorthalidone)	Tier 3	
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents - Drugs For Serious Allergic Reaction		
AUVI-Q INJECTION AUTO-INJECTOR 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML (epinephrine)	Tier 2	KP; QL (2 EA per 365 days)
<i>epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i>	Tier 1	KP; QL (4 EA per 1 FILL)
EPIPEN 2-PAK INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML (epinephrine)	Tier 3	KP; QL (4 EA per 1 FILL)
EPIPEN INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML (epinephrine)	Tier 3	KP; QL (4 EA per 1 FILL)
EPIPEN JR 2-PAK INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML (epinephrine)	Tier 3	KP; QL (4 EA per 1 FILL)
EPIPEN JR INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML (epinephrine)	Tier 3	KP; QL (4 EA per 1 FILL)
NEFFY NASAL SPRAY, NON-AEROSOL 1 MG/SPRAY (0.1 ML), 2 MG/SPRAY (0.1 ML) (epinephrine)	Tier 3	QL (4 EA per 1 FILL)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cardiovascular Sympathomimetics - Drugs For Serious Allergic Reaction		
<i>droxidopa oral capsule 100 mg, 200 mg, 300 mg</i>	Tier 3	PA
<i>midodrine oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG (droxidopa)	Tier 3	PA
Central Alpha-2 Agonists-Thiazide Diuretic And Related Comb. - Drugs For High Blood Pressure		
<i>methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg</i>	Tier 1	
Central Alpha-2 Receptor Agonists - Drugs For High Blood Pressure		
CATAPRES-TTS-1 TRANSDERMAL PATCH WEEKLY 0.1 MG/24 HR (clonidine)	Tier 3	
CATAPRES-TTS-2 TRANSDERMAL PATCH WEEKLY 0.2 MG/24 HR (clonidine)	Tier 3	
CATAPRES-TTS-3 TRANSDERMAL PATCH WEEKLY 0.3 MG/24 HR (clonidine)	Tier 3	
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	Tier 1	
<i>clonidine hcl oral tablet extended release 24 hr 0.17 mg</i>	Tier 3	
<i>clonidine transdermal patch weekly 0.1 mg/24 hr, 0.2 mg/24 hr, 0.3 mg/24 hr</i>	Tier 1	
<i>guanfacine oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	Tier 1	
Digitalis Glycosides - Drugs For The Heart		
digoxin (Digitek Oral Tablet 125 Mcg (0.125 Mg), 250 Mcg (0.25 Mg))	Tier 1	
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i>	Tier 1	
<i>digoxin oral tablet 62.5 mcg (0.0625 mg)</i>	Tier 1	PA
LANOXIN ORAL TABLET 125 MCG (0.125 MG), 250 MCG (0.25 MG) (digoxin)	Tier 3	
LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG) (digoxin)	Tier 3	PA
Direct Acting Vasodilators - Drugs For High Blood Pressure		
<i>hydralazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	Tier 1	
Diuretic - Aldosterone Receptor Antagonist, Non-Selective - Drugs For High Blood Pressure		
ALDACTONE ORAL TABLET 100 MG, 25 MG, 50 MG (spironolactone)	Tier 3	
CAROSPIR ORAL SUSPENSION 25 MG/5 ML (spironolactone)	Tier 3	PA
<i>spironolactone oral suspension 25 mg/5 ml</i>	Tier 1	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
Diuretic - Aldosterone Receptor Antagonist, Selective - Drugs For High Blood Pressure		
<i>eplerenone oral tablet 25 mg, 50 mg</i>	Tier 1	
INSPIRA ORAL TABLET 25 MG, 50 MG (eplerenone)	Tier 3	
Diuretic - Carbonic Anhydrase Inhibitors - Drugs For High Blood Pressure		
<i>acetazolamide oral capsule, extended release 500 mg</i>	Tier 1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	Tier 1	
<i>dichlorphenamide oral tablet 50 mg</i>	Tier 3	PA
<i>methazolamide oral tablet 25 mg, 50 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Diuretic - Loop - Drugs For High Blood Pressure		
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
EDECRIN ORAL TABLET 25 MG (ethacrynic acid)	Tier 3	PA
<i>ethacrynic acid oral tablet 25 mg</i>	Tier 1	PA
FUROSCIX SUBCUTANEOUS KIT 80 MG/10 ML (furosemide)	Tier 3	PA; KP
<i>furosemide oral solution 10 mg/ml</i>	Tier 1	
<i>furosemide oral solution 40 mg/5 ml (8 mg/ml)</i>	Tier 1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
LASIX ORAL TABLET 20 MG, 40 MG, 80 MG (furosemide)	Tier 3	
SOAANZ ORAL TABLET 40 MG (torsemide)	Tier 3	PA
<i>torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	Tier 1	
Diuretic - Osmotic - Drugs For High Blood Pressure		
UREAPRO ORAL POWDER 15 GRAM/SCOOP (urea)	Tier 3	
Diuretic - Potassium Sparing - Drugs For High Blood Pressure		
<i>amiloride oral tablet 5 mg</i>	Tier 1	
DYRENIUM ORAL CAPSULE 100 MG, 50 MG (triamterene)	Tier 3	
<i>triamterene oral capsule 100 mg, 50 mg</i>	Tier 1	
Diuretic - Potassium Sparing-Thiazide And Related Combinations - Drugs For High Blood Pressure		
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	Tier 1	
<i>spironolacton-hydrochlorothiaz oral tablet 25-25 mg</i>	Tier 1	
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>triamterene-hydrochlorothiazid oral tablet 37.5-25 mg, 75-50 mg</i>	Tier 1	
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists - Drugs For High Blood Pressure		
SAMSCA ORAL TABLET 15 MG (tolvaptan)	Tier 3	QL (30 EA per 365 days)
SAMSCA ORAL TABLET 30 MG (tolvaptan)	Tier 3	QL (60 EA per 365 days)
<i>tolvaptan oral tablet 15 mg</i>	Tier 3	QL (30 EA per 365 days)
<i>tolvaptan oral tablet 30 mg</i>	Tier 3	QL (60 EA per 365 days)
Diuretic - Thiazides And Related - Drugs For High Blood Pressure		
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	
DIURIL ORAL SUSPENSION 250 MG/5 ML (chlorothiazide)	Tier 3	
HEMICLOR ORAL TABLET 12.5 MG (chlorthalidone)	Tier 3	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	Tier 1	
<i>hydrochlorothiazide oral tablet 12.5 mg</i>	Tier 1	
<i>hydrochlorothiazide oral tablet 25 mg, 50 mg</i>	Tier 1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	Tier 1	
INZIRQO ORAL SUSPENSION FOR RECONSTITUTION 10 MG/ML (hydrochlorothiazide)	Tier 3	PA
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
THALITONE ORAL TABLET 15 MG (chlorthalidone)	Tier 3	
Ganglionic Blocking, Non-Depolarizing - Drugs For High Blood Pressure		
VECAMYL ORAL TABLET 2.5 MG (mecamylamine HCl)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hyperpolarization-Activated Cyclic Nucleotide-Gated Channel Inhibitors - Drugs For High Blood Pressure		
CORLANOR ORAL SOLUTION 5 MG/5 ML (ivabradine HCl)	Tier 2	QL (20 ML per 1 day)
CORLANOR ORAL TABLET 5 MG, 7.5 MG (ivabradine HCl)	Tier 3	ST: Requires prior prescription for Bisoprolol, Carvedilol, or Metoprolol Succinate within the past 120 days; QL (2 EA per 1 day)
<i>ivabradine oral tablet 5 mg, 7.5 mg</i>	Tier 1	ST: Requires prior prescription for Bisoprolol, Carvedilol, or Metoprolol Succinate within the past 120 days; QL (2 EA per 1 day)
Hypertrophic Cardiomyopathy Treatment Agents, Ablative - Drugs For The Heart		
ABLYSINOL INTRA-ARTERIAL SOLUTION 99 % (ethyl alcohol)	Tier 3	
<i>ethyl alcohol intra-arterial solution 99 %</i>	Tier 1	
Muscarinic Receptor Antagonists (Anticholinergic) - Drugs For Abnormal Heart Rhythms		
ATROPEN INTRAMUSCULAR PEN INJECTOR 0.5 MG/0.7 ML, 1 MG/0.7 ML (atropine sulfate)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Non-Cardiac Selective Beta Blocker-Thiazide Diuretic And Related Comb. - Drugs For High Blood Pressure		
<i>propranolol-hydrochlorothiazid oral tablet 40-25 mg, 80-25 mg</i>	Tier 1	
Pah Agents - Selective Prostacyclin Receptor (Ip) Agonists - Drugs For High Blood Pressure		
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (selexipag)	Tier 3	PA
UPTRAVI ORAL TABLETS,DOSE PACK 200 MCG (140)-800 MCG (60) (selexipag)	Tier 3	PA
Peripheral Alpha-1 Receptor Blockers - Drugs For High Blood Pressure		
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG, 8 MG (doxazosin mesylate)	Tier 3	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24HR 4 MG, 8 MG (doxazosin mesylate)	Tier 3	
DIBENZYLINE ORAL CAPSULE 10 MG (phenoxybenzamine HCl)	Tier 3	PA
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>phenoxybenzamine oral capsule 10 mg</i>	Tier 3	PA
<i>prazosin oral capsule 1 mg, 2 mg, 5 mg</i>	Tier 1	
<i>terazosin oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
TEZRULY ORAL SOLUTION 1 MG/ML (terazosin HCl)	Tier 3	PA
Peripheral Vasodilators, Single Agents - Drugs For High Blood Pressure		
<i>papaverine injection solution 30 mg/ml</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pheochromocytoma, Agents To Treat - Drugs For High Blood Pressure		
DEMSEER ORAL CAPSULE 250 MG (metyrosine)	Tier 3	PA
<i>metyrosine oral capsule 250 mg</i>	Tier 3	PA
Plasma Kallikrein Inhibitor Agents, Recombinant Monoclonal Antibody - Drugs For The Heart		
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2 ML (150 MG/ML) (lanadelumab-flyo)	Tier 3	PA; KP
TAKHZYRO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (150 MG/ML) (lanadelumab-flyo)	Tier 3	PA; KP
Plasma Kallikrein Inhibitor Agents, Small Molecule - Drugs For The Heart		
EKTERLY ORAL TABLET 300 MG (sebetralstat)	Tier 3	PA; QL (4 EA per 1 day)
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (berotralstat hydrochloride)	Tier 3	PA
Pulmonary Antihypertensive Agents - Prostacyclin-Type - Drugs For High Blood Pressure		
ORENITRAM MONTH 1 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG (42) (treprostinil diolamine)	Tier 3	PA
ORENITRAM MONTH 2 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG (210) (treprostinil diolamine)	Tier 3	PA
ORENITRAM MONTH 3 TITRATION KT ORAL TABLET EXTENDED REL,DOSE PACK 0.125 MG (126)- 0.25 MG(42)-1MG (treprostinil diolamine)	Tier 3	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (treprostinil diolamine)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REMODULIN INJECTION SOLUTION 1 MG/ML, 10 MG/ML, 2.5 MG/ML, 5 MG/ML (treprostinil sodium)	Tier 3	PA; KP
<i>treprostinil sodium injection solution 1 mg/ml, 10 mg/ml, 2.5 mg/ml, 5 mg/ml</i>	Tier 3	PA; KP
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 16(112)-32(112) -48(28) MCG, 32 MCG, 48 MCG, 64 MCG (treprostinil)	Tier 3	PA
TYVASO INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML) (treprostinil)	Tier 3	PA
TYVASO INSTITUTIONAL START KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (treprostinil/nebulizer and accessories)	Tier 3	PA
TYVASO REFILL KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (0.6 MG/ML) (treprostinil/nebulizer accessories)	Tier 3	PA
TYVASO STARTER KIT INHALATION SOLUTION FOR NEBULIZATION 1.74 MG/2.9 ML (treprostinil/nebulizer and accessories)	Tier 3	PA
VENTAVIS INHALATION SOLUTION FOR NEBULIZATION 10 MCG/ML, 20 MCG/ML (iloprost tromethamine)	Tier 3	PA
YUTREPIA INHALATION CAPSULE, W/INHALATION DEVICE 106 MCG, 26.5 MCG, 53 MCG, 79.5 MCG (treprostinil sodium)	Tier 3	PA
Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator - Drugs For High Blood Pressure		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (riociguat)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pulmonary Arterial Hypertension - Endothelin Receptor Antagonists - Drugs For High Blood Pressure		
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	Tier 3	PA
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	Tier 3	PA
<i>bosentan oral tablet for suspension 32 mg</i>	Tier 3	PA
LETAIRIS ORAL TABLET 10 MG, 5 MG (ambrisentan)	Tier 3	PA
OPSUMIT ORAL TABLET 10 MG (macitentan)	Tier 3	PA
TRACLEER ORAL TABLET 125 MG, 62.5 MG (bosentan)	Tier 3	PA
TRACLEER ORAL TABLET FOR SUSPENSION 32 MG (bosentan)	Tier 3	PA
Pulmonary Arterial Hypertension - Selective Cgmp-Pde5 Inhibitors - Drugs For High Blood Pressure		
ADCIRCA ORAL TABLET 20 MG (tadalafil)	Tier 3	PA; QL (2 EA per 1 day)
tadalafil (Alyq Oral Tablet 20 Mg)	Tier 3	PA; QL (2 EA per 1 day)
LIQREV ORAL SUSPENSION 10 MG/ML (sildenafil citrate)	Tier 3	PA
REVATIO ORAL TABLET 20 MG (sildenafil citrate)	Tier 3	PA
<i>sildenafil (pulm.hypertension) oral suspension for reconstitution 10 mg/ml</i>	Tier 1	PA
<i>sildenafil (pulm.hypertension) oral tablet 20 mg</i>	Tier 1	PA
<i>tadalafil (pulm. hypertension) oral tablet 20 mg</i>	Tier 3	PA; QL (2 EA per 1 day)
TADLIQ ORAL SUSPENSION 20 MG/5 ML (4 MG/ML) (tadalafil)	Tier 3	PA
Renin Inhibitor, Direct - Drugs For High Blood Pressure		
<i>aliskiren oral tablet 150 mg, 300 mg</i>	Tier 1	
TEKTURNAL ORAL TABLET 150 MG, 300 MG (aliskiren hemifumarate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vasodilator Combinations - Drugs For High Blood Pressure		
BIDIL ORAL TABLET 20-37.5 MG (isosorbide dinitrate/hydralazine HCl)	Tier 3	
<i>isosorbide-hydralazine oral tablet 20-37.5 mg</i>	Tier 1	
Central Nervous System Agents		
Antipsychotic - Muscarinic Agonist/Antagonist Combinations		
COBENFY ORAL CAPSULE 100-20 MG, 125-30 MG, 50-20 MG (xanomeline tartrate/trospium chloride)	Tier 3	ST: Requires prior prescription for a generic atypical Antipsychotic, Rexulti, or Vraylar within the past 120 days; QL (2 EA per 1 day)
COBENFY STARTER PACK ORAL CAPSULE,DOSE PACK 50 MG-20 MG /100 MG-20 MG (xanomeline tartrate/trospium chloride)	Tier 3	ST: Requires prior prescription for a generic atypical Antipsychotic, Rexulti, or Vraylar within the past 120 days
Migraine Therapy - Serotonin Agonist 5-Ht(1) And Nsaid Cox-2 Comb		
SYMBRAVO ORAL TABLET 10-20 MG (rizatriptan benzoate/meloxicam)	Tier 3	
Central Nervous System Agents - Drugs For The Nervous System		
Agents To Treat Episodic Cluster Headaches - Drugs For Migraine Headaches		
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3) (galcanezumab-gnlm)	Tier 2	PA; KP; QL (3 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antianxiety Agent - Antihistamine Type - Drugs For Anxiety		
<i>hydroxyzine hcl oral solution 10 mg/5 ml</i>	Tier 1	
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antianxiety Agent - Benzodiazepines - Drugs For Anxiety		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (alprazolam)	Tier 2	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg</i>	Tier 1	
<i>alprazolam oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG (lorazepam)	Tier 3	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	Tier 1	
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	Tier 1	
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/ML)	Tier 1	
<i>diazepam oral concentrate 5 mg/ml</i>	Tier 1	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	Tier 1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	Tier 1	
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (clonazepam)	Tier 3	
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	Tier 1	
<i>lorazepam oral concentrate 2 mg/ml</i>	Tier 1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1 MG, 2 MG, 3 MG (lorazepam)	Tier 3	
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1.5 MG (lorazepam)	Tier 3	ST: Requires prior prescription for Lorazepam tablets within the past 120 days
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	Tier 1	
VALIUM ORAL TABLET 10 MG, 2 MG, 5 MG (diazepam)	Tier 3	
XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG (alprazolam)	Tier 3	
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG, 2 MG, 3 MG (alprazolam)	Tier 3	
Antianxiety Agent - Dicarbamate Type - Drugs For Anxiety		
<i>meprobamate oral tablet 200 mg, 400 mg</i>	Tier 1	
Antianxiety Agent - Non-Benzodiazepine - Drugs For Anxiety		
BUCAPSOL ORAL CAPSULE 10 MG, 15 MG, 7.5 MG (buspirone HCl)	Tier 3	
<i>buspirone oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	
Anticonvulsant - Ampa-Type Glutamate Receptor Antagonists - Drugs For Seizures /Personality Disorder/Nerve Pain		
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (perampanel)	Tier 2	QL (680 ML per 28 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG (perampanel)	Tier 3	QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG (perampanel)	Tier 3	QL (120 EA per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG (perampanel)	Tier 3	QL (60 EA per 30 days)
<i>perampanel oral tablet 10 mg, 12 mg, 8 mg</i>	Tier 1	QL (30 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>perampanel oral tablet 2 mg</i>	Tier 1	QL (120 EA per 30 days)
<i>perampanel oral tablet 4 mg, 6 mg</i>	Tier 1	QL (60 EA per 30 days)
Anticonvulsant - Barbiturates And Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
MYSOLINE ORAL TABLET 250 MG, 50 MG (primidone)	Tier 3	
<i>phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>phenobarbital oral tablet 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg</i>	Tier 1	
<i>phenobarbital oral tablet 15 mg, 30 mg, 60 mg</i>	Tier 1	
<i>primidone oral tablet 125 mg</i>	Tier 1	
<i>primidone oral tablet 250 mg, 50 mg</i>	Tier 1	
Anticonvulsant - Benzodiazepines - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>clobazam oral suspension 2.5 mg/ml</i>	Tier 1	QL (480 ML per 30 days)
<i>clobazam oral tablet 10 mg, 20 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	Tier 1	
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (clonazepam)	Tier 3	
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG (diazepam)	Tier 3	QL (10 EA per 30 days)
NAYZILAM NASAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML) (midazolam)	Tier 3	QL (10 EA per 30 days)
ONFI ORAL SUSPENSION 2.5 MG/ML (clobazam)	Tier 2	QL (480 ML per 30 days)
ONFI ORAL TABLET 10 MG, 20 MG (clobazam)	Tier 2	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (clobazam)	Tier 2	
VALTOCO NASAL SPRAY, NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML) (diazepam)	Tier 3	QL (10 EA per 30 days)
Anticonvulsant - Cannabinoid Type - Drugs For Seizures /Personality Disorder/Nerve Pain		
EPIDIOLEX ORAL SOLUTION 100 MG/ML (cannabidiol (CBD))	Tier 3	
Anticonvulsant - Carbamates - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>felbamate oral suspension 600 mg/5 ml</i>	Tier 1	
<i>felbamate oral tablet 400 mg, 600 mg</i>	Tier 1	
FELBATOL ORAL TABLET 400 MG, 600 MG (felbamate)	Tier 3	
Anticonvulsant - Carboxylic Acid Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG (divalproex sodium)	Tier 3	
DEPAKOTE ORAL TABLET, DELAYED RELEASE (DR/EC) 125 MG, 250 MG, 500 MG (divalproex sodium)	Tier 3	
DEPAKOTE SPRINKLES ORAL CAPSULE, DELAYED REL SPRINKLE 125 MG (divalproex sodium)	Tier 3	
<i>divalproex oral capsule, delayed rel sprinkle 125 mg</i>	Tier 1	
<i>divalproex oral tablet extended release 24 hr 250 mg, 500 mg</i>	Tier 1	
<i>divalproex oral tablet, delayed release (dr/ec) 125 mg, 250 mg, 500 mg</i>	Tier 1	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	Tier 1	
<i>valproic acid oral capsule 250 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticonvulsant - Functionalized Amino Acid - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>lacosamide intravenous solution 200 mg/20 ml</i>	Tier 1	KP
<i>lacosamide oral solution 10 mg/ml</i>	Tier 1	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Tier 1	
MOTPOLY XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 150 MG, 200 MG (lacosamide)	Tier 3	PA
VIMPAT INTRAVENOUS SOLUTION 200 MG/20 ML (lacosamide)	Tier 3	KP
VIMPAT ORAL SOLUTION 10 MG/ML (lacosamide)	Tier 3	
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (lacosamide)	Tier 3	
Anticonvulsant - Gaba Analogs - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	Tier 1	
<i>gabapentin oral solution 250 mg/5 ml</i>	Tier 1	
<i>gabapentin oral solution 250 mg/5 ml (5 ml), 300 mg/6 ml (6 ml)</i>	Tier 1	
<i>gabapentin oral tablet 600 mg, 800 mg</i>	Tier 1	
GABARONE ORAL TABLET 100 MG, 400 MG (gabapentin)	Tier 3	
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (pregabalin)	Tier 3	
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	Tier 3	
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (gabapentin)	Tier 3	
NEURONTIN ORAL SOLUTION 250 MG/5 ML (gabapentin)	Tier 3	
NEURONTIN ORAL TABLET 600 MG, 800 MG (gabapentin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	Tier 1	
<i>pregabalin oral solution 20 mg/ml</i>	Tier 1	
Anticonvulsant - Gaba Re-Uptake Inhibitor, Nipecotic Acid Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>tiagabine oral tablet 12 mg, 2 mg, 4 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>tiagabine oral tablet 16 mg</i>	Tier 1	QL (3 EA per 1 day)
Anticonvulsant - Gaba Transaminase (Gaba-T) Inhibitor - Drugs For Seizures /Personality Disorder/Nerve Pain		
SABRIL ORAL POWDER IN PACKET 500 MG (vigabatrin)	Tier 2	PA
SABRIL ORAL TABLET 500 MG (vigabatrin)	Tier 2	PA
<i>vigabatrin oral powder in packet 500 mg</i>	Tier 1	PA
<i>vigabatrin oral tablet 500 mg</i>	Tier 1	PA
vigabatrin (Vigadrone Oral Powder In Packet 500 Mg)	Tier 1	PA
vigabatrin (Vigadrone Oral Tablet 500 Mg)	Tier 1	PA
VIGAFYDE ORAL SOLUTION 100 MG/ML (vigabatrin)	Tier 3	PA
vigabatrin (Vigpoder Oral Powder In Packet 500 Mg)	Tier 1	PA
Anticonvulsant - Hydantoins - Drugs For Seizures /Personality Disorder/Nerve Pain		
phenytoin sodium extended (Dilantin Extended Oral Capsule 100 Mg)	Tier 3	
phenytoin (Dilantin Infatabs Oral Tablet,Chewable 50 Mg)	Tier 3	
phenytoin sodium extended (Dilantin Oral Capsule 30 Mg)	Tier 3	
DILANTIN-125 ORAL SUSPENSION 125 MG/5 ML (phenytoin)	Tier 3	
phenytoin sodium extended (Phenytek Oral Capsule 200 Mg, 300 Mg)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>phenytoin oral suspension 125 mg/5 ml</i>	Tier 1	
<i>phenytoin oral tablet, chewable 50 mg</i>	Tier 1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	Tier 1	
Anticonvulsant - Iminostilbene Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
APTOM ORAL TABLET 200 MG, 400 MG (eslicarbazepine acetate)	Tier 3	QL (1 EA per 1 day)
APTOM ORAL TABLET 600 MG, 800 MG (eslicarbazepine acetate)	Tier 3	QL (2 EA per 1 day)
<i>carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	Tier 1	
<i>carbamazepine oral tablet 200 mg</i>	Tier 1	
<i>carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg</i>	Tier 1	
<i>carbamazepine oral tablet, chewable 100 mg</i>	Tier 1	
<i>carbamazepine oral tablet, chewable 200 mg</i>	Tier 1	
CARBATROL ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG (carbamazepine)	Tier 3	
carbamazepine (Eptol Oral Tablet 200 Mg)	Tier 1	
EQUETRO ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG (carbamazepine)	Tier 3	
<i>eslicarbazepine oral tablet 200 mg, 400 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>eslicarbazepine oral tablet 600 mg, 800 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>oxcarbazepine oral suspension 300 mg/5 ml (60 mg/ml)</i>	Tier 1	
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxcarbazepine oral tablet extended release 24 hr 150 mg, 300 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Carbamazepine, Divalproex, Gabapentin, Lamotrigine, Levetiracetam IR/ER, Oxcarbazepine, Topiramate, Valproic Acid, or Zonisamide within the past 365 days; QL (3 EA per 1 day)
<i>oxcarbazepine oral tablet extended release 24 hr 600 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Carbamazepine, Divalproex, Gabapentin, Lamotrigine, Levetiracetam IR/ER, Oxcarbazepine, Topiramate, Valproic Acid, or Zonisamide within the past 365 days; QL (4 EA per 1 day)
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG (oxcarbazepine)	Tier 3	ST: At least 2 prior prescriptions for Carbamazepine, Divalproex, Gabapentin, Lamotrigine, Levetiracetam IR/ER, Oxcarbazepine, Topiramate, Valproic Acid, or Zonisamide within the past 365 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR 600 MG (oxcarbazepine)	Tier 3	ST: At least 2 prior prescriptions for Carbamazepine, Divalproex, Gabapentin, Lamotrigine, Levetiracetam IR/ER, Oxcarbazepine, Topiramate, Valproic Acid, or Zonisamide within the past 365 days; QL (4 EA per 1 day)
TEGRETOL ORAL SUSPENSION 100 MG/5 ML (carbamazepine)	Tier 3	
TEGRETOL ORAL TABLET 200 MG (carbamazepine)	Tier 3	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 200 MG, 400 MG (carbamazepine)	Tier 3	
TRILEPTAL ORAL SUSPENSION 300 MG/5 ML (60 MG/ML) (oxcarbazepine)	Tier 3	
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (oxcarbazepine)	Tier 3	
Anticonvulsant - Monosaccharide Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
EPRONTIA ORAL SOLUTION 25 MG/ML (topiramate)	Tier 3	PA
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 100 MG (topiramate)	Tier 3	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 150 MG, 200 MG (topiramate)	Tier 3	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (2 EA per 1 day)
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 25 MG (topiramate)	Tier 3	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (1 EA per 1 day)
QUDEXY XR ORAL CAPSULE,SPRINKLE,ER 24HR 50 MG (topiramate)	Tier 3	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (7 EA per 1 day)
TOPAMAX ORAL CAPSULE, SPRINKLE 15 MG, 25 MG (topiramate)	Tier 3	
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (topiramate)	Tier 3	
<i>topiramate oral capsule, sprinkle 15 mg, 25 mg</i>	Tier 1	
<i>topiramate oral capsule, sprinkle 50 mg</i>	Tier 1	
<i>topiramate oral capsule,extended release 24hr 100 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>topiramate oral capsule,extended release 24hr 200 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>topiramate oral capsule,extended release 24hr 25 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>topiramate oral capsule,extended release 24hr 50 mg</i>	Tier 1	QL (7 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>topiramate oral capsule,sprinkle,er 24hr 100 mg</i>	Tier 1	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (3 EA per 1 day)
<i>topiramate oral capsule,sprinkle,er 24hr 150 mg, 200 mg</i>	Tier 1	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (2 EA per 1 day)
<i>topiramate oral capsule,sprinkle,er 24hr 25 mg</i>	Tier 1	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (1 EA per 1 day)
<i>topiramate oral capsule,sprinkle,er 24hr 50 mg</i>	Tier 1	ST: Requires prior prescription for Topiramate immediate release tablets/sprinkle capsules within the past 120 days; QL (7 EA per 1 day)
<i>topiramate oral solution 25 mg/ml</i>	Tier 1	PA
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG (topiramate)	Tier 3	QL (3 EA per 1 day)
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG (topiramate)	Tier 3	QL (2 EA per 1 day)
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 25 MG (topiramate)	Tier 3	QL (8 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TROKENDI XR ORAL CAPSULE,EXTENDED RELEASE 24HR 50 MG (topiramate)	Tier 3	QL (7 EA per 1 day)
Anticonvulsant - Neuroactive Steroid Gaba-A Receptor Modulator - Drugs For Seizures /Personality Disorder/Nerve Pain		
ZTALMY ORAL SUSPENSION 50 MG/ML (ganaxolone)	Tier 3	PA
Anticonvulsant - Phenyltriazine Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG, 200 MG, 25 MG, 50 MG (lamotrigine)	Tier 3	
LAMICTAL ODT STARTER (BLUE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG (21) -50 MG (7) (lamotrigine)	Tier 3	
LAMICTAL ODT STARTER (GREEN) ORAL TABLET DISINTEGRATING, DOSE PK 50 MG (42) -100 MG (14) (lamotrigine)	Tier 3	
LAMICTAL ODT STARTER (ORANGE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG(14)-50 MG (14)-100 MG (7) (lamotrigine)	Tier 3	
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (lamotrigine)	Tier 3	
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG (lamotrigine)	Tier 3	
LAMICTAL STARTER (BLUE) KIT ORAL TABLETS,DOSE PACK 25 MG (35) (lamotrigine)	Tier 3	
LAMICTAL STARTER (GREEN) KIT ORAL TABLETS,DOSE PACK 25 MG (84) -100 MG (14) (lamotrigine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAMICTAL STARTER (ORANGE) KIT ORAL TABLETS,DOSE PACK 25 MG (42) -100 MG (7) (lamotrigine)	Tier 3	
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24HR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (lamotrigine)	Tier 3	
LAMICTAL XR STARTER (BLUE) ORAL TABLET EXTENDED REL,DOSE PACK 25 MG (21) -50 MG (7) (lamotrigine)	Tier 3	
LAMICTAL XR STARTER (GREEN) ORAL TABLET EXTENDED REL,DOSE PACK 50 MG(14)-100MG (14)-200 MG (7) (lamotrigine)	Tier 3	
LAMICTAL XR STARTER (ORANGE) ORAL TABLET EXTENDED REL,DOSE PACK 25MG (14)-50 MG (14)-100MG (7) (lamotrigine)	Tier 3	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	Tier 1	
<i>lamotrigine oral tablet disintegrating, dose pk 25 mg (21) - 50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg (42) - 100 mg (14)</i>	Tier 1	
<i>lamotrigine oral tablet extended release 24hr 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	Tier 1	
<i>lamotrigine oral tablet, chewable dispersible 25 mg, 5 mg</i>	Tier 1	
<i>lamotrigine oral tablet,disintegrating 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>lamotrigine oral tablets,dose pack 25 mg (35), 25 mg (42) - 100 mg (7), 25 mg (84) -100 mg (14)</i>	Tier 1	
lamotrigine (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	Tier 3	
lamotrigine (Subvenite Starter (Blue) Kit Oral Tablets,Dose Pack 25 Mg (35))	Tier 3	
lamotrigine (Subvenite Starter (Green) Kit Oral Tablets,Dose Pack 25 Mg (84) -100 Mg (14))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
lamotrigine (Subvenite Starter (Orange) Kit Oral Tablets,Dose Pack 25 Mg (42) -100 Mg (7))	Tier 3	
Anticonvulsant - Pyrrolidine Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
BRIVIACT INTRAVENOUS SOLUTION 50 MG/5 ML (brivaracetam)	Tier 2	KP
BRIVIACT ORAL SOLUTION 10 MG/ML (brivaracetam)	Tier 2	QL (600 ML per 30 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (brivaracetam)	Tier 2	QL (2 EA per 1 day)
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HR 1,000 MG (levetiracetam)	Tier 3	ST: Requires prior prescription for generic Levetiracetam ER within the past 120 days; QL (3 EA per 1 day); Age (Min 12 Years)
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HR 1,500 MG (levetiracetam)	Tier 3	ST: Requires prior prescription for generic Levetiracetam ER within the past 120 days; QL (2 EA per 1 day); Age (Min 12 Years)
KEPPRA ORAL SOLUTION 100 MG/ML (levetiracetam)	Tier 3	
KEPPRA ORAL TABLET 1,000 MG, 250 MG, 500 MG, 750 MG (levetiracetam)	Tier 3	
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG, 750 MG (levetiracetam)	Tier 3	
<i>levetiracetam oral solution 100 mg/ml</i>	Tier 1	
<i>levetiracetam oral tablet 1,000 mg, 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>levetiracetam oral tablet extended release 24 hr 500 mg, 750 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levetiracetam (Roweepra Oral Tablet 500 Mg)	Tier 3	
levetiracetam (Roweepra Xr Oral Tablet Extended Release 24 Hr 500 Mg, 750 Mg)	Tier 3	
SPRITAM ORAL TABLET FOR SUSPENSION 1,000 MG, 250 MG, 500 MG, 750 MG (levetiracetam)	Tier 3	PA
Anticonvulsant - Succinimides - Drugs For Seizures /Personality Disorder/Nerve Pain		
CELONTIN ORAL CAPSULE 300 MG (methsuximide)	Tier 3	
<i>ethosuximide oral capsule 250 mg</i>	Tier 1	
<i>ethosuximide oral solution 250 mg/5 ml</i>	Tier 1	
<i>methsuximide oral capsule 300 mg</i>	Tier 1	
ZARONTIN ORAL CAPSULE 250 MG (ethosuximide)	Tier 3	
ethosuximide (Zarontin Oral Solution 250 Mg/5 Ml)	Tier 3	
Anticonvulsant - Sulfonamide Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG (zonisamide)	Tier 3	
ZONISADE ORAL SUSPENSION 100 MG/5 ML (zonisamide)	Tier 3	PA
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Anticonvulsant - Triazole Derivatives - Drugs For Seizures /Personality Disorder/Nerve Pain		
BANZEL ORAL SUSPENSION 40 MG/ML (rufinamide)	Tier 3	ST: Requires prior prescription for Valproic Acid, Divalproex, or Clobazam within the past 120 days; QL (80 ML per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BANZEL ORAL TABLET 200 MG (rufinamide)	Tier 3	ST: Requires prior prescription for Valproic Acid, Divalproex, or Clobazam within the past 120 days; QL (16 EA per 1 day)
BANZEL ORAL TABLET 400 MG (rufinamide)	Tier 3	ST: Requires prior prescription for Valproic Acid, Divalproex, or Clobazam within the past 120 days; QL (8 EA per 1 day)
<i>rufinamide oral suspension 40 mg/ml</i>	Tier 1	ST: Requires prior prescription for Valproic acid, Divalproex, or Clobazam within the past 120 days; QL (80 ML per 1 day)
<i>rufinamide oral tablet 200 mg</i>	Tier 1	ST: Requires prior prescription for Valproic Acid, Divalproex, or Clobazam within the past 120 days; QL (16 EA per 1 day)
<i>rufinamide oral tablet 400 mg</i>	Tier 1	ST: Requires prior prescription for Valproic Acid, Divalproex, or Clobazam within the past 120 days; QL (8 EA per 1 day)
Anticonvulsant Others - Drugs For Seizures /Personality Disorder/Nerve Pain		
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (stiripentol)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG (stiripentol)	Tier 3	PA
FINTEPLA ORAL SOLUTION 2.2 MG/ML (fenfluramine HCl)	Tier 3	PA
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1) (cenobamate)	Tier 2	QL (2 EA per 1 day)
XCOPRI ORAL TABLET 100 MG, 150 MG, 25 MG, 50 MG (cenobamate)	Tier 2	QL (1 EA per 1 day)
XCOPRI ORAL TABLET 200 MG (cenobamate)	Tier 2	QL (2 EA per 1 day)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14), 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14) (cenobamate)	Tier 2	QL (1 EA per 1 day)
Antidepressant - Alpha-2 Receptor Antagonists (Nassa) - Drugs For Depression		
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg</i>	Tier 1	
<i>mirtazapine oral tablet 7.5 mg</i>	Tier 1	
<i>mirtazapine oral tablet,disintegrating 15 mg, 30 mg, 45 mg</i>	Tier 1	
REMERON ORAL TABLET 15 MG, 30 MG (mirtazapine)	Tier 3	
REMERON SOLTAB ORAL TABLET,DISINTEGRATING 15 MG, 30 MG, 45 MG (mirtazapine)	Tier 3	
Antidepressant - Mao Inhibitor Nonselective And Irreversible-Types A,B - Drugs For Depression		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24 HR, 6 MG/24 HR, 9 MG/24 HR (selegiline)	Tier 3	QL (1 EA per 1 day)
MARPLAN ORAL TABLET 10 MG (isocarboxazid)	Tier 3	
NARDIL ORAL TABLET 15 MG (phenelzine sulfate)	Tier 3	
PARNATE ORAL TABLET 10 MG (tranylcypromine sulfate)	Tier 3	
<i>phenelzine oral tablet 15 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tranylcypromine oral tablet 10 mg</i>	Tier 1	
Antidepressant - Ndma Receptor Antagonist And Ndri Combinations - Drugs For Depression		
AUVELITY ORAL TABLET, IR AND ER, BIPHASIC 45-105 MG (dextromethorphan HBr/bupropion HCl)	Tier 3	ST: Requires prior prescription for Bupropion, Citalopram, Desvenlafaxine, Duloxetine, Escitalopram, Fluoxetine, Fluvoxamine, Mirtazapine, Paroxetine, Sertraline, or Venlafaxine within the past 120 days
Antidepressant - Neuroactive Steroid Gaba-A Receptor Modulator - Drugs For Depression		
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG (zuranolone)	Tier 3	PA
Antidepressant - N-Methyl D-Aspartate (Nmda) Receptor Antagonist - Drugs For Depression		
SPRAVATO NASAL SPRAY, NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3) (esketamine HCl)	Tier 3	PA
Antidepressant - Selective Serotonin Reuptake Inhibitors (Ssris) - Drugs For Depression		
CELEXA ORAL TABLET 10 MG, 20 MG, 40 MG (citalopram hydrobromide)	Tier 3	
<i>citalopram oral capsule 30 mg</i>	Tier 3	
<i>citalopram oral solution 10 mg/5 ml</i>	Tier 1	
<i>citalopram oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>escitalopram oxalate oral solution 5 mg/5 ml</i>	Tier 1	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
<i>fluoxetine oral capsule 10 mg, 20 mg, 40 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluoxetine oral capsule, delayed release (drlec) 90 mg</i>	Tier 1	
<i>fluoxetine oral solution 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>fluoxetine oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>fluoxetine oral tablet 60 mg</i>	Tier 1	
<i>fluvoxamine oral capsule, extended release 24hr 100 mg, 150 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>fluvoxamine oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
LEXAPRO ORAL TABLET 10 MG, 20 MG, 5 MG (escitalopram oxalate)	Tier 3	
<i>paroxetine hcl oral suspension 10 mg/5 ml</i>	Tier 1	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	
<i>paroxetine hcl oral tablet extended release 24 hr 12.5 mg, 25 mg, 37.5 mg</i>	Tier 1	
PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HR 12.5 MG, 25 MG, 37.5 MG (paroxetine HCl)	Tier 3	
PAXIL ORAL SUSPENSION 10 MG/5 ML (paroxetine HCl)	Tier 3	
PAXIL ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG (paroxetine HCl)	Tier 3	
PROZAC ORAL CAPSULE 10 MG, 20 MG, 40 MG (fluoxetine HCl)	Tier 3	
<i>sertraline oral capsule 150 mg, 200 mg</i>	Tier 3	QL (1 EA per 1 day)
<i>sertraline oral concentrate 20 mg/ml</i>	Tier 1	
<i>sertraline oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
ZOLOFT ORAL CONCENTRATE 20 MG/ML (sertraline HCl)	Tier 3	
ZOLOFT ORAL TABLET 100 MG, 25 MG, 50 MG (sertraline HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidepressant - Serotonin-2 Antagonist-Reuptake Inhibitors (Saris) - Drugs For Depression		
<i>nefazodone oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	Tier 1	
RALDESY ORAL SOLUTION 10 MG/ML (trazodone HCl)	Tier 3	PA
<i>trazodone oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	Tier 1	
Antidepressant - Serotonin-Norepinephrine Reuptake Inhibitors (Snris) - Drugs For Depression		
CYMBALTA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 20 MG, 30 MG, 60 MG (duloxetine HCl)	Tier 3	
<i>desvenlafaxine oral tablet extended release 24 hr 100 mg, 50 mg</i>	Tier 1	ST: At least 2 prior prescriptions for generic Paroxetine HCL, Bupropion, Citalopram, Escitalopram, Fluoxetine, Mirtazapine, Sertraline, or Venlafaxine ER/IR within the past 365 days; QL (1 EA per 1 day)
<i>desvenlafaxine succinate oral tablet extended release 24 hr 100 mg, 25 mg, 50 mg</i>	Tier 1	
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG (duloxetine HCl)	Tier 3	
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	Tier 1	
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	Tier 3	ST: Requires prior prescription for two generic Duloxetine 20mg capsules within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DULOXICAINE KIT 30 MG- 4% (duloxetine HCl/lidocaine HCl)	Tier 3	
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG, 75 MG (venlafaxine HCl)	Tier 3	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26) (levomilnacipran HCl)	Tier 2	QL (1 EA per 1 day)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG (levomilnacipran HCl)	Tier 2	QL (1 EA per 1 day)
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HR 100 MG, 25 MG, 50 MG (desvenlafaxine succinate)	Tier 3	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (milnacipran HCl)	Tier 3	ST: At least 2 prior prescriptions for Amitriptyline tablets, Cyclobenzaprine IR tablets, Duloxetine 20/30/60mg capsules, generic Gabapentin IR tablets/capsules, or Pregabalin IR capsules within the past 365 days; QL (2 EA per 1 day)
SAVELLA ORAL TABLETS,DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42) (milnacipran HCl)	Tier 3	ST: At least 2 prior prescriptions for Amitriptyline tablets, Cyclobenzaprine IR tablets, Duloxetine 20/30/60mg capsules, generic Gabapentin IR tablets/capsules, or Pregabalin IR capsules within the past 365 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>venlafaxine besylate oral tablet extended release 24hr 112.5 mg</i>	Tier 3	ST: Requires prior prescription for Venlafaxine HCL ER capsules within the past 120 days; QL (1 EA per 1 day)
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg, 75 mg</i>	Tier 1	
<i>venlafaxine oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	Tier 1	
<i>venlafaxine oral tablet extended release 24hr 150 mg, 225 mg, 37.5 mg, 75 mg</i>	Tier 1	
Antidepressant - Ssri And 5Ht1a Partial Agonist - Drugs For Depression		
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (vilazodone HCl)	Tier 3	ST: Requires prior prescription for Bupropion, Citalopram, Escitalopram, Fluoxetine, Mirtazapine, Paroxetine, Sertraline, or Venlafaxine IR/ER within the past 120 days
<i>vilazodone oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	ST: Requires prior prescription for Bupropion, Citalopram, Escitalopram, Fluoxetine, Mirtazapine, Paroxetine, Sertraline, or Venlafaxine IR/ER within the past 120 days
Antidepressant - Ssri And Serotonin (5-Ht) Receptor Modulator - Drugs For Depression		
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (vortioxetine hydrobromide)	Tier 2	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antidepressant - Tricyclic And Antipsychotic, Phenothiazine Comb - Drugs For Depression		
<i>perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg</i>	Tier 1	
Antidepressant - Tricyclic-Benzodiazepine Combinations - Drugs For Depression		
<i>amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg</i>	Tier 1	
Antidepressant- Ssri And Atypical Antipsych,Dopamine,Serotonin Antagon - Drugs For Depression		
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Tier 1	QL (1 EA per 1 day)
Antidepressant-Norepinephrine And Dopamine Reuptake Inhibitors (Ndris) - Drugs For Depression		
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HR 174 MG, 348 MG, 522 MG (bupropion HBr)	Tier 3	ST: Requires prior prescription for Bupropion HCL within the past 120 days; QL (1 EA per 1 day)
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	Tier 1	
<i>bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg</i>	Tier 1	
<i>bupropion hcl oral tablet extended release 24 hr 450 mg</i>	Tier 3	ST: Requires prior prescription for generic Bupropion within the past 120 days; QL (1 EA per 1 day)
<i>bupropion hcl oral tablet sustained-release 12 hr 100 mg, 150 mg, 200 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WELLBUTRIN SR ORAL TABLET SUSTAINED-RELEASE 12 HR 100 MG, 150 MG, 200 MG (bupropion HCl)	Tier 3	
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 300 MG (bupropion HCl)	Tier 3	
Antidepressant-Tricyclics And Related (Non-Select Reuptake Inhibitors) - Drugs For Depression		
<i>amitriptyline oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg</i>	Tier 1	
ANAFRANIL ORAL CAPSULE 25 MG, 50 MG, 75 MG (clomipramine HCl)	Tier 3	
<i>clomipramine oral capsule 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>desipramine oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>doxepin oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>doxepin oral concentrate 10 mg/ml</i>	Tier 1	
<i>imipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	
<i>imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg</i>	Tier 1	
NORPRAMIN ORAL TABLET 10 MG, 25 MG (desipramine HCl)	Tier 3	
<i>nortriptyline oral capsule 10 mg, 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>nortriptyline oral solution 10 mg/5 ml</i>	Tier 1	
PAMELOR ORAL CAPSULE 10 MG, 25 MG, 50 MG, 75 MG (nortriptyline HCl)	Tier 3	
<i>protriptyline oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>trimipramine oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiparkinson - Dopaminergic-Periph Comt-Dopa-Decarboxylase Inhib Comb - Drugs For Parkinson		
<i>carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg</i>	Tier 1	
Antiparkinson - Dopaminerg-Peripheral Dopa-Decarboxylase Inhibit Comb - Drugs For Parkinson		
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	Tier 1	
<i>carbidopa-levodopa oral tablet extended release 25-100 mg, 50-200 mg</i>	Tier 1	
<i>carbidopa-levodopa oral tablet,disintegrating 10-100 mg, 25-100 mg, 25-250 mg</i>	Tier 1	
CREXONT ORAL CAPSULE,IR -EXTEND REL,BIPHASE 35-140 MG (carbidopa/levodopa)	Tier 3	ST: Requires prior prescription for generic Carbidopa/Levodopa ER within the past 120 days; QL (4 EA per 1 day)
CREXONT ORAL CAPSULE,IR -EXTEND REL,BIPHASE 52.5-210 MG (carbidopa/levodopa)	Tier 3	ST: Requires prior prescription for generic Carbidopa/Levodopa ER within the past 120 days; QL (10 EA per 1 day)
CREXONT ORAL CAPSULE,IR -EXTEND REL,BIPHASE 70-280 MG (carbidopa/levodopa)	Tier 3	ST: Requires prior prescription for generic Carbidopa/Levodopa ER within the past 120 days; QL (7 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CREXONT ORAL CAPSULE,IR -EXTEND REL,BIPHASE 87.5-350 MG (carbidopa/levodopa)	Tier 3	ST: Requires prior prescription for generic Carbidopa/Levodopa ER within the past 120 days; QL (6 EA per 1 day)
DHIVY ORAL TABLET 25-100 MG (carbidopa/levodopa)	Tier 3	
DUOPA J-TUBE INTESTINAL PUMP SUSPENSION 4.63-20 MG/ML (carbidopa/levodopa)	Tier 3	PA
RYTARY ORAL CAPSULE, EXTENDED RELEASE 23.75-95 MG, 36.25-145 MG, 48.75-195 MG, 61.25-245 MG (carbidopa/levodopa)	Tier 3	ST: Requires prior prescription for generic Carbidopa/Levodopa ER within the past 120 days; QL (10 EA per 1 day)
SINEMET ORAL TABLET 10-100 MG, 25-100 MG (carbidopa/levodopa)	Tier 3	
VYALEV CONTIN. SUBCUTANEOUS INFUSION SOLUTION 12-240 MG/ML (foscarbidopa/foslevodopa)	Tier 3	PA; KP
Antiparkinson Adjuvant - Adenosine Receptor Antagonist - Drugs For Parkinson		
NOURIANZ ORAL TABLET 20 MG, 40 MG (istradefylline)	Tier 3	PA
Antiparkinson Adjuvant - Central/Peripheral Comt Inhibitors - Drugs For Parkinson		
TASMAR ORAL TABLET 100 MG (tolcapone)	Tier 3	ST: Requires prior prescription for Comtan (Entacapone) within the past 120 days; QL (3 EA per 1 day)
<i>tolcapone oral tablet 100 mg</i>	Tier 1	ST: Requires prior prescription for Comtan (Entacapone) within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiparkinson Adjuvant - Peripheral Comt Inhibitors - Drugs For Parkinson		
<i>entacapone oral tablet 200 mg</i>	Tier 1	
ONGENTYS ORAL CAPSULE 25 MG, 50 MG (opicapone)	Tier 3	PA
Antiparkinson Adjuvant - Peripheral Dopa-Decarboxylase Inhibitors - Drugs For Parkinson		
<i>carbidopa oral tablet 25 mg</i>	Tier 1	
LODOSYN ORAL TABLET 25 MG (carbidopa)	Tier 3	
Antiparkinson Therapy - Anticholinergic Agents - Drugs For Parkinson		
<i>benztropine oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>trihexyphenidyl oral elixir 0.4 mg/ml</i>	Tier 1	
<i>trihexyphenidyl oral tablet 2 mg, 5 mg</i>	Tier 1	
Antiparkinson Therapy - Dopamine Precursors - Drugs For Parkinson		
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE 42 MG (levodopa)	Tier 3	PA
Antiparkinson Therapy - Ergot Alkaloids And Derivatives - Drugs For Parkinson		
<i>bromocriptine oral capsule 5 mg</i>	Tier 1	
<i>bromocriptine oral tablet 2.5 mg</i>	Tier 1	
Antiparkinson Therapy - Monoamine Oxidase Inhibitor(Mao-B) - Drugs For Parkinson		
AZILECT ORAL TABLET 0.5 MG, 1 MG (rasagiline mesylate)	Tier 3	QL (1 EA per 1 day)
<i>rasagiline oral tablet 0.5 mg, 1 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>selegiline hcl oral capsule 5 mg</i>	Tier 1	
<i>selegiline hcl oral tablet 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XADAGO ORAL TABLET 100 MG, 50 MG (safinamide mesylate)	Tier 3	ST: Requires prior prescription for Carbidopa/Levodopa (Duopa, Parcopa, Rytary, Sinemet IR, or Sinemet CR) within the past 120 days; QL (1 EA per 1 day)
ZELAPAR ORAL TABLET,DISINTEGRATING 1.25 MG (selegiline HCl)	Tier 3	ST: Requires prior prescription for generic Selegiline capsules or tablets within the past 120 days; QL (2 EA per 1 day)
Antiparkinson Therapy - Non-Ergot Dopamine Agonist Agents - Drugs For Parkinson		
<i>amantadine hcl oral capsule 100 mg</i>	Tier 1	
<i>amantadine hcl oral solution 50 mg/5 ml</i>	Tier 1	
<i>amantadine hcl oral tablet 100 mg</i>	Tier 1	
APOKYN SUBCUTANEOUS CARTRIDGE 10 MG/ML (apomorphine HCl)	Tier 3	PA; KP
<i>apomorphine subcutaneous cartridge 10 mg/ml</i>	Tier 3	PA; KP
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG, 68.5 MG (amantadine HCl)	Tier 3	PA
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HR 1.5 MG, 2.25 MG, 3 MG, 3.75 MG (pramipexole di-HCl)	Tier 3	ST: Requires prior prescription for Pramipexole IR or Ropinirole IR within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR (rotigotine)	Tier 2	ST: Requires prior prescription for Pramipexole IR or Ropinirole IR within the past 120 days; QL (1 EA per 1 day)
ONAPGO SUBCUTANEOUS CARTRIDGE 4.9 MG/ ML (apomorphine HCl)	Tier 3	PA; KP
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG, 322 MG/DAY(129 MG X1-193MG X1) (amantadine HCl)	Tier 3	PA
<i>pramipexole oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	Tier 1	
<i>pramipexole oral tablet extended release 24 hr 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</i>	Tier 1	ST: Requires prior prescription for Pramipexole IR or Ropinirole IR within the past 120 days; QL (1 EA per 1 day)
<i>ropinirole oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	Tier 1	
<i>ropinirole oral tablet extended release 24 hr 12 mg, 2 mg, 4 mg, 6 mg, 8 mg</i>	Tier 1	ST: Requires prior prescription for Pramipexole IR or Ropinirole IR within the past 120 days; QL (1 EA per 1 day)
Antipsychotic - Atyp Dopamine-Serotonin Antag Dibenzo-Oxepino Pyrroles - Drugs For Severe Mental Disorders		
<i>asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG (asenapine maleate)	Tier 3	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24 HOUR, 5.7 MG/24 HOUR, 7.6 MG/24 HOUR (asenapine)	Tier 3	ST: Requires prior prescriptions for two generic atypical antipsychotics within the past 365 days; QL (1 EA per 1 day)
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisothiazolones - Drugs For Severe Mental Disorders		
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG (ziprasidone HCl)	Tier 3	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG (lurasidone HCl)	Tier 3	QL (30 EA per 30 days)
LATUDA ORAL TABLET 80 MG (lurasidone HCl)	Tier 3	QL (60 EA per 30 days)
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	Tier 1	QL (30 EA per 30 days)
<i>lurasidone oral tablet 80 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
Antipsychotic - Atypical Dopamine-Serotonin Antag- Benzisoxazole Deriv - Drugs For Severe Mental Disorders		
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (iloperidone)	Tier 3	QL (2 EA per 1 day)
FANAPT TITRATION PACK A ORAL TABLETS,DOSE PACK 1MG(2)-2MG(2)- 4MG(2)-6MG(2) (iloperidone)	Tier 3	QL (8 EA per 28 days)
FANAPT TITRATION PACK B ORAL TABLETS,DOSE PACK 1 MG(6)-2MG(2)- 6 MG(2)-8 MG(2) (iloperidone)	Tier 3	QL (12 EA per 28 days)
FANAPT TITRATION PACK C ORAL TABLETS,DOSE PACK 1 MG(4)-2 MG(2) -6 MG (2) (iloperidone)	Tier 3	QL (8 EA per 28 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG (paliperidone)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG (paliperidone)	Tier 3	QL (2 EA per 1 day)
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	Tier 1	QL (2 EA per 1 day)
RISPERDAL ORAL SOLUTION 1 MG/ML (risperidone)	Tier 3	
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (risperidone)	Tier 3	
<i>risperidone oral solution 1 mg/ml</i>	Tier 1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
<i>risperidone oral tablet, disintegrating 0.25 mg</i>	Tier 1	
<i>risperidone oral tablet, disintegrating 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
Antipsychotic - Atypical Dopamine-Serotonin Antag-Butyrophenone Deriv - Drugs For Severe Mental Disorders		
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (lumeperone tosylate)	Tier 2	QL (1 EA per 1 day)
Antipsychotic - Atypical Dopamine-Serotonin Antag-Dibenzodiazepine Der - Drugs For Severe Mental Disorders		
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	Tier 1	QL (3 EA per 1 day)
CLOZARIL ORAL TABLET 100 MG, 25 MG (clozapine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERSACLOZ ORAL SUSPENSION 50 MG/ML (clozapine)	Tier 3	ST: Requires prior prescriptions for two generic atypical antipsychotics within the past 365 days; QL (18 ML per 1 day)
Antipsychotic - Butyrophenone Derivatives - Drugs For Severe Mental Disorders		
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	Tier 1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	Tier 1	
Antipsychotic - Dibenzoxazepine Derivatives - Drugs For Severe Mental Disorders		
ADASUVE INHALATION AEROSOL POWDR BREATH ACTIVATED 10 MG (loxapine)	Tier 3	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	Tier 1	
Antipsychotic - Dihydroindolones - Drugs For Severe Mental Disorders		
<i>molindone oral tablet 10 mg</i>	Tier 1	QL (8 EA per 1 day)
<i>molindone oral tablet 25 mg</i>	Tier 1	QL (9 EA per 1 day)
<i>molindone oral tablet 5 mg</i>	Tier 1	
Antipsychotic - Diphenylbutylpiperidine Derivatives - Drugs For Severe Mental Disorders		
<i>pimozide oral tablet 1 mg, 2 mg</i>	Tier 1	
Antipsychotic - Phenothiazines, Aliphatic - Drugs For Severe Mental Disorders		
<i>chlorpromazine oral concentrate 100 mg/ml, 30 mg/ml</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chlorpromazine oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
Antipsychotic - Phenothiazines, Piperazine - Drugs For Severe Mental Disorders		
<i>prochlorperazine maleate (Compazine Oral Tablet 10 Mg, 5 Mg)</i>	Tier 3	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	Tier 1	
<i>fluphenazine hcl oral elixir 2.5 mg/5 ml</i>	Tier 1	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>trifluoperazine oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
Antipsychotic - Phenothiazines, Piperidine - Drugs For Severe Mental Disorders		
<i>thioridazine oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Tier 1	
Antipsychotic - Thioxanthenes - Drugs For Severe Mental Disorders		
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Dibenzothiazepine Der - Drugs For Severe Mental Disorders		
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	
<i>quetiapine oral tablet 150 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG (quetiapine fumarate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG (quetiapine fumarate)	Tier 3	
Antipsychotic -Atypical Dopamine-Serotonin Antag-Thienobenzodiazepines - Drugs For Severe Mental Disorders		
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (olanzapine/samidorphan malate)	Tier 3	ST: Requires prior prescription for generic atypical antipsychotic within the past 365 days; QL (1 EA per 1 day)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	Tier 1	
<i>olanzapine oral tablet, disintegrating 10 mg, 15 mg, 20 mg, 5 mg</i>	Tier 1	
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Tier 1	QL (1 EA per 1 day)
ZYPREXA ORAL TABLET 2.5 MG, 20 MG, 5 MG (olanzapine)	Tier 3	
Antipsychotic-Atyp Selective Serotonin 5-Ht2a Inverse Agonists (Ssia) - Drugs For Severe Mental Disorders		
NUPLAZID ORAL CAPSULE 34 MG (pimavanserin tartrate)	Tier 3	PA
NUPLAZID ORAL TABLET 10 MG (pimavanserin tartrate)	Tier 3	PA
Antipsychotic-Atypical, D2 Receptor Partial Agonist-5Ht Serotonin Mixed - Drugs For Severe Mental Disorders		
ABILIFY ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 3	
<i>aripiprazole oral solution 1 mg/ml</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>aripiprazole oral tablet, disintegrating 10 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>aripiprazole oral tablet, disintegrating 15 mg</i>	Tier 1	QL (2 EA per 1 day)
OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG (aripiprazole)	Tier 3	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (brexpiprazole)	Tier 2	QL (1 EA per 1 day)
Antipsychotic-Atypical, D3/D2 Receptor Partial Agonist-Serotonin Mixed - Drugs For Severe Mental Disorders		
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (cariprazine HCl)	Tier 2	QL (1 EA per 1 day)
Antipsychotics, Atypical, Dopamine, Serotonin Antag And Opioid Antag Comb - Drugs For Severe Mental Disorders		
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (olanzapine/samidorphan malate)	Tier 3	ST: Requires prior prescription for generic atypical antipsychotic within the past 365 days; QL (1 EA per 1 day)
Attention Deficit-Hyperact. Disorder (Adhd)-Alpha-2 Receptor Agonist - Drugs For Attention Deficit Disorder		
<i>clonidine hcl oral tablet extended release 12 hr 0.1 mg</i>	Tier 1	
<i>guanfacine oral tablet extended release 24 hr 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
INTUNIV ER ORAL TABLET EXTENDED RELEASE 24 HR 1 MG, 2 MG, 3 MG, 4 MG (guanfacine HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONYDA XR ORAL SUSPENSION,EXTEND RELEASE 24HR 0.1 MG/ML (clonidine HCl)	Tier 3	ST: Requires prior prescription for Clonidine 0.1mg ER tablets within the past 120 days; QL (4 ML per 1 day)
Attention Deficit-Hyperactivity (Adhd) Therapy, Stimulant-Type - Drugs For Attention Deficit Disorder		
dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate (Adderall Oral Tablet 10 Mg, 12.5 Mg, 15 Mg, 20 Mg, 30 Mg, 5 Mg, 7.5 Mg)	Tier 3	QL (2 EA per 1 day)
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 5 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 3	QL (1 EA per 1 day)
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 20 MG, 25 MG, 30 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 3	QL (2 EA per 1 day)
ADZENYS XR-ODT ORAL TABLET,DISINTEG ER BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (amphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
<i>amphetamine oral tablet,disinteg er biphase 24h 12.5 mg, 15.7 mg, 18.8 mg, 3.1 mg, 6.3 mg, 9.4 mg</i>	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (4 EA per 1 day)
APTENSIO XR ORAL CAP,ER SPRINKLE,BIPHASIC 40-60 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (methylphenidate HCl)	Tier 3	ST: Requires prior prescription for Methylphenidate HCL or Relexxii within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZSTARYS ORAL CAPSULE 26.1 MG- 5.2 MG, 39.2 MG- 7.8 MG, 52.3 MG- 10.4 MG (serdexmethylphenidate chloride/dexmethylphenidate HCl)	Tier 2	ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (1 EA per 1 day)
CONCERTA ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 54 MG (methylphenidate HCl)	Tier 3	QL (1 EA per 1 day)
CONCERTA ORAL TABLET EXTENDED RELEASE 24HR 36 MG (methylphenidate HCl)	Tier 3	QL (2 EA per 1 day)
COTEMPLA XR-ODT ORAL TABLET,DISINTEG ER BIPHASE 24H 17.3 MG, 8.6 MG (methylphenidate)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
COTEMPLA XR-ODT ORAL TABLET,DISINTEG ER BIPHASE 24H 25.9 MG (methylphenidate)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (2 EA per 1 day)
DAYTRANA TRANSDERMAL PATCH 24 HOUR 10 MG/9 HR, 15 MG/9 HR, 20 MG/9 HR, 30 MG/9 HR (methylphenidate)	Tier 3	ST: Requires prior prescription for oral Methylphenidate CD/ER/LA formulation or Methylphenidate suspension/solution within the past 120 days; QL (1 EA per 1 day)
DESOXYN ORAL TABLET 5 MG (methamphetamine HCl)	Tier 3	QL (150 EA per 30 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG (dextroamphetamine sulfate)	Tier 3	QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 15 MG (dextroamphetamine sulfate)	Tier 3	QL (120 EA per 30 days)
<i>dexmethylphenidate oral capsule, er biphasic 50-50 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>dextroamphetamine sulfate oral capsule, extended release 10 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral capsule, extended release 15 mg</i>	Tier 1	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate oral capsule, extended release 5 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 15 mg, 2.5 mg, 7.5 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 20 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (3 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 30 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dextroamphetamine-amphetamine oral capsule, er triphasic 24 hr 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 10 mg, 15 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 20 mg, 25 mg, 30 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (2 EA per 1 day)
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR 2.5 MG/ML (amphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (240 ML per 30 days)
DYANAVEL XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10 MG, 15 MG, 20 MG, 5 MG (amphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
amphetamine sulfate (Evekeo Oral Tablet 10 Mg, 5 Mg)	Tier 3	QL (4 EA per 1 day)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (dexamethylphenidate HCl)	Tier 3	QL (2 EA per 1 day)
FOCALIN XR ORAL CAPSULE, ER BIPHASIC 50-50 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG, 5 MG (dexamethylphenidate HCl)	Tier 3	QL (1 EA per 1 day)
JORNAY PM ORAL CAPSULE, DEL REL, EXT REL SPRINK 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (methylphenidate HCl)	Tier 2	ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lisdexamfetamine oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>lisdexamfetamine oral tablet, chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	Tier 1	QL (1 EA per 1 day)
METADATE CD ORAL CAPSULE, ER BIPHASIC 30-70 10 MG, 20 MG, 40 MG, 50 MG, 60 MG (methylphenidate HCl)	Tier 3	QL (1 EA per 1 day)
METADATE CD ORAL CAPSULE, ER BIPHASIC 30-70 30 MG (methylphenidate HCl)	Tier 3	QL (2 EA per 1 day)
methylphenidate HCl (Metadate Er Oral Tablet Extended Release 20 Mg)	Tier 1	QL (90 EA per 30 days)
<i>methamphetamine oral tablet 5 mg</i>	Tier 1	QL (150 EA per 30 days)
METHYLIN ORAL SOLUTION 10 MG/5 ML, 5 MG/5 ML (methylphenidate HCl)	Tier 3	
<i>methylphenidate hcl oral cap, er sprinkle, biphasic 40-60 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg</i>	Tier 3	ST: Requires prior prescription for Methylphenidate HCL or Relexxii within the past 120 days; QL (1 EA per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 40 mg, 50 mg, 60 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 30-70 30 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 50-50 10 mg, 20 mg, 40 mg, 60 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>methylphenidate hcl oral capsule, er biphasic 50-50 30 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml</i>	Tier 1	
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet extended release 10 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>methylphenidate hcl oral tablet extended release 20 mg</i>	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 54 mg</i>	Tier 1	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>methylphenidate hcl oral tablet extended release 24hr 36 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>methylphenidate hcl oral tablet extended release 24hr 45 mg, 63 mg</i>	Tier 3	QL (1 EA per 1 day)
<i>methylphenidate hcl oral tablet extended release 24hr 72 mg</i>	Tier 3	ST: At least 2 prior prescriptions for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, Concerta, or Adderall XR within the past 365 days; QL (1 EA per 1 day)
<i>methylphenidate hcl oral tablet, chewable 10 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>methylphenidate hcl oral tablet, chewable 2.5 mg, 5 mg</i>	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate transdermal patch 24 hour 10 mg/9 hr, 15 mg/9 hr, 20 mg/9 hr, 30 mg/9 hr</i>	Tier 1	ST: Requires prior prescription for oral Methylphenidate CD/ER/LA formulation or Methylphenidate suspension/solution within the past 120 days; QL (1 EA per 1 day)
MYDAYIS ORAL CAPSULE, ER TRIPHASIC 24 HR 12.5 MG, 25 MG, 37.5 MG, 50 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 3	QL (1 EA per 1 day)
QUILLICHEW ER ORAL TABLET, CHEW, IR-ER. BIPHASIC 24HR 20 MG, 40 MG (methylphenidate HCl)	Tier 3	ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUILLICHEW ER ORAL TABLET,CHEW,IR-ER.BIPHASIC24HR 30 MG (methylphenidate HCl)	Tier 3	ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (2 EA per 1 day)
QUILLIVANT XR 25 MG/5 ML SUSP 5 MG/ML (25 MG/5 ML) (methylphenidate HCl)	Tier 3	120mL BOTTLE; ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (240 ML per 30 days)
QUILLIVANT XR 25 MG/5 ML SUSP 5 MG/ML (25 MG/5 ML) (methylphenidate HCl)	Tier 3	150mL BOTTLE; ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (300 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUILLIVANT XR 25 MG/5 ML SUSP 5 MG/ML (25 MG/5 ML) (methylphenidate HCl)	Tier 3	180mL BOTTLE; ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (360 ML per 30 days)
QUILLIVANT XR 25 MG/5 ML SUSP 5 MG/ML (25 MG/5 ML) (methylphenidate HCl)	Tier 3	60mL BOTTLE; ST: Requires prior prescription for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, or Dextroamphetamine/Amphetamine XR/ER within the past 120 days; QL (60 ML per 30 days)
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 54 MG (methylphenidate HCl)	Tier 3	QL (1 EA per 1 day)
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 36 MG (methylphenidate HCl)	Tier 3	QL (2 EA per 1 day)
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 72 MG (methylphenidate HCl)	Tier 3	ST: At least 2 prior prescriptions for generic Lisdexamfetamine, Methylphenidate ER/LA/CD, Concerta, or Adderall XR within the past 365 days; QL (1 EA per 1 day)
RITALIN LA ORAL CAPSULE,ER BIPHASIC 50-50 10 MG, 20 MG, 40 MG (methylphenidate HCl)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RITALIN LA ORAL CAPSULE, ER BIPHASIC 50-50 30 MG (methylphenidate HCl)	Tier 3	QL (2 EA per 1 day)
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG (methylphenidate HCl)	Tier 3	QL (90 EA per 30 days)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG (lisdexamfetamine dimesylate)	Tier 3	QL (1 EA per 1 day)
VYVANSE ORAL TABLET, CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (lisdexamfetamine dimesylate)	Tier 3	QL (1 EA per 1 day)
XELSTRYM TRANSDERMAL PATCH 24 HOUR 13.5 MG/9 HOUR, 18 MG/9 HOUR, 4.5 MG/9 HOUR, 9 MG/9 HOUR (dextroamphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 10 Mg, 5 Mg)	Tier 3	QL (4 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 15 Mg, 2.5 Mg, 7.5 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (4 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 20 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dextroamphetamine sulfate (Zenzedi Oral Tablet 30 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (2 EA per 1 day)
Attention Deficit-Hyperactivity Disorder (Adhd) Therapy, Nri-Type - Drugs For Attention Deficit Disorder		
<i>atomoxetine oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG (viloxazine HCl)	Tier 3	ST: Requires prior prescription for Atomoxetine, Clonidine ER (Kapvay), Dexmethylphenidate, Dextroamphetamine/Amphetamine, Guanfacine ER (INTUNIV), or generic IR Methylphenidate within the past 120 days; QL (1 EA per 1 day)
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG (viloxazine HCl)	Tier 3	ST: Requires prior prescription for Atomoxetine, Clonidine ER (Kapvay), Dexmethylphenidate, Dextroamphetamine/Amphetamine, Guanfacine ER (INTUNIV), or generic IR Methylphenidate within the past 120 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QELBREE ORAL CAPSULE,EXTENDED RELEASE 24HR 200 MG (viloxazine HCl)	Tier 3	ST: Requires prior prescription for Atomoxetine, Clonidine ER (Kapvay), Dexmethylphenidate, Dextroamphetamine/Amphetamine, Guanfacine ER (INTUNIV), or generic IR Methylphenidate within the past 120 days; QL (3 EA per 1 day)
STRATTERA ORAL CAPSULE 10 MG, 100 MG, 18 MG, 25 MG, 40 MG, 60 MG, 80 MG (atomoxetine HCl)	Tier 3	
Benzodiazepines - Drugs For Seizures /Personality Disorder/Nerve Pain		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (alprazolam)	Tier 2	
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>alprazolam oral tablet extended release 24 hr 0.5 mg, 1 mg, 2 mg, 3 mg</i>	Tier 1	
<i>alprazolam oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>amitriptyline-chlordiazepoxide oral tablet 12.5-5 mg, 25-10 mg</i>	Tier 1	
ATIVAN ORAL TABLET 0.5 MG, 1 MG, 2 MG (lorazepam)	Tier 3	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	Tier 1	
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	Tier 1	
<i>clobazam oral suspension 2.5 mg/ml</i>	Tier 1	QL (480 ML per 30 days)
<i>clobazam oral tablet 10 mg, 20 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	Tier 1	
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/ML)	Tier 1	
<i>diazepam oral concentrate 5 mg/ml</i>	Tier 1	
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	Tier 1	
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	Tier 1	
<i>diazepam rectal kit 12.5-15-17.5-20 mg, 2.5 mg, 5-7.5-10 mg</i>	Tier 1	
DORAL ORAL TABLET 15 MG (quazepam)	Tier 3	ST: Requires prior prescription for one of the following oral generics: Eszopiclone, Flurazepam, Temazepam, Zaleplon, or Zolpidem tablets within the past 120 days
<i>estazolam oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>flurazepam oral capsule 15 mg, 30 mg</i>	Tier 1	
HALCION ORAL TABLET 0.25 MG (triazolam)	Tier 3	
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (clonazepam)	Tier 3	
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG (diazepam)	Tier 3	QL (10 EA per 30 days)
LIBRAX (WITH CLIDINIUM) ORAL CAPSULE 5-2.5 MG (chlordiazepoxide/clidinium bromide)	Tier 3	
lorazepam (Lorazepam Intensol Oral Concentrate 2 Mg/ML)	Tier 1	
<i>lorazepam oral concentrate 2 mg/ml</i>	Tier 1	
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 1 MG, 2 MG, 3 MG (lorazepam)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOREEV XR ORAL CAPSULE,EXTENDED RELEASE 24HR 1.5 MG (lorazepam)	Tier 3	ST: Requires prior prescription for Lorazepam tablets within the past 120 days
<i>midazolam (pf) injection solution 5 mg/ml</i>	Tier 1	KP
<i>midazolam injection solution 5 mg/ml</i>	Tier 1	KP
<i>midazolam oral syrup 2 mg/ml</i>	Tier 1	
NAYZILAM NASAL SPRAY, NON-AEROSOL 5 MG/SPRAY (0.1 ML) (midazolam)	Tier 3	QL (10 EA per 30 days)
ONFI ORAL SUSPENSION 2.5 MG/ML (clobazam)	Tier 2	QL (480 ML per 30 days)
ONFI ORAL TABLET 10 MG, 20 MG (clobazam)	Tier 2	QL (2 EA per 1 day)
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	Tier 1	
<i>quazepam oral tablet 15 mg</i>	Tier 1	ST: Requires prior prescription for one of the following oral generics: Eszopiclone, Flurazepam, Temazepam, Zaleplon, or Zolpidem tablets within the past 120 days
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (temazepam)	Tier 3	
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (clobazam)	Tier 2	
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	Tier 1	
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	Tier 1	
VALIUM ORAL TABLET 10 MG, 2 MG, 5 MG (diazepam)	Tier 3	
VALTOCO NASAL SPRAY, NON-AEROSOL 10 MG/SPRAY (0.1 ML), 15 MG/2 SPRAY (7.5/0.1ML X 2), 20 MG/2 SPRAY (10MG/0.1ML X2), 5 MG/SPRAY (0.1 ML) (diazepam)	Tier 3	QL (10 EA per 30 days)
XANAX ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG (alprazolam)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XANAX XR ORAL TABLET EXTENDED RELEASE 24 HR 0.5 MG, 1 MG, 2 MG, 3 MG (alprazolam)	Tier 3	
Bipolar Therapy Agents - Anticonvulsant Type - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>carbamazepine oral capsule, er multiphase 12 hr 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>carbamazepine oral suspension 100 mg/5 ml</i>	Tier 1	
<i>carbamazepine oral tablet 200 mg</i>	Tier 1	
<i>carbamazepine oral tablet extended release 12 hr 100 mg, 200 mg, 400 mg</i>	Tier 1	
<i>carbamazepine oral tablet, chewable 100 mg</i>	Tier 1	
<i>carbamazepine oral tablet, chewable 200 mg</i>	Tier 1	
CARBATROL ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG (carbamazepine)	Tier 3	
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG (divalproex sodium)	Tier 3	
DEPAKOTE ORAL TABLET, DELAYED RELEASE (DR/EC) 125 MG, 250 MG, 500 MG (divalproex sodium)	Tier 3	
DEPAKOTE SPRINKLES ORAL CAPSULE, DELAYED REL SPRINKLE 125 MG (divalproex sodium)	Tier 3	
<i>divalproex oral capsule, delayed rel sprinkle 125 mg</i>	Tier 1	
<i>divalproex oral tablet extended release 24 hr 250 mg, 500 mg</i>	Tier 1	
<i>divalproex oral tablet, delayed release (drlec) 125 mg, 250 mg, 500 mg</i>	Tier 1	
carbamazepine (Epitol Oral Tablet 200 Mg)	Tier 1	
EQUETRO ORAL CAPSULE, ER MULTIPHASE 12 HR 100 MG, 200 MG, 300 MG (carbamazepine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LAMICTAL ODT ORAL TABLET,DISINTEGRATING 100 MG, 200 MG, 25 MG, 50 MG (lamotrigine)	Tier 3	
LAMICTAL ODT STARTER (BLUE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG (21) -50 MG (7) (lamotrigine)	Tier 3	
LAMICTAL ODT STARTER (GREEN) ORAL TABLET DISINTEGRATING, DOSE PK 50 MG (42) -100 MG (14) (lamotrigine)	Tier 3	
LAMICTAL ODT STARTER (ORANGE) ORAL TABLET DISINTEGRATING, DOSE PK 25 MG(14)-50 MG (14)-100 MG (7) (lamotrigine)	Tier 3	
LAMICTAL STARTER (BLUE) KIT ORAL TABLETS,DOSE PACK 25 MG (35) (lamotrigine)	Tier 3	
LAMICTAL STARTER (GREEN) KIT ORAL TABLETS,DOSE PACK 25 MG (84) -100 MG (14) (lamotrigine)	Tier 3	
LAMICTAL STARTER (ORANGE) KIT ORAL TABLETS,DOSE PACK 25 MG (42) -100 MG (7) (lamotrigine)	Tier 3	
<i>lamotrigine oral tablet disintegrating, dose pk 25 mg (21) - 50 mg (7), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg (42) - 100 mg (14)</i>	Tier 1	
<i>lamotrigine oral tablet,disintegrating 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>lamotrigine oral tablets,dose pack 25 mg (35), 25 mg (42) - 100 mg (7), 25 mg (84) -100 mg (14)</i>	Tier 1	
lamotrigine (Subvenite Starter (Blue) Kit Oral Tablets,Dose Pack 25 Mg (35))	Tier 3	
lamotrigine (Subvenite Starter (Green) Kit Oral Tablets,Dose Pack 25 Mg (84) -100 Mg (14))	Tier 3	
lamotrigine (Subvenite Starter (Orange) Kit Oral Tablets,Dose Pack 25 Mg (42) -100 Mg (7))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEGRETOL ORAL SUSPENSION 100 MG/5 ML (carbamazepine)	Tier 3	
TEGRETOL ORAL TABLET 200 MG (carbamazepine)	Tier 3	
TEGRETOL XR ORAL TABLET EXTENDED RELEASE 12 HR 100 MG, 200 MG, 400 MG (carbamazepine)	Tier 3	
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	Tier 1	
<i>valproic acid oral capsule 250 mg</i>	Tier 1	
Bipolar Therapy Agents - Atypical Antipsychotics - Drugs For Severe Mental Disorders		
ABILIFY ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (aripiprazole)	Tier 3	
<i>aripiprazole oral solution 1 mg/ml</i>	Tier 1	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>aripiprazole oral tablet,disintegrating 10 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>aripiprazole oral tablet,disintegrating 15 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>asenapine maleate sublingual tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG (ziprasidone HCl)	Tier 3	
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (olanzapine/samidorphan malate)	Tier 3	ST: Requires prior prescription for generic atypical antipsychotic within the past 365 days; QL (1 EA per 1 day)
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	Tier 1	
<i>olanzapine oral tablet,disintegrating 10 mg, 15 mg, 20 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg</i>	Tier 1	QL (1 EA per 1 day)
OPIPZA ORAL FILM 10 MG, 2 MG, 5 MG (aripiprazole)	Tier 3	
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	
<i>quetiapine oral tablet 150 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	
RISPERDAL ORAL SOLUTION 1 MG/ML (risperidone)	Tier 3	
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (risperidone)	Tier 3	
<i>risperidone oral solution 1 mg/ml</i>	Tier 1	
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
<i>risperidone oral tablet,disintegrating 0.25 mg</i>	Tier 1	
<i>risperidone oral tablet,disintegrating 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
SAPHRIS SUBLINGUAL TABLET 10 MG, 2.5 MG, 5 MG (asenapine maleate)	Tier 3	QL (2 EA per 1 day)
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG (quetiapine fumarate)	Tier 3	
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG, 300 MG, 400 MG, 50 MG (quetiapine fumarate)	Tier 3	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (cariprazine HCl)	Tier 2	QL (1 EA per 1 day)
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
ZYPREXA ORAL TABLET 2.5 MG, 20 MG, 5 MG (olanzapine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bipolar Therapy Agents - Lithium - Drugs For Severe Mental Disorders		
<i>lithium carbonate oral capsule 150 mg, 600 mg</i>	Tier 1	
<i>lithium carbonate oral capsule 300 mg</i>	Tier 1	
<i>lithium carbonate oral tablet 300 mg</i>	Tier 1	
<i>lithium carbonate oral tablet extended release 300 mg, 450 mg</i>	Tier 1	
<i>lithium citrate oral solution 8 meq/5 ml</i>	Tier 1	
LITHOBID ORAL TABLET EXTENDED RELEASE 300 MG (lithium carbonate)	Tier 3	
Cannabis And Cannabinoids - Drugs For Seizures /Personality Disorder/Nerve Pain		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (dronabinol)	Tier 3	QL (2 EA per 1 day)
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	Tier 3	QL (60 ML per 30 days)
Cns Stimulant - Amphetamine Combinations - Drugs For Attention Deficit Disorder		
dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate (Adderall Oral Tablet 10 Mg, 12.5 Mg, 15 Mg, 20 Mg, 30 Mg, 5 Mg, 7.5 Mg)	Tier 3	QL (2 EA per 1 day)
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 10 MG, 15 MG, 5 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 3	QL (1 EA per 1 day)
ADDERALL XR ORAL CAPSULE,EXTENDED RELEASE 24HR 20 MG, 25 MG, 30 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 3	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADZENYS XR-ODT ORAL TABLET,DISINTEG ER BIPHASE 24H 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (amphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
<i>amphetamine oral tablet,disinteg er biphasic 24h 12.5 mg, 15.7 mg, 18.8 mg, 3.1 mg, 6.3 mg, 9.4 mg</i>	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
<i>dextroamphetamine-amphetamine oral capsule, er triphasic 24 hr 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr 20 mg, 25 mg, 30 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (2 EA per 1 day)
DYANAVEL XR ORAL SUSPEN, IR - ER, BIPHASIC 24HR 2.5 MG/ML (amphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (240 ML per 30 days)
DYANAVEL XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10 MG, 15 MG, 20 MG, 5 MG (amphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
MYDAYIS ORAL CAPSULE, ER TRIPHASIC 24 HR 12.5 MG, 25 MG, 37.5 MG, 50 MG (dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cns Stimulant - Amphetamines - Drugs For Attention Deficit Disorder		
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (4 EA per 1 day)
DESOXYN ORAL TABLET 5 MG (methamphetamine HCl)	Tier 3	QL (150 EA per 30 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG (dextroamphetamine sulfate)	Tier 3	QL (4 EA per 1 day)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 15 MG (dextroamphetamine sulfate)	Tier 3	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate oral capsule, extended release 10 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral capsule, extended release 15 mg</i>	Tier 1	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate oral capsule, extended release 5 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>dextroamphetamine sulfate oral solution 5 mg/5 ml</i>	Tier 1	QL (1800 ML per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 15 mg, 2.5 mg, 7.5 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 20 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dextroamphetamine sulfate oral tablet 30 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (2 EA per 1 day)
amphetamine sulfate (Evekeo Oral Tablet 10 Mg, 5 Mg)	Tier 3	QL (4 EA per 1 day)
<i>methamphetamine oral tablet 5 mg</i>	Tier 1	QL (150 EA per 30 days)
dextroamphetamine sulfate (Procentra Oral Solution 5 Mg/5 MI)	Tier 3	QL (1800 ML per 30 days)
XELSTRYM TRANSDERMAL PATCH 24 HOUR 13.5 MG/9 HOUR, 18 MG/9 HOUR, 4.5 MG/9 HOUR, 9 MG/9 HOUR (dextroamphetamine)	Tier 3	ST: Requires prior prescription for Azstarys or Jornay PM within the past 120 days; QL (1 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 10 Mg, 5 Mg)	Tier 3	QL (4 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 15 Mg, 2.5 Mg, 7.5 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (4 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 20 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dextroamphetamine sulfate (Zenzedi Oral Tablet 30 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (2 EA per 1 day)
Cns Stimulant - Analeptics, Methylxanthine-Type - Drugs For The Nervous System		
<i>caffeine citrate oral solution 60 mg/3 ml (20 mg/ml)</i>	Tier 1	
<i>caffeine oral tablet 200 mg</i>	Tier 3	
Diabetic Peripheral Neuropathy Agents - Drugs For Seizures /Personality Disorder/Nerve Pain		
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG (pregabalin)	Tier 3	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (3 EA per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG (pregabalin)	Tier 3	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral tablet extended release 24 hr 165 mg, 82.5 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (3 EA per 1 day)
<i>pregabalin oral tablet extended release 24 hr 330 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (2 EA per 1 day)
Fibromyalgia Agents - Gaba Analogs - Drugs For Seizures /Personality Disorder/Nerve Pain		
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (pregabalin)	Tier 3	
LYRICA ORAL SOLUTION 20 MG/ML (pregabalin)	Tier 3	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	Tier 1	
<i>pregabalin oral solution 20 mg/ml</i>	Tier 1	
Fibromyalgia Agents - Serotonin-Norepinephrine Reuptake-Inhib (Snris) - Drugs For Seizures /Personality Disorder/Nerve Pain		
CYMBALTA ORAL CAPSULE, DELAYED RELEASE (DR/EC) 20 MG, 30 MG, 60 MG (duloxetine HCl)	Tier 3	
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG (duloxetine HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	Tier 1	
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	Tier 3	ST: Requires prior prescription for two generic Duloxetine 20mg capsules within the past 120 days; QL (1 EA per 1 day)
DULOXICAINE KIT 30 MG- 4% (duloxetine HCl/lidocaine HCl)	Tier 3	
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (milnacipran HCl)	Tier 3	ST: At least 2 prior prescriptions for Amitriptyline tablets, Cyclobenzaprine IR tablets, Duloxetine 20/30/60mg capsules, generic Gabapentin IR tablets/capsules, or Pregabalin IR capsules within the past 365 days; QL (2 EA per 1 day)
SAVELLA ORAL TABLETS, DOSE PACK 12.5 MG (5)-25 MG(8)-50 MG(42) (milnacipran HCl)	Tier 3	ST: At least 2 prior prescriptions for Amitriptyline tablets, Cyclobenzaprine IR tablets, Duloxetine 20/30/60mg capsules, generic Gabapentin IR tablets/capsules, or Pregabalin IR capsules within the past 365 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hypnotics - Melatonin - Single Agents - Drugs For Insomnia		
CHILDREN'S MELATONIN ORAL TABLET,CHEWABLE 1 MG (melatonin)	Tier 3	
CHILDREN'S SLEEP (MELATONIN) ORAL LIQUID 1 MG/ML (melatonin)	Tier 3	
KIDS MELATONIN ORAL TABLET,CHEWABLE 1 MG (melatonin)	Tier 3	
MAX SLEEP JUNIOR ORAL LIQUID 1 MG/ML (melatonin)	Tier 3	
<i>melatonin oral capsule 10 mg</i>	Tier 3	
<i>melatonin oral drops 1 mg/4 ml, 10 mg/ml, 3 mg/4 ml</i>	Tier 3	
<i>melatonin oral liquid 2.5 mg/10 ml</i>	Tier 3	
<i>melatonin oral lozenge 5 mg</i>	Tier 3	
<i>melatonin oral tablet 1 mg, 10 mg, 12 mg, 5 mg</i>	Tier 3	
<i>melatonin oral tablet 3 mg</i>	Tier 3	
<i>melatonin oral tablet extended release 10 mg</i>	Tier 3	
<i>melatonin oral tablet,chewable 1 mg, 2.5 mg</i>	Tier 3	
<i>melatonin oral tablet,chewable 5 mg</i>	Tier 3	
<i>melatonin oral tablet,disintegrating 1 mg, 10 mg, 12 mg, 3 mg, 5 mg</i>	Tier 3	
MELATONINMAX ORAL TABLET,CHEWABLE 10 MG (melatonin)	Tier 3	
Hypnotics - Melatonin Combinations - Drugs For Insomnia		
AZO MENOPAUSE NIGHT-MELATONIN ORAL TABLET,CHEWABLE 1-30 MG (melatonin/genistein)	Tier 3	
COMPLETE BALANCE MENOPAUSE RLF ORAL CAPSULE, SEQUENTIAL 175-62-1 MG (NIGHT) (vit B/folic acid/calcium/soy xt/black cohosh xt/melatonin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KIDS SLEEP CALM ORAL TABLET,CHEWABLE 0.5-25-12.5 MG (melatonin/theanine/lemon balm/chamomile flower/lavender)	Tier 3	
KIDS SLEEP IMMUNE HEALTH ORAL TABLET,CHEWABLE 0.5 MG-45 MG- 12.5 MCG-3.75MG (melatonin/ascorbic acid/vitamin D3/zinc citrate/elderberry)	Tier 3	
<i>melatonin-pyridoxine (vit b6) oral tablet 5-1 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet extended release 5-10 mg</i>	Tier 3	
<i>melatonin-pyridoxine hcl (b6) oral tablet, ir and er, biphasic 10-10 mg, 5-10 mg</i>	Tier 3	
<i>melatonin-theanine oral tablet 10-5.5 mg</i>	Tier 3	
<i>melatonin-theanine oral tablet,disintegrating 3-50 mg</i>	Tier 3	
RELAX NIGHT CALM ORAL TABLET,CHEWABLE 1.5-12.5-50-0.5 MG (melatonin/5-hydroxytryptophan/theanine/lemon balm leaf xt)	Tier 3	
REPOZEN SLEEP AID ORAL CAPSULE 5-30-50 MG (melatonin/gamma-aminobutyric acid/valerian)	Tier 3	
SAMBUCUS HONEYBERRY NIGHT ORAL SYRUP 0.5 MG-3.5 GRAM -35 MG/7.5 ML (melatonin/honey/English ivy/elderberry/cider vinegar/C/zinc)	Tier 3	
SLEEP CALM ORAL TABLET,CHEWABLE 3-50-12.5 MG (melatonin/theanine/lemon balm/chamomile flower/lavender)	Tier 3	
SLEEP IMMUNE HEALTH ORAL TABLET,CHEWABLE 3 MG-45 MG-12.5 MCG-3.75 MG (melatonin/ascorbic acid/vitamin D3/zinc citrate/elderberry)	Tier 3	
SLEEP SUPPORT (MELATONIN-HERB) ORAL TABLET, CHEWABLE DISPERSIBLE 1.5-22 MG-MCG (melatonin/herbal complex no.233)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOOTHING NIGHT ORAL POWDER 3-350-250 MG/8.3 GRAM (melatonin/mag carbonate,glycinate/pot bic/GABA/glycine/lemon)	Tier 3	
SOPORDREN ORAL CAPSULE 1-50-25-200 MG (melatonin/GABA/5-HTP/theanine/magnesium citrate,oxide/herbs)	Tier 3	
SUPERIOR SLEEP ORAL CAPSULE 5-50-50 MG (melatonin/5-HTP/tryptophan/theanine/magnesium/vit B6/herbal)	Tier 3	
UNISOM SIMPLE SLUMBERS ORAL TABLET,CHEWABLE 2.5 MG (melatonin/passion flower/lemon balm)	Tier 3	
Hypnotics - Melatonin M1/M2 Receptor Agonists - Drugs For Insomnia		
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (tasimelteon)	Tier 3	PA
HETLIOZ ORAL CAPSULE 20 MG (tasimelteon)	Tier 3	PA
<i>ramelteon oral tablet 8 mg</i>	Tier 1	ST: Requires prior prescription for Eszopiclone (Lunesta), Zaleplon (Sonata), or Zolpidem IR (Ambien) within the past 120 days
ROZEREM ORAL TABLET 8 MG (ramelteon)	Tier 3	ST: Requires prior prescription for Eszopiclone (Lunesta), Zaleplon (Sonata), or Zolpidem IR (Ambien) within the past 120 days
<i>tasimelteon oral capsule 20 mg</i>	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Migraine Therapy - Carboxylic Acid Derivatives - Drugs For Migraine Headaches		
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HR 250 MG, 500 MG (divalproex sodium)	Tier 3	
<i>divalproex oral tablet extended release 24 hr 250 mg, 500 mg</i>	Tier 1	
Migraine Therapy - Cgrp Ligand Blocker, Monoclonal Antibody - Drugs For Migraine Headaches		
AJOVY AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 225 MG/1.5 ML (fremanezumab-vfrm)	Tier 2	PA; KP; QL (1.5 ML per 30 days)
AJOVY SYRINGE SUBCUTANEOUS SYRINGE 225 MG/1.5 ML (fremanezumab-vfrm)	Tier 2	PA; KP; QL (1.5 ML per 30 days)
EMGALITY PEN SUBCUTANEOUS PEN INJECTOR 120 MG/ML (galcanezumab-gnlm)	Tier 2	PA; KP; QL (1 ML per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML (galcanezumab-gnlm)	Tier 2	PA; KP; QL (1 ML per 30 days)
Migraine Therapy - Cgrp Receptor Blockers (Gepants And Mab) - Drugs For Migraine Headaches		
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML, 70 MG/ML (erenumab-aooe)	Tier 2	PA; KP; QL (1 ML per 30 days)
NURTEC ODT ORAL TABLET,DISINTEGRATING 75 MG (rimegepant sulfate)	Tier 2	PA; QL (18 EA per 30 days)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (atogepant)	Tier 2	PA; QL (1 EA per 1 day)
UBRELVY ORAL TABLET 100 MG, 50 MG (ubrogepant)	Tier 2	PA; QL (16 EA per 30 days)
ZAVZPRET NASAL SPRAY, NON-AEROSOL 10 MG/ACTUATION (zavegepant HCl)	Tier 3	PA; QL (8 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Migraine Therapy - Ergot Alkaloids And Derivatives - Drugs For Migraine Headaches		
<i>dihydroergotamine injection solution 1 mg/ml</i>	Tier 1	KP; QL (15 ML per 14 days)
<i>dihydroergotamine nasal spray,non-aerosol 0.5 mg/pump act. (4 mg/ml)</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (8 ML per 28 days)
ERGOMAR SUBLINGUAL TABLET 2 MG (ergotamine tartrate)	Tier 3	QL (10 EA per 7 days)
MIGRANAL NASAL SPRAY, NON-AEROSOL 0.5 MG/PUMP ACT. (4 MG/ML) (dihydroergotamine mesylate)	Tier 3	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (8 ML per 28 days)
TRUDHESA NASAL SPRAY, NON-AEROSOL 0.725 MG/PUMP ACT. (4 MG/ML) (dihydroergotamine mesylate)	Tier 3	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (12 ML per 28 days); Age (Min 18 Years)
Migraine Therapy - Ergot Combinations - Drugs For Migraine Headaches		
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	Tier 1	QL (10 EA per 7 days)
MIGERGOT RECTAL SUPPOSITORY 2-100 MG (ergotamine tartrate/caffeine)	Tier 3	PA
Migraine Therapy - Nsaid Analgesics (Cyclooxygenase Inhibitor) - Drugs For Migraine Headaches		
<i>diclofenac potassium oral powder in packet 50 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELYXYB ORAL SOLUTION 120 MG/4.8 ML (25 MG/ML) (celecoxib)	Tier 3	PA
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1) - Drugs For Migraine Headaches		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
<i>eletriptan oral tablet 20 mg, 40 mg</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
FROVA ORAL TABLET 2.5 MG (frovatriptan succinate)	Tier 3	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
<i>frovatriptan oral tablet 2.5 mg</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
IMITREX ORAL TABLET 100 MG, 25 MG, 50 MG (sumatriptan succinate)	Tier 3	QL (18 EA per 30 days)
IMITREX STATDOSE PEN SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML, 6 MG/0.5 ML (sumatriptan succinate)	Tier 3	KP; QL (18 ML per 30 days)
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 4 MG/0.5 ML, 6 MG/0.5 ML (sumatriptan succinate)	Tier 3	KP; QL (18 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAXALT ORAL TABLET 10 MG (rizatriptan benzoate)	Tier 3	QL (27 EA per 30 days)
MAXALT-MLT ORAL TABLET,DISINTEGRATING 10 MG (rizatriptan benzoate)	Tier 3	QL (27 EA per 30 days)
MIGRANOW KIT,GEL AND TABLET 50 MG- 10 %-4 % (sumatriptan succinate/menthol/camphor)	Tier 3	
<i>naratriptan oral tablet 1 mg, 2.5 mg</i>	Tier 1	QL (18 EA per 30 days)
ONZETRA XSAIL NASAL AEROSOL POWDR BREATH ACTIVATED 11 MG (sumatriptan succinate)	Tier 3	ST: Requires prior prescription for generic Sumatriptan nasal spray within the past 120 days; QL (32 EA per 30 days)
RELPAK ORAL TABLET 20 MG, 40 MG (eletriptan hydrobromide)	Tier 3	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
<i>rizatriptan oral tablet 10 mg, 5 mg</i>	Tier 1	QL (27 EA per 30 days)
<i>rizatriptan oral tablet,disintegrating 10 mg, 5 mg</i>	Tier 1	QL (27 EA per 30 days)
<i>sumatriptan nasal spray,non-aerosol 20 mg/actuation</i>	Tier 1	QL (18 EA per 30 days)
<i>sumatriptan nasal spray,non-aerosol 5 mg/actuation</i>	Tier 1	QL (36 EA per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	QL (18 EA per 30 days)
<i>sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml, 6 mg/0.5 ml</i>	Tier 1	KP; QL (18 ML per 30 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml, 6 mg/0.5 ml</i>	Tier 1	KP; QL (18 ML per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5 ml</i>	Tier 1	KP; QL (18 ML per 30 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	Tier 1	KP; QL (18 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOSYMRA NASAL SPRAY, NON-AEROSOL 10 MG/ACTUATION (sumatriptan)	Tier 3	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (24 EA per 30 days)
ZEMBRACE SYMTOUCH SUBCUTANEOUS PEN INJECTOR 3 MG/0.5 ML (sumatriptan succinate)	Tier 3	KP; ST: Requires prior prescription for generic Sumatriptan injection within the past 120 days; QL (18 ML per 30 days)
<i>zolmitriptan nasal spray, non-aerosol 2.5 mg, 5 mg</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
<i>zolmitriptan oral tablet, disintegrating 2.5 mg, 5 mg</i>	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
ZOMIG NASAL SPRAY, NON-AEROSOL 2.5 MG, 5 MG (zolmitriptan)	Tier 3	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
zolmitriptan (Zomig Oral Tablet 2.5 Mg, 5 Mg)	Tier 1	ST: Requires prior prescription for oral Sumatriptan or Rizatriptan within the past 180 days; QL (18 EA per 30 days)
Migraine Therapy - Selective Serotonin Agonists 5-Ht(1F) - Drugs For Migraine Headaches		
REYVOW ORAL TABLET 100 MG, 50 MG (lasmiditan succinate)	Tier 2	PA; QL (8 EA per 30 days)
Migraine Therapy - Serotonin Agonist 5-Ht(1) And Nsaid Comb. - Drugs For Migraine Headaches		
<i>sumatriptan-naproxen oral tablet 85-500 mg</i>	Tier 3	ST: Requires prior prescription for Sumatriptan within the past 180 days; QL (18 EA per 30 days)
Movement Disorder Drug Therapy - Drugs For The Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (deutetrabenazine)	Tier 3	PA; QL (4 EA per 1 day)
AUSTEDO ORAL TABLET 6 MG (deutetrabenazine)	Tier 3	PA; QL (2 EA per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (deutetrabenazine)	Tier 3	PA; QL (1 EA per 1 day)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG (deutetrabenazine)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INGREZZA INITIATION PK(TARDIV) ORAL CAPSULE,DOSE PACK 40 MG (7)- 80 MG (21) (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
INGREZZA SPRINKLE ORAL CAPSULE, SPRINKLE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	Tier 3	PA
XENAZINE ORAL TABLET 12.5 MG, 25 MG (tetrabenazine)	Tier 3	PA
Movement Disorder Therapy - Huntington's Disease - Drugs For The Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (deutetrabenazine)	Tier 3	PA; QL (4 EA per 1 day)
AUSTEDO ORAL TABLET 6 MG (deutetrabenazine)	Tier 3	PA; QL (2 EA per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (deutetrabenazine)	Tier 3	PA; QL (1 EA per 1 day)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG (deutetrabenazine)	Tier 3	PA
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
INGREZZA SPRINKLE ORAL CAPSULE, SPRINKLE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
<i>tetrabenazine oral tablet 12.5 mg, 25 mg</i>	Tier 3	PA
XENAZINE ORAL TABLET 12.5 MG, 25 MG (tetrabenazine)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Movement Disorder Therapy - Restless Legs Syndrome - Drugs For The Nervous System		
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG (gabapentin enacarbil)	Tier 3	ST: Requires prior prescription for Gabipentin (Neurontin-generic available), Pramipexole IR, or Ropinirole IR within the past 120 days; QL (30 EA per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG (gabapentin enacarbil)	Tier 3	ST: Requires prior prescription for Gabipentin (Neurontin-generic available), Pramipexole IR, or Ropinirole IR within the past 120 days; QL (2 EA per 1 day)
Movement Disorder Therapy - Tardive Dyskinesia - Drugs For The Nervous System		
AUSTEDO ORAL TABLET 12 MG, 9 MG (deutetrabenazine)	Tier 3	PA; QL (4 EA per 1 day)
AUSTEDO ORAL TABLET 6 MG (deutetrabenazine)	Tier 3	PA; QL (2 EA per 1 day)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (deutetrabenazine)	Tier 3	PA; QL (1 EA per 1 day)
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG (deutetrabenazine)	Tier 3	PA
INGREZZA INITIATION PK(TARDIV) ORAL CAPSULE,DOSE PACK 40 MG (7)- 80 MG (21) (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INGREZZA SPRINKLE ORAL CAPSULE, SPRINKLE 40 MG, 60 MG, 80 MG (valbenazine tosylate)	Tier 3	PA; QL (1 EA per 1 day)
Narcolepsy And Cataplexy Therapy Agents - Sedative-Type - Drugs For Sleep Disorder		
LUMRYZ ORAL EXTEND RELEASE GRANULES,PACKET 4.5 GRAM, 6 GRAM, 7.5 GRAM, 9 GRAM (sodium oxybate)	Tier 3	PA
LUMRYZ STARTER PACK ORAL GRANULES ER PACKET, DOSE PACK 4.5-6-7.5 GRAM (sodium oxybate)	Tier 3	PA
<i>sodium oxybate oral solution 500 mg/ml</i>	Tier 3	PA
XYREM ORAL SOLUTION 500 MG/ML (sodium oxybate)	Tier 3	PA
XYWAV ORAL SOLUTION 0.5 GRAM/ML (sodium oxybate/calcium oxybate/magnesium oxybate/pot oxybate)	Tier 3	PA
Narcolepsy Therapy Agents - Dopamine And Ne Reuptake Inhibitor (Dnri) - Drugs For Sleep Disorder		
SUNOSI ORAL TABLET 150 MG, 75 MG (solriamfetol HCl)	Tier 2	PA
Narcolepsy Therapy Agents - H3-Receptor Antagonist/Inverse Agonist - Drugs For Sleep Disorder		
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (pitolisant HCl)	Tier 3	PA
Narcolepsy Therapy Agents - Non-Sympathomimetic - Drugs For Sleep Disorder		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>armodafinil oral tablet 50 mg</i>	Tier 1	QL (3 EA per 1 day)
<i>modafinil oral tablet 100 mg, 200 mg</i>	Tier 1	QL (2 EA per 1 day)
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG (armodafinil)	Tier 3	QL (1 EA per 1 day)
NUVIGIL ORAL TABLET 50 MG (armodafinil)	Tier 3	QL (3 EA per 1 day)
PROVIGIL ORAL TABLET 100 MG, 200 MG (modafinil)	Tier 3	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Narcolepsy Therapy Agents - Stimulant-Type, Piperidine Derivative - Drugs For Sleep Disorder		
METHYLIN ORAL SOLUTION 10 MG/5 ML, 5 MG/5 ML (methylphenidate HCl)	Tier 3	
<i>methylphenidate hcl oral solution 10 mg/5 ml, 5 mg/5 ml</i>	Tier 1	
<i>methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	QL (90 EA per 30 days)
<i>methylphenidate hcl oral tablet, chewable 10 mg</i>	Tier 1	QL (6 EA per 1 day)
<i>methylphenidate hcl oral tablet, chewable 2.5 mg, 5 mg</i>	Tier 1	QL (90 EA per 30 days)
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG (methylphenidate HCl)	Tier 3	QL (90 EA per 30 days)
Narcolepsy Therapy Agents- Stimulant-Type, Sympathomimetic, Amphetamines - Drugs For Sleep Disorder		
dextroamphetamine sulf-saccharate/amphetamine sulf-aspartate (Adderall Oral Tablet 10 Mg, 12.5 Mg, 15 Mg, 20 Mg, 30 Mg, 5 Mg, 7.5 Mg)	Tier 3	QL (2 EA per 1 day)
<i>amphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (4 EA per 1 day)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG (dextroamphetamine sulfate)	Tier 3	QL (4 EA per 1 day)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 15 MG (dextroamphetamine sulfate)	Tier 3	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate oral capsule, extended release 10 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral capsule, extended release 15 mg</i>	Tier 1	QL (120 EA per 30 days)
<i>dextroamphetamine sulfate oral capsule, extended release 5 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dextroamphetamine sulfate oral tablet 15 mg, 2.5 mg, 7.5 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (4 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 20 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (3 EA per 1 day)
<i>dextroamphetamine sulfate oral tablet 30 mg</i>	Tier 1	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (2 EA per 1 day)
<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (2 EA per 1 day)
amphetamine sulfate (Evekeo Oral Tablet 10 Mg, 5 Mg)	Tier 3	QL (4 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 10 Mg, 5 Mg)	Tier 3	QL (4 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 15 Mg, 2.5 Mg, 7.5 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
dextroamphetamine sulfate (Zenzedi Oral Tablet 20 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (3 EA per 1 day)
dextroamphetamine sulfate (Zenzedi Oral Tablet 30 Mg)	Tier 3	ST: Requires prior prescription for Dextroamphetamine Sulfate IR 5/10mg tablets or Dextroamphetamine solution within the past 120 days; QL (2 EA per 1 day)
Neuropathic Pain Therapy - Drugs For Seizures /Personality Disorder/Nerve Pain		
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG (pregabalin)	Tier 3	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (3 EA per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG (pregabalin)	Tier 3	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral tablet extended release 24 hr 165 mg, 82.5 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (3 EA per 1 day)
<i>pregabalin oral tablet extended release 24 hr 330 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (2 EA per 1 day)
Postherpetic Neuralgia Agents - Drugs For Seizures /Personality Disorder/Nerve Pain		
DULOXICaine KIT 30 MG- 4% (duloxetine HCl/lidocaine HCl)	Tier 3	
<i>gabapentin oral tablet extended release 24 hr 300 mg</i>	Tier 3	ST: Requires prior prescription for Gabapentin IR within the past 120 days; QL (1 EA per 1 day)
<i>gabapentin oral tablet extended release 24 hr 600 mg</i>	Tier 3	ST: Requires prior prescription for Gabapentin IR within the past 120 days; QL (2 EA per 1 day)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG (gabapentin)	Tier 3	ST: Requires prior prescription for Gabapentin IR within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 750 MG, 900 MG (gabapentin)	Tier 3	ST: Requires prior prescription for Gabapentin IR within the past 120 days; QL (2 EA per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG (pregabalin)	Tier 3	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (3 EA per 1 day)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG (pregabalin)	Tier 3	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (2 EA per 1 day)
<i>pregabalin oral tablet extended release 24 hr 165 mg, 82.5 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pregabalin oral tablet extended release 24 hr 330 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Gabapentin, tricyclic antidepressant, Divalproex, Duloxetine, Pregabalin IR, Venlafaxine, Valproic Acid within the past 365 days; QL (2 EA per 1 day)
Pseudobulbar Affect (Pba) Agents, Nmda Antagonists Type - Drugs For Severe Mental Disorders		
NUDEXTA ORAL CAPSULE 20-10 MG (dextromethorphan Hbr/quinidine sulfate)	Tier 3	PA
Sedative-Hypnotic - Barbiturates - Drugs For Insomnia		
<i>phenobarbital oral elixir 20 mg/5 ml (4 mg/ml)</i>	Tier 1	
<i>phenobarbital oral tablet 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg</i>	Tier 1	
<i>phenobarbital oral tablet 15 mg, 30 mg, 60 mg</i>	Tier 1	
Sedative-Hypnotic - Benzodiazepines - Drugs For Insomnia		
DORAL ORAL TABLET 15 MG (quazepam)	Tier 3	ST: Requires prior prescription for one of the following oral generics: Eszopiclone, Flurazepam, Temazepam, Zaleplon, or Zolpidem tablets within the past 120 days
<i>estazolam oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>flurazepam oral capsule 15 mg, 30 mg</i>	Tier 1	
HALCION ORAL TABLET 0.25 MG (triazolam)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>midazolam oral syrup 2 mg/ml</i>	Tier 1	
<i>quazepam oral tablet 15 mg</i>	Tier 1	ST: Requires prior prescription for one of the following oral generics: Eszopiclone, Flurazepam, Temazepam, Zaleplon, or Zolpidem tablets within the past 120 days
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (temazepam)	Tier 3	
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	Tier 1	
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	Tier 1	
Sedative-Hypnotic - Gaba-Receptor Modulators - Drugs For Insomnia		
AMBIEN CR ORAL TABLET,EXT RELEASE MULTIPHASE 12.5 MG, 6.25 MG (zolpidem tartrate)	Tier 3	QL (1 EA per 1 day)
AMBIEN ORAL TABLET 10 MG, 5 MG (zolpidem tartrate)	Tier 3	QL (1 EA per 1 day)
EDLUAR SUBLINGUAL TABLET 10 MG, 5 MG (zolpidem tartrate)	Tier 3	ST: Requires prior prescription for Zolpidem IR (Ambien) within the past 180 days; QL (1 EA per 1 day)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	Tier 1	QL (1 EA per 1 day)
LUNESTA ORAL TABLET 1 MG, 2 MG, 3 MG (eszopiclone)	Tier 3	QL (1 EA per 1 day)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zolpidem oral capsule 7.5 mg</i>	Tier 3	
<i>zolpidem oral tablet 10 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zolpidem oral tablet,ext release multiphase 12.5 mg, 6.25 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>zolpidem sublingual tablet 1.75 mg, 3.5 mg</i>	Tier 1	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Sedative-Hypnotic - Orexin Receptor Antagonist - Drugs For Insomnia		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (suvorexant)	Tier 2	ST: Requires prior prescription for Eszopiclone, Zaleplon, or Zolpidem Tartrate within the past 130 days; QL (1 EA per 1 day)
DAYVIGO ORAL TABLET 10 MG, 5 MG (lemborexant)	Tier 2	ST: Requires prior prescription for Eszopiclone, Zaleplon, or Zolpidem Tartrate within the past 130 days; QL (1 EA per 1 day)
QUVIVIQ ORAL TABLET 25 MG, 50 MG (daridorexant HCl)	Tier 3	ST: Requires prior prescription of Zolpidem Tartrate, Eszopiclone, or Zaleplon within the last 130 days; QL (1 EA per 1 day)
Sedative-Hypnotic - Selective Alpha2-Adrenoreceptor Agonists - Drugs For Insomnia		
IGALMI SUBLINGUAL FILM 120 MCG, 180 MCG (dexmedetomidine HCl)	Tier 3	PA
Sedative-Hypnotic - Tricyclic Antidepressant Type - Drugs For Insomnia		
<i>doxepin oral tablet 3 mg, 6 mg</i>	Tier 1	ST: Requires prior prescription for Doxepin solution or 10mg capsules, Eszopiclone, Zaleplon, or Zolpidem Tartrate within the past 120 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SILENOR ORAL TABLET 3 MG, 6 MG (doxepin HCl)	Tier 3	ST: Requires prior prescription for Doxepin solution or 10mg capsules, Eszopiclone, Zaleplon, or Zolpidem Tartrate within the past 120 days; QL (1 EA per 1 day)
Chemical Dependency, Agents To Treat - Drugs For Addiction		
Agents For Opioid Withdrawal, Central Alpha-2 Adrenergic Agonist-Type - Drugs For Opioid Addiction		
<i>lofexidine oral tablet 0.18 mg</i>	Tier 3	PA
LUCEMYRA ORAL TABLET 0.18 MG (lofexidine HCl)	Tier 3	PA
Agents For Opioid Withdrawal, Opioid-Type - Drugs For Opioid Addiction		
<i>buprenorphine hcl sublingual tablet 2 mg, 8 mg</i>	Tier 1	
<i>buprenorphine-naloxone sublingual film 12-3 mg, 2-0.5 mg, 4-1 mg, 8-2 mg</i>	Tier 1	
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg, 8-2 mg</i>	Tier 1	
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG (buprenorphine HCl/naloxone HCl)	Tier 3	
SUBOXONE SUBLINGUAL FILM 8-2 MG (buprenorphine HCl/naloxone HCl)	Tier 2	
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (buprenorphine HCl/naloxone HCl)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alcohol Abstinence Therapy - Glutamate And Gaba System Type - Drugs For Alcohol Addiction		
<i>acamprosate oral tablet, delayed release (dr/ec) 333 mg</i>	Tier 1	
Alcohol Abstinence Therapy - Opioid Receptor Antagonist-Type - Drugs For Alcohol Addiction		
<i>naltrexone oral tablet 50 mg</i>	Tier 1	
Alcohol Deterrents - Drugs For Alcohol Addiction		
<i>disulfiram oral tablet 250 mg, 500 mg</i>	Tier 1	
Smoking Deterrents - Ne And Dopamine Reuptake Inhibitor (Ndri)-Type - Drugs For Smoking Addiction		
<i>bupropion hcl (smoking deter) oral tablet extended release 12 hr 150 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 2 IN 1 DAY, LIMITED TO 180 IN 365 DAYS AND 18 YEARS OF AGE OR OLDER
Smoking Deterrents - Nicotine-Type - Drugs For Smoking Addiction		
<i>nicotine (polacrilex) buccal gum 2 mg, 4 mg</i>	PV	\$0 COPAY IF QUANTITY 24 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
<i>nicotine (polacrilex) buccal lozenge 2 mg, 4 mg</i>	PV	\$0 COPAY IF QUANTITY 20 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nicotine (polacrilex) buccal mini lozenge 2 mg, 4 mg</i>	PV	\$0 COPAY IF QUANTITY 20 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
<i>nicotine transdermal patch 24 hour 14 mg/24 hr, 21 mg/24 hr, 7 mg/24 hr</i>	PV	\$0 COPAY IF QUANTITY 1 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
<i>nicotine transdermal patch, td daily, sequential 21-14-7 mg/24 hr</i>	PV	\$0 COPAY IF QUANTITY 1 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
NICOTROL NS NASAL SPRAY, NON-AEROSOL 10 MG/ML (nicotine)	Tier 2	\$0 COPAY IF 18 YEARS OF AGE OR OLDER
QUIT 2 BUCCAL GUM 2 MG (nicotine polacrilex)	PV	\$0 COPAY IF QUANTITY 24 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
QUIT 2 BUCCAL LOZENGE 2 MG (nicotine polacrilex)	PV	\$0 COPAY IF QUANTITY 20 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
QUIT 4 BUCCAL GUM 4 MG (nicotine polacrilex)	PV	\$0 COPAY IF QUANTITY 24 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUIT 4 BUCCAL LOZENGE 4 MG (nicotine polacrilex)	PV	\$0 COPAY IF QUANTITY 20 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
STOP SMOKING AID BUCCAL LOZENGE 2 MG, 4 MG (nicotine polacrilex)	PV	\$0 COPAY IF QUANTITY 20 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER
Smoking Deterrents - Nicotinic Receptor Partial Agonist, Alpha4beta2 - Drugs For Smoking Addiction		
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	Tier 1	\$0 COPAY IF QUANTITY 2 IN 1 DAY, LIMITED TO 180 IN 365 DAYS AND 18 YEARS OF AGE OR OLDER; QL (2 EA per 1 day)
<i>varenicline tartrate oral tablets,dose pack 0.5 mg (11)- 1 mg (42)</i>	Tier 1	\$0 COPAY IF QUANTITY 2 IN 1 DAY, LIMITED TO 180 IN 365 DAYS, AND 18 YEARS OF AGE OR OLDER; QL (2 EA per 1 day)
Chemicals-Pharmaceutical Adjuvants		
Bulk Chemicals		
<i>alum, ammonium (bulk) powder</i>	Tier 3	
<i>ascorbic acid(vitamin c)(bulk) granules 100 %</i>	Tier 3	
<i>benzoin (bulk) topical tincture</i>	Tier 3	
<i>glutathione (bulk) powder 100 %</i>	Tier 3	
<i>guaiacol liquid</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrogen peroxide (bulk) solution 30 %</i>	Tier 3	
<i>hydroxyethyl methacrylate,bulk liquid 96 %</i>	Tier 3	
<i>sodium bicarb-sodium chloride powder</i>	Tier 3	
SWEET OIL OIL (olive oil)	Tier 3	
TECHNA NAT UNSWT TROCHE BASEG2 POWDER (troche base no.247)	Tier 3	
<i>vitamin e acetate (bulk) liquid 125 unit/ml</i>	Tier 3	
Chemicals - Cryopreservative Agents		
CRYOSERV SOLUTION 99 % (dimethyl sulfoxide)	Tier 3	
Chemicals - Fixed Oils		
<i>olive oil oil</i>	Tier 3	
SWEET OIL OIL (olive oil)	Tier 3	
Chemicals - Solvents		
<i>isopropyl alcohol solution 70 %, 91 %, 99 %</i>	Tier 3	
MURI-LUBE OIL (mineral oil, light sterile)	Tier 3	
<i>sesame oil oil</i>	Tier 3	
<i>sodium succinate powder</i>	Tier 3	
Pharmaceutical Adjuvant - Anticorrosive Agents		
<i>butylated hydroxytoluene powder</i>	Tier 3	
Pharmaceutical Adjuvant - Capsule Excipients		
CAPSUBLEND-H POWDER (cellulose/silica gel/mannitol/magnesium stearate)	Tier 3	
Pharmaceutical Adjuvant - Coloring Agents		
<i>methylene blue (bulk-solid) powder</i>	Tier 3	
Pharmaceutical Adjuvant - Flavoring Agents		
<i>ethyl acetate liquid</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SWEET OIL OIL (olive oil)	Tier 3	
Pharmaceutical Adjuvant - Hypromellose Capsules (Empty)		
CAPSULE #3 (HYPROMELLOSE) ORAL CAPSULE (hypromellose capsules (empty))	Tier 3	
Pharmaceutical Adjuvant - Inhalation Vehicles		
HYPER-SAL INHALATION SOLUTION FOR NEBULIZATION 3.5 %, 7 % (sodium chloride for inhalation)	Tier 3	
NEBUSAL INHALATION SOLUTION FOR NEBULIZATION 3 % (sodium chloride for inhalation)	Tier 1	
NEBUSAL INHALATION SOLUTION FOR NEBULIZATION 6 % (sodium chloride for inhalation)	Tier 3	
PULMOSAL INHALATION SOLUTION FOR NEBULIZATION 7 % (sodium chloride for inhalation)	Tier 3	
<i>sodium chloride inhalation solution for nebulization 0.9 %, 10 %, 3 %, 7 %</i>	Tier 1	
Pharmaceutical Adjuvant - Liquid Vehicles Other		
PCCA SUSPENDIT ANHYDROUS LIQUID (liquid base no.261)	Tier 3	
Pharmaceutical Adjuvant - Oral Thickening Agents		
GELMIX ORAL POWDER (maltodextrin/carob)	Tier 3	
GELMIX ORAL POWDER IN PACKET (maltodextrin/carob)	Tier 3	
SIMPLYTHICK ORAL GEL IN PACKET 4 GRAM (xanthan gum)	Tier 3	
THICK AND EASY ORAL POWDER IN PACKET (starch)	Tier 3	
Pharmaceutical Adjuvant - Oral Vehicles		
<i>sorbitol solution 70 %</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNISPEND ANHYDROUS SWEET ORAL SUSPENSION (compound vehicle suspension sugar-free no.24)	Tier 3	
Pharmaceutical Adjuvant - Surfactants		
<i>polysorbate 80 solution</i>	Tier 3	
Pharmaceutical Adjuvant - Suspending Agents		
<i>hydroxypropyl cellulose powder</i>	Tier 3	
<i>hypromellose powder</i>	Tier 3	
METHOCEL E 4 M POWDER (hypromellose)	Tier 3	
Pharmaceutical Adjuvant - Tableting		
<i>cellulose (bulk) powder</i>	Tier 3	
Pharmaceutical Adjuvant - Troche/Soft Lozenge Base		
TECHNA NAT UNSWT TROCHE BASEG2 POWDER (troche base no.247)	Tier 3	
Cognitive Disorder Therapy		
Rett Syndrome Agents - Glypromate (Gpe) Analogs		
DAYBUE ORAL SOLUTION 200 MG/ML (trofinetide)	Tier 3	PA
Cognitive Disorder Therapy - Drugs For The Nervous System		
Alzheimer's Disease Therapy - Amyloid Directed Monoclonal Antibody - Drugs For Alzheimer's Disease		
LEQEMBI IQLIK SUBCUTANEOUS AUTO-INJECTOR 360 MG/1.8 ML (lecanemab-irmb)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alzheimer's Disease Therapy - Cholinesterase Inhibitors - Drugs For Alzheimer's Disease		
ADLARITY TRANSDERMAL PATCH WEEKLY 10 MG/24 HOUR, 5 MG/24 HOUR (donepezil HCl)	Tier 3	PA
ARICEPT ORAL TABLET 10 MG, 23 MG, 5 MG (donepezil HCl)	Tier 3	
<i>donepezil oral tablet 10 mg, 23 mg, 5 mg</i>	Tier 1	
<i>donepezil oral tablet,disintegrating 10 mg, 5 mg</i>	Tier 1	
EXELON PATCH TRANSDERMAL PATCH 24 HOUR 13.3 MG/24 HOUR, 4.6 MG/24 HOUR, 9.5 MG/24 HOUR (rivastigmine)	Tier 3	QL (30 EA per 30 days)
<i>galantamine oral capsule,ext rel. pellets 24 hr 16 mg, 24 mg, 8 mg</i>	Tier 1	QL (30 EA per 30 days)
<i>galantamine oral solution 4 mg/ml</i>	Tier 1	QL (200 ML per 30 days)
<i>galantamine oral tablet 12 mg, 4 mg, 8 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	Tier 1	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24 hour, 4.6 mg/24 hour, 9.5 mg/24 hour</i>	Tier 1	QL (30 EA per 30 days)
ZUNVEYL ORAL TABLET,DELAYED RELEASE (DR/EC) 10 MG, 15 MG, 5 MG (benzgalantamine gluconate)	Tier 3	ST: Requires prior prescription for generic Galantamine tablets or Galantamine ER capsules within the past 120 days; QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Alzheimer's Disease Therapy - Nmda Receptor Antagonists - Drugs For Alzheimer's Disease		
<i>memantine oral capsule,sprinkle,er 24hr 14 mg, 21 mg, 28 mg, 7 mg</i>	Tier 1	ST: Requires prior prescription for Memantine immediate release tablets within the past 120 days; QL (30 EA per 30 days)
<i>memantine oral solution 2 mg/ml</i>	Tier 1	QL (300 ML per 30 days)
<i>memantine oral tablet 10 mg, 5 mg</i>	Tier 1	QL (60 EA per 30 days)
<i>memantine oral tablets,dose pack 5-10 mg</i>	Tier 1	QL (49 EA per 28 days)
NAMENDA TITRATION PAK ORAL TABLETS,DOSE PACK 5-10 MG (memantine HCl)	Tier 3	QL (49 EA per 28 days)
NAMENDA XR ORAL CAP,SPRINKLE,ER 24HR DOSE PACK 7-14-21-28 MG (memantine HCl)	Tier 2	ST: Requires prior prescription for Memantine immediate release tablets within the past 120 days; QL (28 EA per 28 days)
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 7 MG (memantine HCl)	Tier 3	ST: Requires prior prescription for Memantine immediate release tablets within the past 120 days; QL (30 EA per 30 days)
Alzheimer's Thx - Nmda Receptor Antag. And Cholinesterase Inhib. Comb - Drugs For Alzheimer's Disease		
<i>memantine-donepezil oral capsule,sprinkle,er 24hr 14-10 mg, 21-10 mg, 28-10 mg</i>	Tier 1	ST: Requires prior prescriptions for Donepezil and Memantine within the past 365 days; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 14-10 MG, 21-10 MG, 28-10 MG (memantine HCl/donepezil HCl)	Tier 3	ST: Requires prior prescriptions for Donepezil and Memantine within the past 365 days; QL (1 EA per 1 day)
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR 7-10 MG (memantine HCl/donepezil HCl)	Tier 2	ST: Requires prior prescriptions for Donepezil and Memantine within the past 365 days; QL (1 EA per 1 day)
Cognitive Disorder Therapy - Cerebral Vasodilators - Drugs For Alzheimer's Disease		
ergoloid oral tablet 1 mg	Tier 1	
Contraceptives - Drugs For Women		
Contraceptive - Vaginal Ph Modulator - Medical Supplies And Durable Medical Equipment		
PHEXXI VAGINAL GEL 1.8-1-0.4 % (lactic acid/citric acid/potassium bitartrate)	PV	
Contraceptive Implant - Progestin - Birth Control Pills		
NEXPLANON SUBDERMAL IMPLANT 68 MG (etonogestrel)	PV	
Contraceptive Injectable - Progestin - Birth Control Pills		
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (medroxyprogesterone acetate)	Tier 3	KP
DEPO-PROVERA INTRAMUSCULAR SYRINGE 150 MG/ML (medroxyprogesterone acetate)	Tier 3	KP
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SYRINGE 104 MG/0.65 ML (medroxyprogesterone acetate)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>medroxyprogesterone intramuscular suspension 150 mg/ml</i>	PV	
<i>medroxyprogesterone intramuscular syringe 150 mg/ml</i>	PV	
Contraceptive Intrauterine - Copper IUD - Birth Control Pills		
MIUDELLA INTRAUTERINE INTRAUTERINE DEVICE 175 SQUARE MM (copper)	PV	
PARAGARD T 380A INTRAUTERINE INTRAUTERINE DEVICE 380 SQUARE MM (copper)	PV	
PARAGARD T380A (SINGLE HAND) INTRAUTERINE INTRAUTERINE DEVICE 380 SQUARE MM (copper)	PV	
Contraceptive Intrauterine - Progesterone IUD - Birth Control Pills		
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 17.5 MCG/24 HR (5 YRS) 19.5 MG (levonorgestrel)	PV	
LILETTA INTRAUTERINE INTRAUTERINE DEVICE 20.4 MCG/24 HR (8 YRS) 52 MG (levonorgestrel)	PV	
MIRENA INTRAUTERINE INTRAUTERINE DEVICE 21 MCG/24HR (UP TO 8 YRS) 52 MG (levonorgestrel)	PV	
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 14 MCG/24 HR (3 YRS) 13.5 MG (levonorgestrel)	PV	
Contraceptive Oral - Biphaseic - Birth Control Pills		
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Amethia Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	PV	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Ashlyna Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	PV	
desogestrel-ethinyl estradiol/ethinyl estradiol (Azurette (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CAMRESE LO ORAL TABLETS,DOSE PACK,3 MONTH 0.1 MG-20 MCG (84)/10 MCG (7) (levonorgestrel/ethinyl estradiol and ethinyl estradiol)	PV	
CAMRESE ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (84)/10 MCG (7) (levonorgestrel/ethinyl estradiol and ethinyl estradiol)	PV	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Daysee Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	PV	
<i>desog-e.estradiol/e.estradiol oral tablet 0.15-0.02 mgx21 /0.01 mg x 5</i>	PV	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Jaimiess Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	PV	
desogestrel-ethinyl estradiol/ethinyl estradiol (Kariva (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	PV	
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	PV	
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG (24)/10 MCG (2) (norethindrone acetate-ethinyl estradiol/ferrous fumarate)	PV	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Lojaimiess Oral Tablets,Dose Pack,3 Month 0.1 Mg-20 Mcg (84)/10 Mcg (7))	PV	
desogestrel-ethinyl estradiol/ethinyl estradiol (Pimtrea (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	PV	
desogestrel-ethinyl estradiol/ethinyl estradiol (Simliya (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	PV	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Simpesse Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (84)/10 Mcg (7))	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desogestrel-ethinyl estradiol/ethinyl estradiol (Viorele (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	PV	
desogestrel-ethinyl estradiol/ethinyl estradiol (Volnea (28) Oral Tablet 0.15-0.02 Mgx21 /0.01 Mg X 5)	PV	
Contraceptive Oral - Monophasic - Birth Control Pills		
levonorgestrel/ethinyl estradiol (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Altavera (28) Oral Tablet 0.15-0.03 Mg)	PV	
norethindrone-ethinyl estradiol (Alyacen 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Amethyst (28) Oral Tablet 90-20 Mcg (28))	PV	
desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-0.03 Mg)	PV	
levonorgestrel/ethinyl estradiol (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Aubra Oral Tablet 0.1-20 Mg-Mcg)	PV	
norethindrone acetate/ethinyl estradiol (Aurovela 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	PV	
norethindrone acetate/ethinyl estradiol (Aurovela 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Aurovela 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Aurovela Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Aurovela Fe 1-20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVERI ORAL TABLET 0.15 MG-0.03 MG (21)/36.5 MG(7) (desogestrel/ethinyl estradiol/ferrous bis-glycinate chelate)	PV	
levonorgestrel/ethinyl estradiol (Aviane Oral Tablet 0.1-20 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Ayuna Oral Tablet 0.15-0.03 Mg)	PV	
BALCOLTRA ORAL TABLET 0.1 MG-0.02 MG (21)/IRON (7) (levonorgestrel/ethinyl estradiol/iron)	Tier 3	
norethindrone-ethinyl estradiol (Balziva (28) Oral Tablet 0.4-35 Mg-Mcg)	PV	
BEYAZ ORAL TABLET 3-0.02-0.451 MG (24) (4) (drospirenone/ethinyl estradiol/levomefolate calcium)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Blisovi 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Blisovi Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Blisovi Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
norethindrone-ethinyl estradiol (Briellyn Oral Tablet 0.4-35 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Charlotte 24 Fe Oral Tablet,Chewable 1 Mg-20 Mcg(24) /75 Mg (4))	PV	
levonorgestrel/ethinyl estradiol (Chateal Eq (28) Oral Tablet 0.15-0.03 Mg)	PV	
norgestrel-ethinyl estradiol (Cryselle (28) Oral Tablet 0.3-30 Mg-Mcg)	PV	
desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet 0.15-0.03 Mg)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desogestrel-ethinyl estradiol (Cyred Oral Tablet 0.15-0.03 Mg)	PV	
norethindrone-ethinyl estradiol (Dasetta 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Dolishale Oral Tablet 90-20 Mcg (28))	PV	
<i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4), 3-0.03-0.451 mg (21) (7)</i>	PV	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	PV	
norgestrel-ethinyl estradiol (Elinest Oral Tablet 0.3-30 Mg-Mcg)	PV	
desogestrel-ethinyl estradiol (Enskyce Oral Tablet 0.15-0.03 Mg)	PV	
norgestimate-ethinyl estradiol (Estarylla Oral Tablet 0.25-0.035 Mg)	PV	
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	PV	
levonorgestrel/ethinyl estradiol (Falmina (28) Oral Tablet 0.1-20 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Feirza Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7), 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	
FEMLYV ORAL TABLET,DISINTEGRATING 1 MG- 20 MCG (norethindrone acetate/ethinyl estradiol)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Finzala Oral Tablet,Chewable 1 Mg-20 Mcg(24) /75 Mg (4))	PV	
norethindrone-ethinyl estradiol/ferrous fumarate (Galbriela Oral Tablet,Chewable 0.8Mg-25Mcg(24) And 75 Mg (4))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Gemmily Oral Capsule 1 Mg-20 Mcg (24)/75 Mg (4))	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Hailey 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Hailey Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Hailey Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate/ethinyl estradiol (Hailey Oral Tablet 1.5-30 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Iclevia Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (91))	PV	
levonorgestrel/ethinyl estradiol (Introvale Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (91))	PV	
desogestrel-ethinyl estradiol (Isibloom Oral Tablet 0.15-0.03 Mg)	PV	
ethinyl estradiol/drospirenone (Jasmiel (28) Oral Tablet 3-0.02 Mg)	PV	
JOLESSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-30 MCG (91) (levonorgestrel/ethinyl estradiol)	PV	
levonorgestrel/ethinyl estradiol/iron (Joyeaux Oral Tablet 0.1 Mg-0.02 Mg (21)/Iron (7))	PV	
desogestrel-ethinyl estradiol (Juleber Oral Tablet 0.15-0.03 Mg)	PV	
norethindrone acetate/ethinyl estradiol (Junel 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	PV	
norethindrone acetate/ethinyl estradiol (Junel 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Junel Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Junel Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Junel Fe 24 Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	PV	
norethindrone-ethinyl estradiol/ferrous fumarate (Kaitlib Fe Oral Tablet,Chewable 0.8Mg-25Mcg(24) And 75 Mg (4))	PV	
desogestrel-ethinyl estradiol (Kalliga Oral Tablet 0.15-0.03 Mg)	PV	
ethynodiol diacetate-ethinyl estradiol (Kelnor 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	PV	
ethynodiol diacetate-ethinyl estradiol (Kelnor 1/50 (28) Oral Tablet 1-50 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Kurvelo (28) Oral Tablet 0.15-0.03 Mg)	PV	
norethindrone acetate/ethinyl estradiol (Larin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	PV	
norethindrone acetate/ethinyl estradiol (Larin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Larin 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Larin Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Larin Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
LAYOLIS FE ORAL TABLET,CHEWABLE 0.8MG-25MCG(24) AND 75 MG (4) (norethindrone-ethinyl estradiol/ferrous fumarate)	PV	
levonorgestrel/ethinyl estradiol (Lessina Oral Tablet 0.1-20 Mg-Mcg)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
levonorgest-eth.estradiol-iron oral tablet 0.1 mg-0.02 mg (21)/iron (7)	PV	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg, 90-20 mcg (28)	PV	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month 0.15 mg-30 mcg (91)	PV	
levonorgestrel/ethinyl estradiol (Levora-28 Oral Tablet 0.15-0.03 Mg)	PV	
norethindrone acetate/ethinyl estradiol (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Tier 3	
norethindrone acetate/ethinyl estradiol (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Tier 3	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Loestrin Fe 1.5/30 (28-Day) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	Tier 3	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Loestrin Fe 1/20 (28-Day) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	Tier 3	
ethinyl estradiol/drospirenone (Loryna (28) Oral Tablet 3-0.02 Mg)	PV	
norgestrel-ethinyl estradiol (Low-Ogestrel (28) Oral Tablet 0.3-30 Mg-Mcg)	PV	
ethinyl estradiol/drospirenone (Lo-Zumandimine (28) Oral Tablet 3-0.02 Mg)	PV	
levonorgestrel/ethinyl estradiol (Lutera (28) Oral Tablet 0.1-20 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Marlissa (28) Oral Tablet 0.15-0.03 Mg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Merzee Oral Capsule 1 Mg-20 Mcg (24)/75 Mg (4))	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Mibelas 24 Fe Oral Tablet,Chewable 1 Mg-20 Mcg(24) /75 Mg (4))	PV	
norethindrone acetate/ethinyl estradiol (Microgestin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	PV	
norethindrone acetate/ethinyl estradiol (Microgestin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Microgestin Fe 1.5/30 (28) Oral Tablet 1.5 Mg-30 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Microgestin Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
norgestimate-ethinyl estradiol (Mili Oral Tablet 0.25-0.035 Mg)	PV	
levonorgestrel/ethinyl estradiol/iron (Minzoya Oral Tablet 0.1 Mg-0.02 Mg (21)/Iron (7))	PV	
norgestimate-ethinyl estradiol (Mono-Linyah Oral Tablet 0.25-0.035 Mg)	PV	
norethindrone-ethinyl estradiol (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	PV	
NEXTSTELLIS ORAL TABLET 3 MG- 14.2 MG (28) (drospirenone/estetrol)	PV	
ethinyl estradiol/drospirenone (Nikki (28) Oral Tablet 3-0.02 Mg)	PV	
<i>noreth-ethinyl estradiol-iron oral tablet,chewable 0.4mg-35mcg(21) and 75 mg (7), 0.8mg-25mcg(24) and 75 mg (4)</i>	PV	
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	PV	
<i>norethindrone-e.estradiol-iron oral capsule 1 mg-20 mcg (24)/75 mg (4)</i>	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone-e.estradiol-iron oral tablet 1.5 mg-30 mcg (21)/75 mg (7)	PV	
norethindrone-e.estradiol-iron oral tablet,chewable 1 mg-20 mcg(24) /75 mg (4)	PV	
norgestimate-ethinyl estradiol oral tablet 0.25-0.035 mg	PV	
norethindrone-ethinyl estradiol (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	PV	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG (21) (norethindrone-ethinyl estradiol)	PV	
norethindrone-ethinyl estradiol (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	PV	
norethindrone-ethinyl estradiol (Nylia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	PV	
OCELLA ORAL TABLET 3-0.03 MG (ethinyl estradiol/drospirenone)	PV	
norethindrone-ethinyl estradiol (Philith Oral Tablet 0.4-35 Mg-Mcg)	PV	
levonorgestrel/ethinyl estradiol (Portia 28 Oral Tablet 0.15-0.03 Mg)	PV	
desogestrel-ethinyl estradiol (Reclipsen (28) Oral Tablet 0.15-0.03 Mg)	PV	
SAFYRAL ORAL TABLET 3-0.03-0.451 MG (21) (7) (drospirenone/ethinyl estradiol/levomefolate calcium)	PV	
levonorgestrel/ethinyl estradiol (Setlakin Oral Tablets,Dose Pack,3 Month 0.15 Mg-30 Mcg (91))	PV	
norgestimate-ethinyl estradiol (Sprintec (28) Oral Tablet 0.25-0.035 Mg)	PV	
levonorgestrel/ethinyl estradiol (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	PV	
ethinyl estradiol/drospirenone (Syeda Oral Tablet 3-0.03 Mg)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tarina 24 Fe Oral Tablet 1 Mg-20 Mcg (24)/75 Mg (4))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tarina Fe 1/20 (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tarina Fe 1-20 Eq (28) Oral Tablet 1 Mg-20 Mcg (21)/75 Mg (7))	PV	
TAYTULLA ORAL CAPSULE 1 MG-20 MCG (24)/75 MG (4) (norethindrone acetate-ethinyl estradiol/ferrous fumarate)	PV	
norgestrel-ethinyl estradiol (Turqoz (28) Oral Tablet 0.3-30 Mg-Mcg)	PV	
TYBLUME ORAL TABLET,CHEWABLE 0.1 MG- 20 MCG (levonorgestrel/ethinyl estradiol)	PV	
drospirenone/ethinyl estradiol/levomefolate calcium (Tydemy Oral Tablet 3-0.03-0.451 Mg (21) (7))	PV	
ethynodiol diacetate-ethinyl estradiol (Valtya Oral Tablet 1-50 Mg-Mcg)	PV	
ethinyl estradiol/drospirenone (Vestura (28) Oral Tablet 3-0.02 Mg)	PV	
levonorgestrel/ethinyl estradiol (Vienva Oral Tablet 0.1-20 Mg-Mcg)	PV	
norethindrone-ethinyl estradiol (Vyfemla (28) Oral Tablet 0.4-35 Mg-Mcg)	PV	
norgestimate-ethinyl estradiol (Vylibra Oral Tablet 0.25-0.035 Mg)	PV	
norethindrone-ethinyl estradiol (Wera (28) Oral Tablet 0.5-35 Mg-Mcg)	PV	
norethindrone-ethinyl estradiol/ferrous fumarate (Wymzya Fe Oral Tablet,Chewable 0.4Mg-35Mcg(21) And 75 Mg (7))	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone-ethinyl estradiol/ferrous fumarate (Xelria Fe Oral Tablet, Chewable 0.4Mg-35Mcg(21) And 75 Mg (7))	PV	
YASMIN (28) ORAL TABLET 3-0.03 MG (ethinyl estradiol/drospirenone)	Tier 3	
YAZ (28) ORAL TABLET 3-0.02 MG (ethinyl estradiol/drospirenone)	Tier 3	
ethinyl estradiol/drospirenone (Zarah Oral Tablet 3-0.03 Mg)	PV	
ethynodiol diacetate-ethinyl estradiol (Zovia 1-35 (28) Oral Tablet 1-35 Mg-Mcg)	PV	
ethinyl estradiol/drospirenone (Zumandimine (28) Oral Tablet 3-0.03 Mg)	PV	
Contraceptive Oral - Progestin - Birth Control Pills		
norethindrone (Camila Oral Tablet 0.35 Mg)	PV	
norethindrone (Deblitane Oral Tablet 0.35 Mg)	PV	
norethindrone (Emzahh Oral Tablet 0.35 Mg)	PV	
norethindrone (Errin Oral Tablet 0.35 Mg)	PV	
norethindrone (Heather Oral Tablet 0.35 Mg)	PV	
norethindrone (Incassia Oral Tablet 0.35 Mg)	PV	
norethindrone (Jencycla Oral Tablet 0.35 Mg)	PV	
norethindrone (Lyleq Oral Tablet 0.35 Mg)	PV	
norethindrone (Lyza Oral Tablet 0.35 Mg)	PV	
norethindrone (Meleya Oral Tablet 0.35 Mg)	PV	
NORA-BE ORAL TABLET 0.35 MG (norethindrone)	PV	
<i>norethindrone (contraceptive) oral tablet 0.35 mg</i>	PV	
OPILL ORAL TABLET 0.075 MG (norgestrel)	PV	
norethindrone (Orquidea Oral Tablet 0.35 Mg)	PV	
norethindrone (Sharobel Oral Tablet 0.35 Mg)	PV	
SLYND ORAL TABLET 4 MG (28) (drospirenone)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norethindrone (Tulana Oral Tablet 0.35 Mg)	PV	
Contraceptive Oral - Quadruphasic - Birth Control Pills		
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	PV	
NATAZIA ORAL TABLET 3 MG/2 MG-2 MG/ 2 MG-3 MG/1 MG (estradiol valerate/dienogest)	PV	
RIVELSA ORAL TABLETS,DOSE PACK,3 MONTH 0.15 MG-20 MCG/ 0.15 MG-25 MCG (levonorgestrel/ethinyl estradiol and ethinyl estradiol)	PV	
levonorgestrel/ethinyl estradiol and ethinyl estradiol (Rosyrah Oral Tablets,Dose Pack,3 Month 0.15 Mg-20 Mcg/ 0.15 Mg-25 Mcg)	PV	
Contraceptive Oral - Triphasic - Birth Control Pills		
norethindrone-ethinyl estradiol (Alyacen 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	PV	
norethindrone-ethinyl estradiol (Aranelle (28) Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	PV	
desogestrel-ethinyl estradiol (Caziant (28) Oral Tablet 0.1/.125/.15-25 Mg-Mcg)	PV	
norethindrone-ethinyl estradiol (Dasetta 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	PV	
levonorgestrel/ethinyl estradiol (Enpresse Oral Tablet 50-30 (6)/75-40 (5)/125-30(10))	PV	
LEENA 28 ORAL TABLET 0.5/1/0.5-35 MG-MCG (norethindrone-ethinyl estradiol)	PV	
levonorgestrel/ethinyl estradiol (Levonest (28) Oral Tablet 50-30 (6)/75-40 (5)/125-30(10))	PV	
<i>levonorg-eth estrad triphasic oral tablet 50-30 (6)/75-40 (5)/125-30(10)</i>	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-0.025 mg, 0.18/0.215/0.25 mg-0.035mg (28)</i>	PV	
norethindrone-ethinyl estradiol (Nortrel 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	PV	
norethindrone-ethinyl estradiol (Nylia 7/7/7 (28) Oral Tablet 0.5/0.75/1 Mg- 35 Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tilia Fe Oral Tablet 1-20(5)/1-30(7) /1Mg-35Mcg (9))	PV	
norgestimate-ethinyl estradiol (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-0.035Mg (28))	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Tri-Legest Fe Oral Tablet 1-20(5)/1-30(7) /1Mg-35Mcg (9))	PV	
norgestimate-ethinyl estradiol (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-0.035Mg (28))	PV	
norgestimate-ethinyl estradiol (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-0.025 Mg)	PV	
norgestimate-ethinyl estradiol (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-0.025 Mg)	PV	
norgestimate-ethinyl estradiol (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-0.025 Mg)	PV	
norgestimate-ethinyl estradiol (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-0.025 Mg)	PV	
norgestimate-ethinyl estradiol (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-0.035Mg (28))	PV	
norgestimate-ethinyl estradiol (Tri-Sprintec (28) Oral Tablet 0.18/0.215/0.25 Mg-0.035Mg (28))	PV	
levonorgestrel/ethinyl estradiol (Trivora (28) Oral Tablet 50-30 (6)/75-40 (5)/125-30(10))	PV	
norgestimate-ethinyl estradiol (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-0.025 Mg)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
norgestimate-ethinyl estradiol (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-0.035Mg (28))	PV	
desogestrel-ethinyl estradiol (Velivet Triphasic Regimen (28) Oral Tablet 0.1/.125/.15-25 Mg-Mcg)	PV	
norethindrone acetate-ethinyl estradiol/ferrous fumarate (Xarah Fe Oral Tablet 1-20(5)/1-30(7) /1Mg-35Mcg (9))	PV	
Contraceptive Transdermal Combinations - Estrogen And Progestin Comb. - Birth Control Pills		
<i>norelgestromin-ethin.estradiol transdermal patch weekly 150-35 mcg/24 hr</i>	PV	
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24 HR (levonorgestrel/ethinyl estradiol)	PV	
norelgestromin/ethinyl estradiol (Xulane Transdermal Patch Weekly 150-35 Mcg/24 Hr)	PV	
norelgestromin/ethinyl estradiol (Zafemy Transdermal Patch Weekly 150-35 Mcg/24 Hr)	PV	
Contraceptives - Intravaginal, Systemic - Estrogen And Progestin Comb. - Birth Control Pills		
ANNOVERA VAGINAL RING 0.15-0.013 MG/24 HOUR (segesterone acetate/ethinyl estradiol)	PV	
etonogestrel/ethinyl estradiol (Eluryng Vaginal Ring 0.12-0.015 Mg/24 Hr)	PV	
etonogestrel/ethinyl estradiol (Enilloring Vaginal Ring 0.12-0.015 Mg/24 Hr)	PV	
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24 hr</i>	PV	
etonogestrel/ethinyl estradiol (Haloette Vaginal Ring 0.12-0.015 Mg/24 Hr)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUVARING VAGINAL RING 0.12-0.015 MG/24 HR (etonogestrel/ethinyl estradiol)	Tier 3	
Emergency Contraceptives - Birth Control Pills		
AFTER PILL ORAL TABLET 1.5 MG (levonorgestrel)	PV	
AFTERA ORAL TABLET 1.5 MG (levonorgestrel)	PV	
ECONTRA EZ ORAL TABLET 1.5 MG (levonorgestrel)	PV	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	PV	
ELLA ORAL TABLET 30 MG (ulipristal acetate)	PV	
HER STYLE ORAL TABLET 1.5 MG (levonorgestrel)	PV	
<i>levonorgestrel oral tablet 1.5 mg</i>	PV	
MY CHOICE ORAL TABLET 1.5 MG (levonorgestrel)	PV	
MY WAY ORAL TABLET 1.5 MG (levonorgestrel)	PV	
NEW DAY ORAL TABLET 1.5 MG (levonorgestrel)	PV	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	PV	
OPTION-2 ORAL TABLET 1.5 MG (levonorgestrel)	PV	
TAKE ACTION ORAL TABLET 1.5 MG (levonorgestrel)	PV	
Emergency Contraceptives - Progesterone Agonist/Antagonist Type - Birth Control Pills		
ELLA ORAL TABLET 30 MG (ulipristal acetate)	PV	
Emergency Contraceptives - Progestin Type - Birth Control Pills		
AFTER PILL ORAL TABLET 1.5 MG (levonorgestrel)	PV	
AFTERA ORAL TABLET 1.5 MG (levonorgestrel)	PV	
ECONTRA EZ ORAL TABLET 1.5 MG (levonorgestrel)	PV	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HER STYLE ORAL TABLET 1.5 MG (levonorgestrel)	PV	
<i>levonorgestrel oral tablet 1.5 mg</i>	PV	
MY CHOICE ORAL TABLET 1.5 MG (levonorgestrel)	PV	
MY WAY ORAL TABLET 1.5 MG (levonorgestrel)	PV	
NEW DAY ORAL TABLET 1.5 MG (levonorgestrel)	PV	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (levonorgestrel)	PV	
OPTION-2 ORAL TABLET 1.5 MG (levonorgestrel)	PV	
TAKE ACTION ORAL TABLET 1.5 MG (levonorgestrel)	PV	
Spermicides - Birth Control Pills		
VAGINAL CONTRACEPTIVE FILM VAGINAL FILM 28 % (nonoxynol 9)	PV	
VCF CONTRACEPTIVE FILM VAGINAL FILM 28 % (nonoxynol 9)	PV	
VCF CONTRACEPTIVE GEL VAGINAL GEL 4 % (nonoxynol 9)	PV	
Dermatological		
Dermatitis Agents, Systemic - IL-31 Receptor Alpha Antagonist Mab		
NEMLUVIO SUBCUTANEOUS PEN INJECTOR 30 MG (nemolizumab-ilto)	Tier 3	PA; KP
Dermatological - Nitric Oxide Releasing Agents		
ZELSUVMI TOPICAL GEL 10.3 % (berdazimer sodium)	Tier 3	PA
Hair Growth Agents - Kinase Inhibitor		
LEQSELVI ORAL TABLET 8 MG (deuruxolitinib phosphate)	Tier 3	PA
LITFULO ORAL CAPSULE 50 MG (ritlecitinib tosylate)	Tier 3	PA
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (baricitinib)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Drugs For The Skin		
Acne Therapy Systemic - Retinoids And Derivatives - Drugs For The Skin		
ABSORICA LD ORAL CAPSULE 16 MG, 24 MG, 32 MG, 8 MG (isotretinoin, micronized)	Tier 3	ST: Requires prior prescription for preferred generic Isotretinoin within the past 120 days
isotretinoin (Accutane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	
isotretinoin (Amnesteem Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	
isotretinoin (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	
<i>isotretinoin oral capsule 25 mg, 35 mg</i>	Tier 3	ST: Requires prior prescription for preferred generic Isotretinoin within the past 120 days
isotretinoin (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Tier 1	
Acne Therapy Systemic - Tetracycline Antibiotic - Drugs For The Skin		
<i>minocycline oral capsule, extended release 24hr 135 mg, 45 mg, 90 mg</i>	Tier 3	ST: Requires prior prescription for generic Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 12 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>minocycline oral tablet extended release 24 hr 105 mg, 115 mg, 135 mg, 45 mg, 55 mg, 65 mg, 80 mg, 90 mg</i>	Tier 3	ST: Requires prior prescription for generic Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
SEYSARA ORAL TABLET 100 MG, 150 MG, 60 MG (sarecycline HCl)	Tier 3	ST: Requires prior prescription for generic Doxycycline or Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 9 Years)
XIMINO ORAL CAPSULE,EXTENDED RELEASE 24HR 135 MG, 45 MG, 90 MG (minocycline HCl)	Tier 3	ST: Requires prior prescription for generic Minocycline IR within the past 120 days; QL (1 EA per 1 day); Age (Min 12 Years)
Acne Therapy Topical - Androgen Receptor Inhibitors - Drugs For The Skin		
WINLEVI TOPICAL CREAM 1 % (clascoterone)	Tier 3	PA; QL (60 GM per 30 days)
Acne Therapy Topical - Anti-Infective - Drugs For The Skin		
ABENOR HP TOPICAL LOTION 15-4 % (sulfacetamide sodium/niacinamide)	Tier 3	
ABENOR TOPICAL CREAM 10-4 % (sulfacetamide sodium/niacinamide)	Tier 3	
ACIOXIAY TOPICAL CREAM 15-4 % (azelaic acid/niacinamide)	Tier 3	
ACZONE TOPICAL GEL 5 % (dapsone)	Tier 3	
ACZONE TOPICAL GEL WITH PUMP 7.5 % (dapsone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMZEEQ TOPICAL FOAM 4 % (minocycline HCl)	Tier 3	ST: At least 2 prior prescriptions for generic topicals: Adapalene/Benzoyl Peroxide, Clindamycin Phosphate/Benzoyl Peroxide, Erythromycin/Benzoyl Peroxide, Sulfacetamide Sodium/Sulfur, or Tretinoin within the past 365 days; Age (Min 9 Years)
APORIX TOPICAL GEL 1-4 % (clindamycin/niacinamide)	Tier 3	
<i>azelaic acid topical gel 15 %</i>	Tier 1	
AZELEX TOPICAL CREAM 20 % (azelaic acid)	Tier 3	ST: Requires prior prescription for one generic topicals: sulfacetamide+/- sulfur, clindamycin+/- benzoyl peroxide, erythromycin+/- benzoyl peroxide, adapalene+/- benzoyl peroxide, or tretinoin within the past 120 days
CLEOCIN T TOPICAL LOTION 1 % (clindamycin phosphate)	Tier 3	
CLEOCIN T TOPICAL SOLUTION 1 % (clindamycin phosphate)	Tier 3	QL (180 ML per 1 FILL)
clindamycin phosphate (Clindacin Etz Topical Swab 1 %)	Tier 3	
clindamycin phosphate (Clindacin P Topical Swab 1 %)	Tier 3	
clindamycin phosphate (Clindacin Topical Foam 1 %)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLINDAGEL TOPICAL GEL, ONCE DAILY 1 % (clindamycin phosphate)	Tier 3	ST: Requires prior prescription for Clindamycin Phosphate 1% gel within the past 120 days
<i>clindamycin phosphate topical foam 1 %</i>	Tier 1	
<i>clindamycin phosphate topical gel 1 %</i>	Tier 1	
<i>clindamycin phosphate topical gel, once daily 1 %</i>	Tier 1	ST: Requires prior prescription for Clindamycin Phosphate 1% gel within the past 120 days
<i>clindamycin phosphate topical lotion 1 %</i>	Tier 1	
<i>clindamycin phosphate topical solution 1 %</i>	Tier 1	QL (180 ML per 1 FILL)
<i>clindamycin phosphate topical swab 1 %</i>	Tier 1	
<i>dapsone topical gel 5 %</i>	Tier 1	
<i>dapsone topical gel 7.5 %</i>	Tier 3	
<i>dapsone topical gel with pump 7.5 %</i>	Tier 1	
DEOXIA TOPICAL GEL 1-4 % (clindamycin/niacinamide)	Tier 3	
ECEOXIA TOPICAL CREAM 10-4 % (sulfacetamide sodium/niacinamide)	Tier 3	
erythromycin base in ethanol (Ery Pads Topical Swab 2 %)	Tier 1	
ERYGEL TOPICAL GEL 2 % (erythromycin base in ethanol)	Tier 3	
<i>erythromycin with ethanol topical gel 2 %</i>	Tier 1	
<i>erythromycin with ethanol topical solution 2 %</i>	Tier 1	QL (180 ML per 1 FILL)
EVOCLIN TOPICAL FOAM 1 % (clindamycin phosphate)	Tier 3	
FINACEA TOPICAL FOAM 15 % (azelaic acid)	Tier 2	
KLARON TOPICAL SUSPENSION 10 % (sulfacetamide sodium)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OXIAICE TOPICAL LOTION 15-4 % (sulfacetamide sodium/niacinamide)	Tier 3	
RUMILO TOPICAL CREAM 15-4 % (azelaic acid/niacinamide)	Tier 3	
<i>sulfacetamide sodium (acne) topical suspension 10 %</i>	Tier 1	
Acne Therapy Topical - Anti-Infective Combinations Other - Drugs For The Skin		
ADMIRAZOL HP TOPICAL CREAM 8.5-5-2 % (dapson/spironolactone/niacinamide)	Tier 3	
ADMIRAZOL TOPICAL CREAM 6-5-2 % (dapson/spironolactone/niacinamide)	Tier 3	
ALIXI HP TOPICAL CREAM 8.5-4 % (dapson/niacinamide)	Tier 3	
ALIXI TOPICAL CREAM 6-4 % (dapson/niacinamide)	Tier 3	
APORIX TOPICAL LOTION 1-4 % (clindamycin/niacinamide)	Tier 3	
CLINDACIN ETZ TOPICAL KIT 1 % (clindamycin phosphate/skin cleanser comb no.19)	Tier 3	
CLINDACIN PAC TOPICAL KIT 1 % (clindamycin phosphate/skin cleanser comb no.19)	Tier 3	
DEOXIA TOPICAL LOTION 1-4 % (clindamycin/niacinamide)	Tier 3	
DIADIMAXIA TOPICAL CREAM 6-5-2 % (dapson/spironolactone/niacinamide)	Tier 3	
DIADIMAXIA TOPICAL GEL 6-5-2 % (dapson/spironolactone/niacinamide)	Tier 3	
DIAOXIA TOPICAL CREAM 6-4 % (dapson/niacinamide)	Tier 3	
DIAOXIA TOPICAL GEL 6-4 % (dapson/niacinamide)	Tier 3	
DIASDIMAXIA TOPICAL CREAM 8.5-5-2 % (dapson/spironolactone/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIASDIMAXIA TOPICAL GEL 8.5-5-2 % (dapsone/spironolactone/niacinamide)	Tier 3	
DIASOXIA TOPICAL CREAM 8.5-4 % (dapsone/niacinamide)	Tier 3	
DIASOXIA TOPICAL GEL 8.5-4 % (dapsone/niacinamide)	Tier 3	
Acne Therapy Topical - Anti-Infective-Keratolytic Combinations - Drugs For The Skin		
ACANYA TOPICAL GEL WITH PUMP 1.2-2.5 % (clindamycin phosphate/benzoyl peroxide)	Tier 3	ST: Requires prior prescription for generic Clindamycin/Benzoyl Peroxide gel within the past 120 days
APEXOL HP TOPICAL SUSPENSION 5-10 % (salicylic acid/sulfacetamide sodium)	Tier 3	
APEXOL TOPICAL SUSPENSION 2-8 % (salicylic acid/sulfacetamide sodium)	Tier 3	
ARTILIS HP TOPICAL GEL 5-1-4 % (benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ARTILIS TOPICAL GEL 2.5-1-4 % (benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 1	
AVAR LS TOPICAL CLEANSER 10-2 % (sulfacetamide sodium/sulfur)	Tier 3	
AVAR TOPICAL CLEANSER 10-5 % (W/W) (sulfacetamide sodium/sulfur)	Tier 3	QL (1419 GM per 1 FILL)
BENZAMYCIN TOPICAL GEL 3-5 % (erythromycin base/benzoyl peroxide)	Tier 3	
BP 10-1 TOPICAL CLEANSER 10-1 % (sulfacetamide sodium/sulfur)	Tier 3	
CLEANSING WASH TOPICAL CLEANSER 10-4-10 % (sulfacetamide sodium/sulfur/urea)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clindamycin-benzoyl peroxide topical gel 1-5 %, 1.2 %(1 % base) -5 %</i>	Tier 1	
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %</i>	Tier 1	ST: Requires prior prescription for generic Clindamycin/Benzoyl Peroxide gel within the past 120 days
<i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %, 1.2 %(1 % base) -3.75 %</i>	Tier 1	
DRAXACE TOPICAL SUSPENSION 2-8 % (salicylic acid/sulfacetamide sodium)	Tier 3	
DRAXACEY TOPICAL SUSPENSION 2-8 % (salicylic acid/sulfacetamide sodium)	Tier 3	
DRIXECE TOPICAL SUSPENSION 5-10 % (salicylic acid/sulfacetamide sodium)	Tier 3	
<i>erythromycin-benzoyl peroxide topical gel 3-5 %</i>	Tier 1	
INZDEOXIA TOPICAL GEL 2.5-1-4 % (benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
NEUAC KIT TOPICAL COMBO PACK, CREAM AND GEL 1.2-5 % (clindamycin phosphate/benzoyl peroxide/emollient comb no.94)	Tier 3	
clindamycin phosphate/benzoyl peroxide (Neuac Topical Gel 1.2 %(1 % Base) -5 %)	Tier 1	
ONEXTON TOPICAL GEL WITH PUMP 1.2 %(1 % BASE) - 3.75 % (clindamycin phosphate/benzoyl peroxide)	Tier 3	
ONZDEOXIA TOPICAL GEL 5-1-4 % (benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
PLEXION CLEANSING CLOTHS TOPICAL PADS, MEDICATED 9.8-4.8 % (sulfacetamide sodium/sulfur)	Tier 3	
PLEXION TOPICAL CLEANSER 9.8-4.8 % (sulfacetamide sodium/sulfur)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROSULA CLEANSING CLOTHS TOPICAL PADS, MEDICATED 10-5 % (sulfacetamide sodium/sulfur)	Tier 3	
ROSULA TOPICAL CLEANSER 10-4.5 % (sulfacetamide sodium/sulfur)	Tier 3	
SSS 10-5 TOPICAL CREAM 10-5 % (W/W) (sulfacetamide sodium/sulfur)	Tier 3	
SSS 10-5 TOPICAL FOAM 10-5 % (sulfacetamide sodium/sulfur)	Tier 3	
<i>sulfacetamide sodium-sulfur topical cleanser 10-2 %, 9-4 %, 9-4.5 %, 9.8-4.8 %</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i>	Tier 1	QL (1419 GM per 1 FILL)
<i>sulfacetamide sodium-sulfur topical cleanser 8-4 %</i>	Tier 1	
<i>sulfacetamide sodium-sulfur topical cream 10-2 %, 10-5 % (w/w), 9.8-4.8 %</i>	Tier 3	
<i>sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 10-5 % (w/w), 9.8-4.8 %</i>	Tier 3	
<i>sulfacetamide sodium-sulfur topical pads, medicated 10-4 %</i>	Tier 3	
<i>sulfacetamide sodium-sulfur topical suspension 10-5 %, 8-4 %, 9-4.25 %</i>	Tier 3	
<i>sulfacetamide sod-sulfur-urea topical cleanser 10-5-10 %</i>	Tier 1	QL (1419 ML per 1 FILL)
SULFACLEANSE 8-4 TOPICAL SUSPENSION 8-4 % (sulfacetamide sodium/sulfur)	Tier 3	
SUMADAN TOPICAL CLEANSER 9-4.5 % (sulfacetamide sodium/sulfur)	Tier 3	
SUMADAN TOPICAL KIT 9-4.5 % (sulfacetamide sodium/sulfur/skin cleanser comb no.23)	Tier 3	
SUMADAN XLT TOPICAL COMBO PACK,CLEANSER AND CREAM 9 %-4.5 % -SPF 25 (sulfacetamide sodium/sulfur/avobenzone/octinoxate/octyl sal)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUMAXIN CP TOPICAL KIT 10-4 % (sulfacetamide sodium/sulfur/skin cleanser comb no.23)	Tier 3	
SUMAXIN TOPICAL CLEANSER 9-4 % (sulfacetamide sodium/sulfur)	Tier 3	
ZMA CLEAR TOPICAL SUSPENSION 9-4.5 % (sulfacetamide sodium/sulfur)	Tier 3	
Acne Therapy Topical - Anti-Infective-Retinoid Combinations - Drugs For The Skin		
ADEINZDE TOPICAL GEL 0.1-2.5-1 % (adapalene/benzoyl peroxide/clindamycin phosphate)	Tier 3	
ADERMICA HP TOPICAL GEL 0.05-2.5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ADERMICA TOPICAL GEL 0.025-2.5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ALOMIRA HP TOPICAL GEL 0.1-5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ALOMIRA LP TOPICAL GEL 0.025-5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ALOMIRA TOPICAL GEL 0.05-5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ALUXOF HP TOPICAL GEL 0.1-10-2-4-4 % (tretinoin/benzoyl peroxide/clindamycin/spironolactone/niacin)	Tier 3	
ALUXOF TOPICAL GEL 0.05-10-2-4-4 % (tretinoin/benzoyl peroxide/clindamycin/spironolactone/niacin)	Tier 3	
AUGUSTIL TOPICAL GEL 0.025-1-2-4 % (tretinoin/clindamycin phosphate/spironolactone/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVIDORA HP TOPICAL CREAM 0.05-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
AVIDORA TOPICAL CREAM 0.025-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
AVIDORA TOPICAL SOLUTION 0.025-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
AWANIS TOPICAL CREAM 0.025-8.5-2 % (tretinoin/dapsone/niacinamide)	Tier 3	
CABTREO TOPICAL GEL 0.15-3.1-1.2 % (adapalene/benzoyl peroxide/clindamycin phosphate)	Tier 3	PA
<i>clindamycin-tretinoin topical gel 1.2-0.025 %</i>	Tier 3	ST: Requires prior prescription for Clindamycin gel or Tretinoin 0.025% gel within the past 120 days
DEOXIADEMTAR TOPICAL GEL 0.025-1-2-4 % (tretinoin/clindamycin phosphate/spironolactone/niacinamide)	Tier 3	
DEOXIATAR TOPICAL SOLUTION 0.025-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
DEOXIAVAR TOPICAL CREAM 0.05-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
DIASAXIATAR TOPICAL CREAM 0.025-8.5-2 % (tretinoin/dapsone/niacinamide)	Tier 3	
DIASAXIATAR TOPICAL GEL 0.025-8.5-2 % (tretinoin/dapsone/niacinamide)	Tier 3	
INZDEAXIATAR TOPICAL GEL 0.025-2.5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
INZDEAXIAVAR TOPICAL GEL 0.05-2.5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOUNZDOMDIOXIATAR TOPICAL GEL 0.05-10-2-4-4 % (tretinoin/benzoyl peroxide/clindamycin/spironolactone/niacin)	Tier 3	
ONZDEAXIADEMTAR TOPICAL GEL 0.025-5-1-2-2 % (tretinoin/benzoyl peroxide/clindamycin/spironolactone/niacin)	Tier 3	
ONZDEAXIADEMVAR TOPICAL GEL 0.05-5-1-2-2 % (tretinoin/benzoyl peroxide/clindamycin/spironolactone/niacin)	Tier 3	
ONZDEAXIATAR TOPICAL GEL 0.025-5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ONZDEAXIAVAR TOPICAL GEL 0.05-5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
ONZDEAXIAZAR TOPICAL GEL 0.1-5-1-2 % (tretinoin/benzoyl peroxide/clindamycin phosphate/niacinamide)	Tier 3	
TARDEOXIA TOPICAL CREAM 0.025-1-4 % (tretinoin/clindamycin phosphate/niacinamide)	Tier 3	
UNZDOMDIOXIAZAR TOPICAL GEL 0.1-10-2-4-4 % (tretinoin/benzoyl peroxide/clindamycin/spironolactone/niacin)	Tier 3	
Acne Therapy Topical - Keratolytic - Drugs For The Skin		
BENZEPRO (MICROSPHERES) TOPICAL CLEANSER 7 % (benzoyl peroxide microspheres)	Tier 3	
BENZEPRO TOPICAL TOWELETTE 6 % (benzoyl peroxide)	Tier 3	
<i>benzoyl peroxide topical cleanser 7 %</i>	Tier 3	
<i>benzoyl peroxide topical foam 9.8 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BPO TOPICAL GEL 8 % (benzoyl peroxide)	Tier 1	
PACNEX HP TOPICAL PADS, MEDICATED 7 % (benzoyl peroxide)	Tier 3	
PACNEX LP TOPICAL PADS, MEDICATED 4.25 % (benzoyl peroxide)	Tier 3	
PR BENZOYL PEROXIDE TOPICAL CLEANSER 7 % (benzoyl peroxide microspheres)	Tier 1	
Acne Therapy Topical - Keratolytic-Glucocorticoid Combinations - Drugs For The Skin		
VANOXIDE-HC TOPICAL SUSPENSION 5-0.5 % (benzoyl peroxide/hydrocortisone)	Tier 2	
Acne Therapy Topical - Retinoid Combinations Other - Drugs For The Skin		
ADAINZOXIA TOPICAL GEL 0.3-2.5-4 % (adapalene/benzoyl peroxide/niacinamide)	Tier 3	
<i>adapalene-benzoyl peroxide topical gel with pump 0.1-2.5 %, 0.3-2.5 %</i>	Tier 1	
ALURIS HP PLUS TOPICAL CREAM 0.1-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
ALURIS HP TOPICAL CREAM 0.1-4 % (tretinoin/niacinamide)	Tier 3	
ALURIS LP PLUS TOPICAL CREAM 0.025-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
ALURIS LP TOPICAL CREAM 0.025-4 % (tretinoin/niacinamide)	Tier 3	
ALURIS PLUS TOPICAL CREAM 0.05-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
ALURIS TOPICAL CREAM 0.05-4 % (tretinoin/niacinamide)	Tier 3	
ALURIS TOPICAL GEL 0.05-4 % (tretinoin/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
APHORIA TOPICAL GEL 0.3-2.5-4 % (adapalene/benzoyl peroxide/niacinamide)	Tier 3	
AZALTA HP TOPICAL GEL 0.05-5-2 % (tretinoin/spironolactone/niacinamide)	Tier 3	
AZALTA TOPICAL GEL 0.025-5-2 % (tretinoin/spironolactone/niacinamide)	Tier 3	
EPIDUO FORTE TOPICAL GEL WITH PUMP 0.3-2.5 % (adapalene/benzoyl peroxide)	Tier 3	
EPIDUO TOPICAL GEL WITH PUMP 0.1-2.5 % (adapalene/benzoyl peroxide)	Tier 3	
IDYYXIATAR TOPICAL GEL 0.025-5 % (tretinoin/niacinamide)	Tier 3	
OXIATAR TOPICAL CREAM 0.025-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
OXIAVARRY TOPICAL CREAM 0.05-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
OXIAVARY TOPICAL CREAM 0.1-4 % (tretinoin/niacinamide)	Tier 3	
OXIAZAR TOPICAL CREAM 0.1-0.5-4 % (tretinoin/hyaluronate sodium/niacinamide)	Tier 3	
SAROXIA TOPICAL CREAM 0.05-4 % (tretinoin/niacinamide)	Tier 3	
SIRVANA TOPICAL GEL 0.025-5 % (tretinoin/niacinamide)	Tier 3	
SORIXIA TOPICAL CREAM 0.05-4 % (tretinoin/niacinamide)	Tier 3	
TARDIMAXIA TOPICAL GEL 0.025-5-2 % (tretinoin/spironolactone/niacinamide)	Tier 3	
TAROXIA TOPICAL CREAM 0.025-4 % (tretinoin/niacinamide)	Tier 3	
TAROXIA TOPICAL GEL 0.025-4 % (tretinoin/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TWYNEO TOPICAL CREAM 0.1-3 % (tretinoin/benzoyl peroxide)	Tier 3	
VARDIMAXIA TOPICAL GEL 0.05-5-2 % (tretinoin/spironolactone/niacinamide)	Tier 3	
VAROXIA TOPICAL CREAM 0.05-4 % (tretinoin/niacinamide)	Tier 3	
VAROXIA TOPICAL GEL 0.05-4 % (tretinoin/niacinamide)	Tier 3	
Acne Therapy Topical - Retinoids And Derivatives - Drugs For The Skin		
<i>adapalene topical cream 0.1 %</i>	Tier 1	
<i>adapalene topical gel 0.3 %</i>	Tier 1	
<i>adapalene topical gel with pump 0.3 %</i>	Tier 1	
<i>adapalene topical lotion 0.1 %</i>	Tier 1	Age (Max 39 Years)
<i>adapalene topical solution 0.1 %</i>	Tier 3	ST: Requires prior prescription for Adapalene 0.1% gel within the past 120 days
<i>adapalene topical swab 0.1 %</i>	Tier 3	ST: Requires prior prescription for Adapalene 0.1% gel within the past 120 days; QL (1 EA per 1 day)
AKLIEF TOPICAL CREAM 0.005 % (trifarotene)	Tier 3	ST: Requires prior prescription for one of the following generic topicals: Tazarotene, Tretinoin, or Adapalene (gel, cream, lotion, or solution) within the past 120 days; Age (Max 39 Years)
ALTRENO TOPICAL LOTION 0.05 % (tretinoin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALVOX HP TOPICAL CREAM 0.1-4 % (tazarotene/niacinamide)	Tier 3	
ALVOX TOPICAL CREAM 0.05-4 % (tazarotene/niacinamide)	Tier 3	
ARAZLO TOPICAL LOTION 0.045 % (tazarotene)	Tier 3	ST: Requires prior prescription for one of the following generic topicals: Tazarotene, Tretinoin, or Adapalene (gel, cream, lotion, or solution) within the past 120 days
ATRALIN TOPICAL GEL 0.05 % (tretinoin)	Tier 3	
AVITA TOPICAL CREAM 0.025 % (tretinoin)	Tier 1	
AVITA TOPICAL GEL 0.025 % (tretinoin)	Tier 1	
DIFFERIN TOPICAL CREAM 0.1 % (adapalene)	Tier 3	
DIFFERIN TOPICAL GEL WITH PUMP 0.3 % (adapalene)	Tier 3	
DIFFERIN TOPICAL LOTION 0.1 % (adapalene)	Tier 3	Age (Max 39 Years)
ETHOXIA TOPICAL CREAM 0.05-4 % (tazarotene/niacinamide)	Tier 3	
ITHOXIA TOPICAL CREAM 0.1-4 % (tazarotene/niacinamide)	Tier 3	
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.04 %, 0.1 % (tretinoin microspheres)	Tier 3	Age (Max 39 Years)
RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 % (tretinoin microspheres)	Tier 3	ST: Requires prior prescriptions for generic Tretinoin Microspheres 0.04% and 0.10% within the past 365 days; Age (Max 39 Years)
RETIN-A MICRO TOPICAL GEL 0.04 %, 0.1 % (tretinoin microspheres)	Tier 3	Age (Max 39 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RETIN-A TOPICAL CREAM 0.025 %, 0.05 %, 0.1 % (tretinoin)	Tier 3	
RETIN-A TOPICAL GEL 0.01 %, 0.025 % (tretinoin)	Tier 3	
<i>tazarotene topical foam 0.1 %</i>	Tier 3	ST: Requires prior prescription for one of the following generic topicals: Tazarotene, Tretinoin, or Adapalene (gel, cream, lotion, or solution) within the past 120 days
<i>tretinoin microspheres topical gel 0.04 %, 0.1 %</i>	Tier 1	Age (Max 39 Years)
<i>tretinoin microspheres topical gel with pump 0.04 %, 0.1 %</i>	Tier 1	Age (Max 39 Years)
<i>tretinoin microspheres topical gel with pump 0.08 %</i>	Tier 1	ST: Requires prior prescriptions for generic Tretinoin Microspheres 0.04% and 0.10% within the past 365 days; Age (Max 39 Years)
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	Tier 1	
<i>tretinoin topical gel 0.01 %, 0.025 %, 0.05 %</i>	Tier 1	
Acne Therapy Topical Combinations Other - Drugs For The Skin		
ADALINA TOPICAL GEL 5-4 % (spironolactone/niacinamide)	Tier 3	
DIMOXIA TOPICAL GEL 5-4 % (spironolactone/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antipsoriatic - Retinoid (Vitamin A Derivative) - Glucocorticoid - Drugs For The Skin		
DUOBRII TOPICAL LOTION 0.01-0.045 % (halobetasol propionate/tazarotene)	Tier 3	ST: Requires prior prescription for Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol (except foam/shampoo), Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) within the past 120 days; QL (200 GM per 28 days)
Antipsoriatic - Vitamin D Analog - Glucocorticoid Combinations - Drugs For The Skin		
<i>calcipotriene-betamethasone topical ointment 0.005-0.064 %</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>calcipotriene-betamethasone topical suspension 0.005-0.064 %</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
ENSTILAR TOPICAL FOAM 0.005-0.064 % (calcipotriene/betamethasone dipropionate)	Tier 2	
TACLONEX TOPICAL SUSPENSION 0.005-0.064 % (calcipotriene/betamethasone dipropionate)	Tier 3	ST: Requires prior prescription for a topical corticosteroid within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WYNZORA TOPICAL CREAM 0.005-0.064 % (calcipotriene/betamethasone dipropionate)	Tier 3	ST: Requires prior prescription for generic Taclonex ointment within the past 120 days
Antipsoriatic Agents - Interleukin 12 And Il-23 Inhibitors, Mc Antibody - Drugs For The Skin		
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML (ustekinumab)	Tier 3	PA; KP
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML (ustekinumab)	Tier 3	PA; KP
STEQEYMA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML (ustekinumab-stba)	Tier 3	PA; KP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5 ML (ustekinumab-kfce)	Tier 3	PA; KP
YESINTEK SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML (ustekinumab-kfce)	Tier 3	PA; KP
Antipsoriatic Agents - Interleukin-23 (Il-23) Antagonist, Mc Antibody - Drugs For The Skin		
SKYRIZI SUBCUTANEOUS PEN INJECTOR 150 MG/ML (risankizumab-rzaa)	Tier 3	PA; KP
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML (risankizumab-rzaa)	Tier 3	PA; KP
TREMFYA ONE-PRESS SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML (guselkumab)	Tier 3	PA; KP
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML (guselkumab)	Tier 3	PA; KP
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML (guselkumab)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antipsoriatic Agents - Interleukin-36 (Il-36) Receptor Antagonist, Mc - Drugs For The Skin		
SPEVIGO SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML (spesolimab-sbzo)	Tier 3	KP
Antipsoriatic Agents - Tyrosine Kinase 2 (Tyk2) Inhibitor - Drugs For The Skin		
SOTYKTU ORAL TABLET 6 MG (deucravacitinib)	Tier 3	PA
Antipsoriatic Agents-Interleukin-17 (Il-17) Antagonist, Mc Antibody - Drugs For The Skin		
BIMZELX AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 160 MG/ML, 320 MG/2 ML (bimekizumab-bkzx)	Tier 3	PA; KP
BIMZELX SUBCUTANEOUS SYRINGE 160 MG/ML, 320 MG/2 ML (bimekizumab-bkzx)	Tier 3	PA; KP
COSENTYX (2 SYRINGES) SUBCUTANEOUS SYRINGE 150 MG/ML (secukinumab)	Tier 2	PA; KP
COSENTYX PEN (2 PENS) SUBCUTANEOUS PEN INJECTOR 150 MG/ML (secukinumab)	Tier 2	PA; KP
COSENTYX PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML (secukinumab)	Tier 2	PA; KP
COSENTYX SUBCUTANEOUS SYRINGE 150 MG/ML (secukinumab)	Tier 2	PA; KP
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML (secukinumab)	Tier 3	PA; KP
COSENTYX UNOREADY PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML (secukinumab)	Tier 3	PA; KP
SILIQ SUBCUTANEOUS SYRINGE 210 MG/1.5 ML (brodalumab)	Tier 3	PA; KP
TALTZ AUTOINJECTOR (2 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML (ixekizumab)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TALTZ AUTOINJECTOR (3 PACK) SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML (ixekizumab)	Tier 3	PA; KP
TALTZ AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 80 MG/ML (ixekizumab)	Tier 3	PA; KP
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML, 40 MG/0.5 ML, 80 MG/ML (ixekizumab)	Tier 3	PA; KP
Dermatitis - Janus Kinase (Jak) Inhibitors - Drugs For The Skin		
ANZUPGO TOPICAL CREAM 2 % (delgocitinib)	Tier 3	PA; QL (60 GM per 30 days)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (abrocitinib)	Tier 3	PA
OPZELURA TOPICAL CREAM 1.5 % (ruxolitinib phosphate)	Tier 2	PA; QL (60 GM per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG (upadacitinib)	Tier 3	PA
Dermatitis Agents, Systemic - Interleukin-13 Inhibitors Mab - Drugs For The Skin		
ADBRY SUBCUTANEOUS AUTO-INJECTOR 300 MG/2 ML (tralokinumab-ldrm)	Tier 3	PA; KP
ADBRY SUBCUTANEOUS SYRINGE 150 MG/ML (tralokinumab-ldrm)	Tier 3	PA; KP
EBGLYSS PEN SUBCUTANEOUS PEN INJECTOR 250 MG/2 ML (lebrikizumab-lbkz)	Tier 3	PA; KP
EBGLYSS SYRINGE SUBCUTANEOUS SYRINGE 250 MG/2 ML (lebrikizumab-lbkz)	Tier 3	PA; KP
Dermatitis Agents, Systemic-IL-4 Receptor Alpha Antagonist (IL-4Ra) Mab - Drugs For The Skin		
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML (dupilumab)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML (dupilumab)	Tier 3	PA; KP
Dermatitis Or Eczema Agents, Topical - Phosphodiesterase-4 Inhibitors - Drugs For The Skin		
EUCRISA TOPICAL OINTMENT 2 % (crisaborole)	Tier 2	PA; QL (100 GM per 30 days)
ZORYVE TOPICAL CREAM 0.15 % (roflumilast)	Tier 2	PA; QL (60 GM per 30 days)
Dermatological - Antibacterial Aminoglycosides - Drugs For The Skin		
<i>gentamicin topical cream 0.1 %</i>	Tier 1	QL (90 GM per 1 FILL)
<i>gentamicin topical ointment 0.1 %</i>	Tier 1	QL (90 GM per 1 FILL)
Dermatological - Antibacterial And Antifungal Agents - Drugs For The Skin		
QUINJA TOPICAL GEL 1.25-1 % (iodoquinol/aloe polysaccharides no.1)	Tier 3	
Dermatological - Antibacterial Other - Drugs For The Skin		
BASADROX TOPICAL GEL IN PACKET (silver)	Tier 3	
BATIZIA TOPICAL OINTMENT 2-2 % (mupirocin/lidocaine)	Tier 3	
CENTANY AT TOPICAL OINTMENT KIT 2 % (mupirocin)	Tier 3	
CENTANY TOPICAL OINTMENT 2 % (mupirocin)	Tier 3	QL (90 GM per 1 FILL)
<i>mupirocin calcium topical cream 2 %</i>	Tier 1	QL (90 GM per 1 FILL)
<i>mupirocin topical ointment 2 %</i>	Tier 1	QL (90 GM per 1 FILL)
NANRAN TOPICAL OINTMENT 2-2 % (mupirocin/lidocaine)	Tier 3	
NORMLGEL AG TOPICAL GEL 0.11 % (silver carbonate)	Tier 3	
<i>silver nitrate topical solution 0.5 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>silver nitrate topical solution 10 %, 25 %, 50 %</i>	Tier 1	
SILVRSTAT TOPICAL GEL 32 PPM (silver)	Tier 3	
SOLOX GEL TOPICAL GEL 55 PPM (silver nitrate)	Tier 3	
Dermatological - Antibacterial Pleuromutilin Derivatives - Drugs For The Skin		
ALTABAX TOPICAL OINTMENT 1 % (retapamulin)	Tier 3	ST: Requires prior prescription for Mupirocin ointment within the past 120 days
Dermatological - Antibacterial Quinolones - Drugs For The Skin		
XEPI TOPICAL CREAM 1 % (ozenoxacin)	Tier 3	ST: Requires prior prescription for Mupirocin ointment within the past 120 days
Dermatological - Antibacterial, Antifungal Agent With Glucocorticoid - Drugs For The Skin		
ALCORTIN A TOPICAL GEL IN PACKET 2-1-1 % (hydrocortisone acetate/iodoquinol/aloe polysaccharides no.2)	Tier 3	
DAZINIA TOPICAL CREAM 2-1-2.5 % (ketoconazole/iodoquinol/hydrocortisone)	Tier 3	
<i>hydrocortisone-iodoquinol-aloe2 topical gel 2-1-1 %</i>	Tier 3	
<i>hydrocortisone-iodoquinol-aloe topical cream in packet 1.9-1 %</i>	Tier 1	
PHEODOYO TOPICAL CREAM 2-1-2.5 % (ketoconazole/iodoquinol/hydrocortisone)	Tier 3	
VYTONE TOPICAL CREAM IN PACKET 1.9-1 % (hydrocortisone acetate/iodoquinol/aloe vera)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antibacterial-Glucocorticoid Combinations - Drugs For The Skin		
NEO-SYNALAR KIT TOPICAL CREAM 0.5 % (0.35 % BASE)-0.025 % (neomycin sulfate/fluocinolone acetone/emollient comb no.65)	Tier 3	ST: Requires prior prescription for generic Fluocinolone Acetonide (cream, oil, ointment or solution) within the past 120 days
NEO-SYNALAR TOPICAL CREAM 0.5 % (0.35 % BASE)-0.025 % (neomycin sulfate/fluocinolone acetone)	Tier 3	ST: Requires prior prescription for generic Fluocinolone Acetonide (cream, oil, ointment or solution) within the past 120 days
Dermatological - Anticholinergic Hyperhidrosis Treatment Agents - Drugs For The Skin		
QBREXZA TOPICAL TOWELETTE 2.4 % (glycopyrronium tosylate)	Tier 2	PA
SOFDRA TOPICAL GEL WITH PUMP 12.45 % (72 MG /ACTUATION) (sofipironium bromide)	Tier 3	PA
Dermatological - Antifungal Allylamines - Drugs For The Skin		
<i>naftifine topical cream 1 %</i>	Tier 1	
<i>naftifine topical cream 2 %</i>	Tier 1	QL (180 GM per 1 FILL)
<i>naftifine topical gel 2 %</i>	Tier 1	
NAFTIN TOPICAL GEL 2 % (naftifine HCl)	Tier 3	
Dermatological - Antifungal Amphoteric Polyene Macrolides - Drugs For The Skin		
nystatin (Klayesta Topical Powder 100,000 Unit/Gram)	Tier 1	
nystatin (Nyamyc Topical Powder 100,000 Unit/Gram)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nystatin topical cream 100,000 unit/gram</i>	Tier 1	
<i>nystatin topical ointment 100,000 unit/gram</i>	Tier 1	QL (90 GM per 1 FILL)
<i>nystatin topical powder 100,000 unit/gram</i>	Tier 1	
nystatin (Nystop Topical Powder 100,000 Unit/Gram)	Tier 1	
Dermatological - Antifungal Combinations Other - Drugs For The Skin		
DENVITA TOPICAL CREAM 2-4 % (ketoconazole/niacinamide)	Tier 3	
DIFMETIOXRIME TOPICAL SOLUTION 4-2-1-4 % (fluconazole/ibuprofen/itraconazole/terbinafine HCl)	Tier 3	
EXODERM TOPICAL LOTION 25-1 % (sodium thiosulfate/salicylic acid)	Tier 1	
FENOVIA TOPICAL SOLUTION 4-2-1-4 % (fluconazole/ibuprofen/itraconazole/terbinafine HCl)	Tier 3	
FERVINA TOPICAL LOTION 3-5-20 % (ciclopirox olamine/itraconazole/urea)	Tier 3	
FIDILA TOPICAL SHAMPOO 2-2 % (ketoconazole/salicylic acid)	Tier 3	
FRIVO TOPICAL CREAM 1-4 % (econazole nitrate/niacinamide)	Tier 3	
HEXIOUNYL TOPICAL LOTION 3-5-20 % (ciclopirox olamine/itraconazole/urea)	Tier 3	
IMIOXIA TOPICAL CREAM 1-4 % (econazole nitrate/niacinamide)	Tier 3	
PHEDRAX TOPICAL SHAMPOO 2-2 % (ketoconazole/salicylic acid)	Tier 3	
PHEOXIA TOPICAL CREAM 2-4 % (ketoconazole/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antifungal Hydroxypyridinone - Drugs For The Skin		
CICLODAN KIT TOPICAL COMBO PACK 0.77 % (ciclopirox olamine/skin cleanser combination no.28)	Tier 3	
CICLODAN KIT TOPICAL SOLUTION 8 % (ciclopirox/urea/camphor/menthol/eucalyptol)	Tier 3	QL (19.8 ML per 1 FILL)
ciclopirox olamine (Ciclodan Topical Cream 0.77 %)	Tier 3	QL (180 GM per 1 FILL)
ciclopirox (Ciclodan Topical Solution 8 %)	Tier 3	QL (19.8 ML per 1 FILL)
<i>ciclopirox topical cream 0.77 %</i>	Tier 1	QL (180 GM per 1 FILL)
<i>ciclopirox topical gel 0.77 %</i>	Tier 1	
<i>ciclopirox topical shampoo 1 %</i>	Tier 1	
<i>ciclopirox topical solution 8 %</i>	Tier 1	QL (19.8 ML per 1 FILL)
<i>ciclopirox topical suspension 0.77 %</i>	Tier 1	QL (180 ML per 1 FILL)
<i>ciclopirox-ure-camph-menth-euc topical solution 8 %</i>	Tier 1	QL (19.8 ML per 1 FILL)
DAFILOR TOPICAL SHAMPOO 0.77-2 % (ciclopirox olamine/salicylic acid)	Tier 3	
FILOMA TOPICAL SOLUTION 8-1-1 % (ciclopirox olamine/fluconazole/terbinafine HCl)	Tier 3	
HAXDRAX TOPICAL SHAMPOO 0.77-2 % (ciclopirox olamine/salicylic acid)	Tier 3	
HIXDEFRIMA TOPICAL SOLUTION 8-1-1 % (ciclopirox olamine/fluconazole/terbinafine HCl)	Tier 3	
LOPROX (AS OLAMINE) TOPICAL CREAM 0.77 % (ciclopirox olamine)	Tier 3	QL (180 GM per 1 FILL)
LOPROX (AS OLAMINE) TOPICAL SUSPENSION 0.77 % (ciclopirox olamine)	Tier 3	QL (180 ML per 1 FILL)
LOPROX KIT TOPICAL COMBO PACK 0.77 % (ciclopirox olamine/skin cleanser combination no.40)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOPROX KIT TOPICAL KIT, SUSPENSION AND CLEANSER 0.77 % (ciclopirox olamine/skin cleanser combination no.40)	Tier 3	
Dermatological - Antifungal Imidazole And Related Agents - Drugs For The Skin		
<i>clotrimazole topical cream 1 %</i>	Tier 1	
<i>clotrimazole topical solution 1 %</i>	Tier 1	
<i>econazole nitrate topical cream 1 %</i>	Tier 1	QL (170 GM per 1 FILL)
ECOZA TOPICAL FOAM 1 % (econazole nitrate)	Tier 3	
ERTACZO TOPICAL CREAM 2 % (sertaconazole nitrate)	Tier 3	
EXELDERM TOPICAL CREAM 1 % (sulconazole nitrate)	Tier 2	
EXELDERM TOPICAL SOLUTION 1 % (sulconazole nitrate)	Tier 2	
<i>ketoconazole topical cream 2 %</i>	Tier 1	QL (180 GM per 1 FILL)
<i>ketoconazole topical foam 2 %</i>	Tier 3	ST: Requires prior prescription for Ketoconazole 2% cream/shampoo within the past 120 days
<i>ketoconazole topical shampoo 2 %</i>	Tier 1	QL (360 ML per 1 FILL)
KETODAN KIT TOPICAL COMBO PACK 2 % (ketoconazole/skin cleanser combination no.28)	Tier 3	
ketoconazole (Ketodan Topical Foam 2 %)	Tier 3	ST: Requires prior prescription for Ketoconazole 2% cream/shampoo within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>luliconazole topical cream 1 %</i>	Tier 1	ST: Requires prior prescriptions for Ketoconazole and Clotrimazole cream within the past 365 days; QL (60 GM per 28 days)
LUZU TOPICAL CREAM 1 % (luliconazole)	Tier 3	ST: Requires prior prescriptions for Ketoconazole and Clotrimazole cream within the past 365 days; QL (60 GM per 28 days)
<i>miconazole nitrate-zinc ox-pet topical ointment 0.25-15-81.35 %</i>	Tier 1	
<i>oxiconazole topical cream 1 %</i>	Tier 1	QL (180 GM per 1 FILL)
OXISTAT TOPICAL LOTION 1 % (oxiconazole nitrate)	Tier 3	
<i>sulconazole topical cream 1 %</i>	Tier 1	
<i>sulconazole topical solution 1 %</i>	Tier 1	
VUSION TOPICAL OINTMENT 0.25-15-81.35 % (miconazole nitrate/zinc oxide/petrolatum,white)	Tier 3	
XOLEGEL TOPICAL GEL 2 % (ketoconazole)	Tier 3	ST: Requires prior prescription for Ketoconazole 2% cream/shampoo within the past 120 days
Dermatological - Antifungal Oxaborole - Drugs For The Skin		
<i>tavaborole topical solution with applicator 5 %</i>	Tier 1	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antifungal Triazole - Drugs For The Skin		
JUBLIA TOPICAL SOLUTION WITH APPLICATOR 10 % (efinaconazole)	Tier 3	PA
Dermatological - Antifungal-Glucocorticoid Combinations - Drugs For The Skin		
CLOBEZIN TOPICAL COMBO PACK 1-0.05-0.44 % (clotrimazole/betamethasone/menthol/zinc oxide/petrolatum,wht)	Tier 3	
<i>clotrimazole-betamethasone topical cream 1-0.05 %</i>	Tier 1	
<i>clotrimazole-betamethasone topical lotion 1-0.05 %</i>	Tier 1	
DELIBON TOPICAL CREAM 2-2.5 % (ketoconazole/hydrocortisone)	Tier 3	
DERMACINRX THERAZOLE PAK TOPICAL COMBO PACK 1-0.05-20 % (clotrimazole/betamethasone dipropionate/zinc oxide)	Tier 3	
DERMAZENE TOPICAL CREAM IN PACKET 1-1 % (hydrocortisone/iodoquinol)	Tier 3	
DIONARIS TOPICAL SHAMPOO 0.77-0.05-3 % (ciclopirox olamine/clobetasol propionate/salicylic acid)	Tier 3	
DIVENDO TOPICAL SHAMPOO 0.77-0.05 % (ciclopirox olamine/clobetasol propionate)	Tier 3	
HAXCHLO TOPICAL SHAMPOO 0.77-0.05 % (ciclopirox olamine/clobetasol propionate)	Tier 3	
HAXCHLODREX TOPICAL SHAMPOO 0.77-0.05-3 % (ciclopirox olamine/clobetasol propionate/salicylic acid)	Tier 3	
<i>hydrocortisone-iodoquinol topical cream 1-1 %</i>	Tier 1	
<i>nystatin-triamcinolone topical cream 100,000-0.1 unit/g-%</i>	Tier 1	
<i>nystatin-triamcinolone topical ointment 100,000-0.1 unit/gram-%</i>	Tier 1	QL (180 GM per 1 FILL)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHEYO TOPICAL CREAM 2-2.5 % (ketoconazole/hydrocortisone)	Tier 3	
Dermatological - Antifungals Other - Drugs For The Skin		
<i>triacetin liquid 100 %</i>	Tier 3	
Dermatological - Antineoplastic Alkylating Agents - Drugs For The Skin		
VALCHLOR TOPICAL GEL 0.016 % (mechlorethamine HCl)	Tier 3	PA
Dermatological - Antineoplastic Antimetabolites - Drugs For The Skin		
CARAC TOPICAL CREAM 0.5 % (fluorouracil)	Tier 3	PA
EFUDEX TOPICAL CREAM 5 % (fluorouracil)	Tier 3	
<i>fluorouracil topical cream 0.5 %</i>	Tier 1	PA
<i>fluorouracil topical cream 5 %</i>	Tier 1	
<i>fluorouracil topical solution 2 %, 5 %</i>	Tier 1	
TOLAK TOPICAL CREAM 4 % (fluorouracil)	Tier 2	
Dermatological - Antineoplastic Or Premalign. Lesions - Antimicrotubule - Drugs For The Skin		
KLISYRI (250 MG) TOPICAL OINTMENT IN PACKET 1 % (tirbanibulin)	Tier 3	QL (5 EA per 1 FILL)
KLISYRI (350 MG) TOPICAL OINTMENT IN PACKET 1 % (tirbanibulin)	Tier 3	QL (5 EA per 1 FILL)
Dermatological - Antineoplastic Or Premalignant Lesions - Nsaid's - Drugs For The Skin		
<i>diclofenac sodium topical gel 3 %</i>	Tier 1	QL (100 GM per 1 FILL)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antineoplastic Retinoids - Drugs For The Skin		
PANRETIN TOPICAL GEL 0.1 % (alitretinoin)	Tier 3	QL (60 GM per 28 days)
Dermatological - Antineoplastic Selective Retinoid X Receptor Agonist - Drugs For The Skin		
<i>bexarotene topical gel 1 %</i>	Tier 3	PA
TARGRETIN TOPICAL GEL 1 % (bexarotene)	Tier 2	PA
Dermatological - Antiperspirants - Drugs For The Skin		
DRYSOL DAB-O-MATIC TOPICAL SOLUTION 20 % (aluminum chloride)	Tier 2	
DRYSOL TOPICAL SOLUTION 20 % (aluminum chloride)	Tier 2	
Dermatological - Antipsoriatic Agents Systemic, Photosensitizing - Drugs For The Skin		
<i>methoxsalen oral capsule, liqd-filled, rapid rel 10 mg</i>	Tier 1	
Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives - Drugs For The Skin		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antipsoriatic Agents Topical - Drugs For The Skin		
BRYHALI TOPICAL LOTION 0.01 % (halobetasol propionate)	Tier 3	ST: Requires prior prescription for Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol (except foam/shampoo), Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) within the past 120 days; QL (400 GM per 1 FILL)
<i>calcipotriene scalp solution 0.005 %</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>calcipotriene topical cream 0.005 %</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>calcipotriene topical foam 0.005 %</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>calcipotriene topical ointment 0.005 %</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcitriol topical ointment 3 mcg/gram</i>	Tier 1	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>clobetasol topical cream 0.025 %</i>	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days; QL (200 GM per 30 days)
DIOOXIA TOPICAL CREAM 0.005-4 % (calcipotriene/niacinamide)	Tier 3	
DRITHOCREME HP TOPICAL CREAM 1 % (anthralin)	Tier 2	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>halobetasol propionate topical foam 0.05 %</i>	Tier 3	ST: Requires prior prescription for generic Halobetasol cream/ointment or Clobetasol foam within the past 120 days; QL (100 GM per 1 FILL)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IMPOYZ TOPICAL CREAM 0.025 % (clobetasol propionate)	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days; QL (200 GM per 30 days)
halobetasol propionate (Lexette Topical Foam 0.05 %)	Tier 3	ST: Requires prior prescription for generic halobetasol cream/ointment or clobetasol foam within the past 120 days; QL (100 GM per 1 FILL)
PURAZIL TOPICAL CREAM 0.005-4 % (calcipotriene/niacinamide)	Tier 3	
SORILUX TOPICAL FOAM 0.005 % (calcipotriene)	Tier 3	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
<i>tazarotene topical cream 0.05 %</i>	Tier 1	Age (Max 39 Years)
<i>tazarotene topical cream 0.1 %</i>	Tier 1	
<i>tazarotene topical gel 0.05 %, 0.1 %</i>	Tier 1	Age (Max 39 Years)
TAZORAC TOPICAL CREAM 0.05 % (tazarotene)	Tier 3	Age (Max 39 Years)
TAZORAC TOPICAL CREAM 0.1 % (tazarotene)	Tier 3	
TAZORAC TOPICAL GEL 0.05 %, 0.1 % (tazarotene)	Tier 3	Age (Max 39 Years)
TRIONEX TOPICAL KIT 0.005 % (calcipotriene/transparent dressing)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRAVATE TOPICAL LOTION 0.05 % (halobetasol propionate)	Tier 3	ST: Requires prior prescription for Betamethasone augmented (ointment, gel, lotion), Clobetasol (spray, lotion, gel, ointment, cream, solution), Fluocinonide 0.1% cream, Halobetasol 0.05% (cream, ointment) within the past 120 days; QL (120 ML per 30 days)
VECTICAL TOPICAL OINTMENT 3 MCG/GRAM (calcitriol)	Tier 3	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
VTAMA TOPICAL CREAM 1 % (tapinarof)	Tier 2	PA; QL (60 GM per 30 days)
ZITHRANOL TOPICAL SHAMPOO 1 % (anthralin micronized)	Tier 3	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
ZORYVE TOPICAL CREAM 0.3 % (roflumilast)	Tier 2	PA; QL (60 GM per 30 days)
Dermatological - Antipsoriatics Systemic, Phosphodiesterase 4 Inhib. - Drugs For The Skin		
OTEZLA ORAL TABLET 20 MG, 30 MG (apremilast)	Tier 3	PA
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47) (apremilast)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Antiseborrheic - Drugs For The Skin		
LOUTREX TOPICAL CREAM (emollient combination no.85)	Tier 1	
MICURADERM TOPICAL EMULSION (emollient combination no.43)	Tier 3	
OVACE PLUS SHAMPOO TOPICAL SHAMPOO 10 % (sulfacetamide sodium)	Tier 2	
OVACE PLUS TOPICAL CLEANSER 10 % (sulfacetamide sodium)	Tier 3	
OVACE PLUS TOPICAL CREAM 10 % (sulfacetamide sodium)	Tier 3	
OVACE PLUS TOPICAL LOTION 9.8 % (sulfacetamide sodium)	Tier 3	ST: Requires prior prescription for Ciclopirox (shampoo/gel) or Ketoconazole (shampoo/cream) within the past 120 days
OVACE PLUS WASH TOPICAL CLEANSER, GEL 10 % (sulfacetamide sodium)	Tier 3	
OVACE TOPICAL CLEANSER 10 % (sulfacetamide sodium)	Tier 3	
PLEXION NS TOPICAL SHAMPOO 9.8 % (sulfacetamide sodium)	Tier 3	
PROMISEB TOPICAL CREAM (emollient combination no.43)	Tier 3	
<i>selenium sulfide topical lotion 2.5 %</i>	Tier 1	
<i>selenium sulfide topical shampoo 2.25 %, 2.3 %</i>	Tier 1	
<i>sulfacetamide sodium topical cleanser 10 %</i>	Tier 1	
<i>sulfacetamide sodium topical cleanser, gel 10 %</i>	Tier 1	
<i>sulfacetamide sodium topical shampoo 10 %</i>	Tier 3	
<i>sulfacetamide sodium topical shampoo 9.8 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TERSI FOAM TOPICAL FOAM 2.25 % (selenium sulfide)	Tier 3	
ZORYVE TOPICAL FOAM 0.3 % (roflumilast)	Tier 2	PA; QL (60 GM per 30 days)
Dermatological - Antiviral, Herpes - Drugs For The Skin		
<i>acyclovir topical cream 5 %</i>	Tier 3	ST: At least 2 prior prescriptions for oral generic Acyclovir, Famciclovir, or Valacyclovir within the past 365 days
<i>acyclovir topical ointment 5 %</i>	Tier 1	
<i>penciclovir topical cream 1 %</i>	Tier 3	
ZOVIRAX TOPICAL OINTMENT 5 % (acyclovir)	Tier 3	
Dermatological - Antiviral-Glucocorticoid Combinations - Drugs For The Skin		
XERESE TOPICAL CREAM 5-1 % (acyclovir/hydrocortisone)	Tier 3	ST: Requires prior prescription for oral Acyclovir, Famciclovir, or Valacyclovir within the past 120 days; QL (10 GM per 365 days)
Dermatological - Burn Products - Drugs For The Skin		
NEXOBRID TOPICAL GEL 8.8 % (anacaulase-bcdb)	Tier 3	
Dermatological - Burn Products Anti-Infective - Drugs For The Skin		
<i>mafenide acetate topical packet 50 gram</i>	Tier 1	
SILVADENE TOPICAL CREAM 1 % (silver sulfadiazine)	Tier 3	
<i>silver sulfadiazine topical cream 1 %</i>	Tier 1	
SSD TOPICAL CREAM 1 % (silver sulfadiazine)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SULFAMYLON TOPICAL CREAM 85 MG/G (mafenide acetate)	Tier 3	
SULFAMYLON TOPICAL PACKET 50 GRAM (mafenide acetate)	Tier 3	
Dermatological - Calcineurin Inhibitors - Drugs For The Skin		
ELIDEL TOPICAL CREAM 1 % (pimecrolimus)	Tier 3	ST: Requires prior prescription for Clobetasol (cream or ointment), Hydrocortisone (1% or 2.5% cream or ointment), generic Mometasone (cream or ointment), or Triamcinolone (0.1% or 0.5% cream or ointment) within the past 120 days
ELYZIA (WITH HYALURONATE) TOPICAL CREAM 0.1-1-4 % (tacrolimus/hyaluronate sodium/niacinamide)	Tier 3	
ELYZIA TOPICAL OINTMENT 0.1-4 % (tacrolimus/niacinamide)	Tier 3	
HOVYN TOPICAL SOLUTION 0.1 % (tacrolimus)	Tier 3	
NUJO TOPICAL SOLUTION 0.1 % (tacrolimus)	Tier 3	
NUJU TOPICAL CREAM 0.1 % (tacrolimus in vehicle base no.238)	Tier 3	
OXIANUJO (WITH HYALURONATE) TOPICAL CREAM 0.1-1-4 % (tacrolimus/hyaluronate sodium/niacinamide)	Tier 3	
OXIANUJO TOPICAL OINTMENT 0.1-4 % (tacrolimus/niacinamide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pimecrolimus topical cream 1 %</i>	Tier 1	ST: Requires prior prescription for Clobetasol (cream or ointment), Hydrocortisone (1% or 2.5% cream or ointment), generic Mometasone (cream or ointment), or Triamcinolone (0.1% or 0.5% cream or ointment) within the past 120 days
<i>tacrolimus topical ointment 0.03 %, 0.1 %</i>	Tier 1	ST: Requires prior prescription for Clobetasol (cream or ointment), Hydrocortisone (1% or 2.5% cream or ointment), generic Mometasone (cream or ointment), or Triamcinolone (0.1% or 0.5% cream or ointment) within the past 120 days
VEVEN TOPICAL CREAM 0.1 % (tacrolimus in vehicle base no.238)	Tier 3	
Dermatological - Depigmenting Agents - Drugs For The Skin		
BLANCHE TOPICAL CREAM 4 % (hydroquinone)	Tier 3	
<i>hydroquinone topical cream 4 %</i>	Tier 1	
KAXM TOPICAL EMULSION 4 % (hydroquinone)	Tier 3	
KEXM TOPICAL EMULSION 6 % (hydroquinone)	Tier 3	
KUTEA TOPICAL EMULSION 8 % (hydroquinone)	Tier 3	
KUXM TOPICAL EMULSION 8 % (hydroquinone)	Tier 3	
MEDORFA HP PLUS TOPICAL EMULSION 8 % (hydroquinone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDORFA HP TOPICAL EMULSION 8 % (hydroquinone)	Tier 3	
MEDORFA LP TOPICAL EMULSION 4 % (hydroquinone)	Tier 3	
MEDORFA TOPICAL EMULSION 6 % (hydroquinone)	Tier 3	
OBAGI ELASTIDERM TOPICAL CREAM 4 % (hydroquinone)	Tier 1	
OBAGI NU-DERM BLENDER TOPICAL CREAM 4 % (hydroquinone)	Tier 1	
OBAGI NU-DERM CLEAR TOPICAL CREAM 4 % (hydroquinone)	Tier 1	
Dermatological - Depigmenting Combinations - Drugs For The Skin		
KATARAXAP TOPICAL EMULSION 4-0.025-0.025 % (hydroquinone/tretinoin/triamcinolone acetonide)	Tier 3	
KATARVIA TOPICAL EMULSION 4-0.025 % (hydroquinone/tretinoin)	Tier 3	
KATARYA TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KATARYAXN TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KEIDO TOPICAL EMULSION 6-1 % (hydroquinone/hyaluronate sodium)	Tier 3	
KETARYA TOPICAL EMULSION 6-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KEVARAXAP TOPICAL EMULSION 6-0.05-0.025 % (hydroquinone/tretinoin/triamcinolone acetonide)	Tier 3	
KEVARTIA TOPICAL EMULSION 6-0.05 % (hydroquinone/tretinoin)	Tier 3	
KEVARYA TOPICAL EMULSION 6-0.05-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KEYA TOPICAL EMULSION 6-0.5 % (hydroquinone/hydrocortisone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KOTARAXAP TOPICAL EMULSION 5-0.025-0.025 % (hydroquinone/tretinoin/triamcinolone acetonide)	Tier 3	
KUTAR TOPICAL EMULSION 8-0.025 % (hydroquinone/tretinoin)	Tier 3	
KUTARVIA TOPICAL EMULSION 8-0.025 % (hydroquinone/tretinoin)	Tier 3	
KUTARYAXM TOPICAL EMULSION 8-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KUTARYAXMPA TOPICAL EMULSION 8-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KUVARYA TOPICAL EMULSION 8-0.05-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
KUVARYE TOPICAL EMULSION 8-0.05-1 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MAVILO HP TOPICAL EMULSION 6-0.05-0.025 % (hydroquinone/tretinoin/triamcinolone acetonide)	Tier 3	
MAVILO LP TOPICAL EMULSION 4-0.025-0.025 % (hydroquinone/tretinoin/triamcinolone acetonide)	Tier 3	
MAVILO TOPICAL EMULSION 5-0.025-0.025 % (hydroquinone/tretinoin/triamcinolone acetonide)	Tier 3	
MECORIX HP TOPICAL EMULSION 8-0.05-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MECORIX PLUS TOPICAL EMULSION 8-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MECORIX TOPICAL EMULSION 8-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MEDORFA PLUS TOPICAL EMULSION 6-1 % (hydroquinone/hyaluronate sodium)	Tier 3	
MEKAM HP TOPICAL EMULSION 6-0.05-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEKAM TOPICAL EMULSION 6-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MELIDU TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MELONDIS PLUS TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MELONDIS TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MIMORA TOPICAL EMULSION 6-0.5 % (hydroquinone/hydrocortisone)	Tier 3	
MOKURA LP TOPICAL EMULSION 4-0.025 % (hydroquinone/tretinoin)	Tier 3	
MOKURA MOD TOPICAL EMULSION 6-0.05 % (hydroquinone/tretinoin)	Tier 3	
MOKURA PLUS TOPICAL EMULSION 8-0.025 % (hydroquinone/tretinoin)	Tier 3	
MOKURA TOPICAL EMULSION 8-0.025 % (hydroquinone/tretinoin)	Tier 3	
MOLEXI TOPICAL EMULSION 4-0.025-2.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MYTHIUS TOPICAL EMULSION 8-0.05-1 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
MYVORI TOPICAL CREAM 10-4 % (lactic acid/niacinamide)	Tier 3	
OBAGI NU-DERM SUNFADER TOPICAL CREAM 4 %-SPF 15 (hydroquinone/sunscreens (oxybenzone/octinoxate))	Tier 3	
OBAGI-C CLARIFYING SERUM TOPICAL LIQUID 4-10 % (hydroquinone/ascorbic acid)	Tier 3	
OBAGI-C THERAPY NIGHT TOPICAL CREAM 4 % (hydroquinone/ascorbic acid/vit E acetate (d-alpha tocoph))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROOXIA TOPICAL CREAM 10-4 % (lactic acid/niacinamide)	Tier 3	
TRI-LUMA TOPICAL CREAM 0.01-4-0.05 % (fluocinolone acetonide/tretinoin/hydroquinone)	Tier 3	
YAXATARXYN TOPICAL EMULSION 4-0.025-0.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
YOKATAR TOPICAL EMULSION 4-0.025-2.5 % (hydroquinone/tretinoin/hydrocortisone)	Tier 3	
Dermatological - Emollient Combinations - Drugs For The Skin		
<i>ceramides 1,3,6-ii topical cream</i>	Tier 3	
CERAVE DAILY MOISTURIZING TOPICAL LOTION (ceramides 1,3,6-II)	Tier 3	
CERAVE FOAMING FACIAL TOPICAL CLEANSER (ceramides 1,3,6-II/niacinamide)	Tier 3	
CERAVE PM TOPICAL LOTION,EXTENDED RELEASE (ceramides 1,3,6-II/niacinamide/hyaluronic acid)	Tier 3	
CERAVE SA (WITH NIACINAMIDE) TOPICAL CLEANSER (ceramides (1,3,6-II)/salicylic acid/niacinamide)	Tier 3	
CERAVE SA (WITH NIACINAMIDE) TOPICAL CREAM (ceramides (1,3,6-II)/salicylic acid/niacinamide)	Tier 3	
CERAVE SA TOPICAL LOTION (salicylic acid/ceramides 1,3,6-II)	Tier 3	
CERAVE TOPICAL CLEANSER (ceramides 1,3,6-II)	Tier 3	
CERAVE TOPICAL CREAM (ceramides 1,3,6-II)	Tier 3	
MOISTURIZING NORMAL-DRY SKIN TOPICAL LOTION (ceramides 1,3,6-II)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Emollient Combinations Other - Drugs For The Skin		
ADVANCED SKIN CARE TOPICAL LOTION (glycerin/mineral oil/dimethicone/petrolatum,white)	Tier 3	
HPR PLUS HYDROGEL TOPICAL KIT, CREAM AND GEL (emol53/sod mag fluorosilicat/cyclomethicone/phos acid/bicarb)	Tier 3	
HPR PLUS-MB HYDROGEL TOPICAL COMBO PACK, GEL AND FOAM 96.53-3-0.4 -0.066 % (emol53/e.water/NaMgFS/NaPhos/NaCl/hypochlorous acid/NahypoCl)	Tier 3	
MB HYDROGEL (CYCLOMETHICONE) TOPICAL KIT, CREAM AND GEL (emol53/sod mag fluorosilicat/cyclomethicone/phos acid/bicarb)	Tier 3	
MB HYDROGEL TOPICAL KIT, CREAM AND GEL 96.53-3-0.4 -0.066 % (emol53/e.water/NaMgFS/NaPhos/NaCl/hypochlorous acid/NahypoCl)	Tier 1	
Dermatological - Emollient Mixtures - Drugs For The Skin		
ATRAPRO CP TOPICAL COMBO PACK, CREAM AND GEL (emollient combination no.47/emollient combination no.60)	Tier 3	
ATRAPRO HYDROGEL TOPICAL GEL (emollient combination no.60)	Tier 3	
AVO CREAM TOPICAL EMULSION (emollient combination no.10)	Tier 3	
CELACYN TOPICAL GEL WITH PUMP (emollient combination no.60)	Tier 3	
CERACADE TOPICAL EMULSION (emollient combination no.103)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CERAMAX TOPICAL CREAM (emollient combination no.101)	Tier 3	
CERAMAX TOPICAL LOTION (emollient combination no.101)	Tier 3	
COCOA BUTTER FORMULA - VIT E TOPICAL LIQUID (emollient combination no.123)	Tier 3	
CUTEMOL EMOLLIENT TOPICAL CREAM (emollient combination no.125)	Tier 3	
DERMASO PLUS TOPICAL CREAM (emollient combination no.122)	Tier 3	
DEXERYL TOPICAL CREAM (emollient combination no.104)	Tier 3	
DRY SKIN THERAPY(WITH LANOLIN) TOPICAL LOTION (lanolin/mineral oil)	Tier 3	
DRY SKIN THERAPY(W-PETROLATUM) TOPICAL CREAM (lanolin alcohols/mineral oil/petrolatum,white/ceresin)	Tier 3	
EMULSION SB TOPICAL EMULSION (emollient combination no.32)	Tier 3	
ENTTY TOPICAL SPRAY, NON-AEROSOL (palm oil/hyaluronate sodium)	Tier 3	
EPICERAM TOPICAL EMULSION, EXTENDED RELEASE (emollient combination no.32)	Tier 3	PA
EUCERIN ADVANCED REPAIR TOPICAL CREAM (emollient combination no.119)	Tier 3	
EUCERIN INTENSIVE REPAIR TOPICAL LOTION (emollient combination no.110)	Tier 3	
GOLD BOND THERAPEUTIC FOOT TOPICAL CREAM (emollient combination no.120)	Tier 3	
HALUCORT TOPICAL GEL (emollient combination no.56/hyaluronic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HAPRODERM TOPICAL GEL (emollient combination no.56/hyaluronic acid)	Tier 3	
HPR PLUS TOPICAL CREAM (emollient combination no.53)	Tier 3	
HPR PLUS TOPICAL FOAM (emollient combination no.53)	Tier 3	
HPR TOPICAL FOAM (emollient combination no.44)	Tier 3	
HYGIENIC CLEANSING LOTION TOPICAL LOTION (mineral oil/lanolin oil/propylene glycol)	Tier 3	
INTENSE DRY SKIN THERAPY TOPICAL LOTION (emollient combination no.110)	Tier 3	
LEVICYN ANTIPRURITIC SG TOPICAL SPRAY GEL (emollient combination no.60)	Tier 3	
LOUTREX TOPICAL CREAM (emollient combination no.85)	Tier 1	
LOYON TOPICAL SPRAY, NON-AEROSOL (dicaprylyl carbonate/dimethicone)	Tier 3	
LUXAMEND TOPICAL CREAM (emollient combination no.10)	Tier 3	
MICURADERM TOPICAL EMULSION (emollient combination no.43)	Tier 3	
MINERIN CREME TOPICAL CREAM (lanolin alcohols/mineral oil/petrolatum, white/ceresin)	Tier 3	
MOISTURIZING CREAM TOPICAL CREAM (glycerin/dimethicone/petrolatum, white/water)	Tier 3	
MOITURIZING LOTION TOPICAL LOTION (vit E acetate (d-alpha tocoph)/glycerin/dimethicone/water)	Tier 3	
NEOSALUS TOPICAL CREAM (emollient combination no.47)	Tier 3	
NEOSALUS TOPICAL LOTION (emollient combination no.47)	Tier 3	
NUTRASEB TOPICAL CREAM (emollient combination no.107)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORGANIC NIPPLE BALM TOPICAL OINTMENT (sunflower/olive/beeswax/coconut/shear butter/marigold/argan)	Tier 3	
PRESERA TOPICAL FOAM (emollient combination no.80)	Tier 3	
PROMISEB TOPICAL CREAM (emollient combination no.43)	Tier 3	
PRUCLAIR TOPICAL CREAM (vitamin E acet (dl,tocopheryl)/grape/hyaluronic acid)	Tier 3	
PRUMYX TOPICAL CREAM (emollient combination no.35)	Tier 1	
SEBUDERM TOPICAL GEL (emollient combination no.60)	Tier 3	
SKIN THERAPY TOPICAL LIQUID (emollient combination no.41)	Tier 3	
SONAFINE TOPICAL EMULSION (emollient combination no.10)	Tier 3	
THERAPEUTIC MOISTURIZING CREAM TOPICAL CREAM (lanolin alcohols/mineral oil/petrolatum,white/ceresin)	Tier 3	
ULTRA MOISTURE TOPICAL LOTION (emollient combination no.40)	Tier 3	
<i>vitamin e-safflower oil topical oil</i>	Tier 3	
<i>vitamin e-vitamins a and d topical cream</i>	Tier 3	
XCLAIR TOPICAL CREAM (hyaluronate sodium/vit E/emollient no.12/allantoin/shear tree)	Tier 3	
Dermatological - Emollients - Drugs For The Skin		
AMLACTIN TOPICAL LOTION 12 % (ammonium lactate)	Tier 1	
<i>ammonium lactate topical cream 12 %</i>	Tier 1	
<i>ammonium lactate topical lotion 12 %</i>	Tier 1	
<i>glycerin topical liquid</i>	Tier 3	
<i>glycerin topical solution 99.5 %</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERASTAT TOPICAL CREAM (keratin)	Tier 3	
KERASTAT TOPICAL GEL 5 % (keratin)	Tier 3	
LANOLIN (HPA) TOPICAL CREAM 100 % (modified lanolin)	Tier 3	
RADIAGEL TOPICAL GEL (emollient base)	Tier 3	
urea topical cream 10 %, 20 %	Tier 3	
urea topical lotion 10 %	Tier 3	
vitamin e (dl, acetate) topical oil	Tier 3	
Dermatological - Enzymes - Drugs For The Skin		
SANTYL TOPICAL OINTMENT 250 UNIT/GRAM (collagenase Clostridium histolyticum)	Tier 3	PA
Dermatological - Eyelid Cleansers - Drugs For The Skin		
ACUICYN TOPICAL SPRAY, NON-AEROSOL 0.01 % (hypochlorous acid/sodium chloride)	Tier 3	
AVENOVA TOPICAL SPRAY, NON-AEROSOL 0.01 % (hypochlorous acid/sodium chloride)	Tier 3	
CLEANSING EYELID MOIST PADS TOPICAL PADS, MEDICATED (eyelid cleanser combination no.8)	Tier 3	
CLEANSING EYELID WIPES EXT STR TOPICAL PADS, MEDICATED (eyelid cleanser combination no.10)	Tier 3	
EYELID WIPES (WITH CHAMOMILE) TOPICAL TOWELETTE (eyelid cleanser combination no.6)	Tier 3	
OCUSOFT LID SCRUB ALLERGY TOPICAL PADS, MEDICATED (eyelid cleanser combination no.13)	Tier 3	
VISTA MEIBO EYELID CLEANSING TOPICAL FOAM (eyelid cleanser combination no.11)	Tier 3	
VISTA MEIBO EYELID CLEANSING TOPICAL PADS, MEDICATED (eyelid cleanser combination no.12)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Glucocorticoid - Drugs For The Skin		
ADVANCED ALLERGY COLLECT KIT TOPICAL KIT 2.5 % (hydrocortisone)	Tier 1	
hydrocortisone (Ala-Cort Topical Cream 1 %)	Tier 1	
hydrocortisone (Ala-Scalp Topical Lotion 2 %)	Tier 1	ST: Requires prior prescription for Hydrocortisone 2.5% lotion within the past 120 days
<i>alclometasone topical cream 0.05 %</i>	Tier 1	
<i>alclometasone topical ointment 0.05 %</i>	Tier 1	
<i>amcinonide topical cream 0.1 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone 0.1% ointment, Fluticasone 0.005% ointment, Mometasone 0.1% ointment, or Triamcinolone 0.5% ointment or cream within the past 120 days
<i>amcinonide topical ointment 0.1 %</i>	Tier 3	
hydrocortisone (Anusol-Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 3	
diflorasone diacetate/emollient base (Apexicon E Topical Cream 0.05 %)	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days; QL (180 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
fluticasone propionate (Beser Topical Lotion 0.05 %)	Tier 3	
<i>betamethasone dipropionate topical cream 0.05 %</i>	Tier 1	
<i>betamethasone dipropionate topical lotion 0.05 %</i>	Tier 1	
<i>betamethasone dipropionate topical ointment 0.05 %</i>	Tier 1	
<i>betamethasone valerate topical cream 0.1 %</i>	Tier 1	
<i>betamethasone valerate topical foam 0.12 %</i>	Tier 1	
<i>betamethasone valerate topical lotion 0.1 %</i>	Tier 1	
<i>betamethasone valerate topical ointment 0.1 %</i>	Tier 1	
<i>betamethasone, augmented topical cream 0.05 %</i>	Tier 1	
<i>betamethasone, augmented topical gel 0.05 %</i>	Tier 1	
<i>betamethasone, augmented topical lotion 0.05 %</i>	Tier 1	
<i>betamethasone, augmented topical ointment 0.05 %</i>	Tier 1	
BRYHALI TOPICAL LOTION 0.01 % (halobetasol propionate)	Tier 3	ST: Requires prior prescription for Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol (except foam/shampoo), Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) within the past 120 days; QL (400 GM per 1 FILL)
CAPEX TOPICAL SHAMPOO 0.01 % (fluocinolone acetone)	Tier 3	
<i>clobetasol scalp solution 0.05 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clobetasol topical cream 0.025 %</i>	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days; QL (200 GM per 30 days)
<i>clobetasol topical cream 0.05 %</i>	Tier 1	
<i>clobetasol topical foam 0.05 %</i>	Tier 1	
<i>clobetasol topical gel 0.05 %</i>	Tier 1	
<i>clobetasol topical lotion 0.05 %</i>	Tier 1	
<i>clobetasol topical ointment 0.05 %</i>	Tier 1	
<i>clobetasol topical shampoo 0.05 %</i>	Tier 1	
<i>clobetasol topical spray,non-aerosol 0.05 %</i>	Tier 1	
<i>clobetasol-emollient topical cream 0.05 %</i>	Tier 1	
<i>clobetasol-emollient topical foam 0.05 %</i>	Tier 1	
CLOBEX TOPICAL LOTION 0.05 % (clobetasol propionate)	Tier 3	
CLOBEX TOPICAL SHAMPOO 0.05 % (clobetasol propionate)	Tier 3	
CLOBEX TOPICAL SPRAY, NON-AEROSOL 0.05 % (clobetasol propionate)	Tier 3	
<i>clocortolone pivalate topical cream 0.1 %</i>	Tier 1	ST: Requires prior prescription for Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clobetasol propionate (Clodan Topical Shampoo 0.05 %)	Tier 3	
CORDRAN TAPE LARGE ROLL TOPICAL TAPE 4 MCG/CM2 (flurandrenolide)	Tier 3	ST: Requires prior prescription for Betamethasone augmented (ointment, gel, lotion), Clobetasol (spray, lotion, gel, ointment, cream, solution), Fluocinonide 0.1% cream, Halobetasol 0.05% (cream, ointment) within the past 120 days; QL (2 EA per 30 days)
CORDRAN TOPICAL CREAM 0.025 % (flurandrenolide)	Tier 3	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
CORDRAN TOPICAL CREAM 0.05 % (flurandrenolide)	Tier 3	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days
CORDRAN TOPICAL LOTION 0.05 % (flurandrenolide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CORDRAN TOPICAL OINTMENT 0.05 % (flurandrenolide)	Tier 3	ST: Requires prior prescription for Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment within the past 120 days; QL (180 GM per 30 days)
DERMA-SMOOTHIE/FS BODY OIL TOPICAL OIL 0.01 % (fluocinolone acetonide)	Tier 3	
DERMA-SMOOTHIE/FS SCALP OIL SCALP OIL 0.01 % (fluocinolone acetonide/shower cap)	Tier 3	
<i>desonide topical cream 0.05 %</i>	Tier 1	
<i>desonide topical gel 0.05 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days
<i>desonide topical lotion 0.05 %</i>	Tier 1	
<i>desonide topical ointment 0.05 %</i>	Tier 1	
DESOWEN TOPICAL CREAM 0.05 % (desonide)	Tier 3	
<i>desoximetasone topical cream 0.05 %, 0.25 %</i>	Tier 1	
<i>desoximetasone topical gel 0.05 %</i>	Tier 1	
<i>desoximetasone topical ointment 0.05 %, 0.25 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desoximetasone topical spray,non-aerosol 0.25 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol (except foam/shampoo), Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) within the past 120 days
<i>diflorasone topical cream 0.05 %</i>	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days; QL (180 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
 PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
 PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diflorasone topical ointment 0.05 %</i>	Tier 3	ST: Requires prior prescription for Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol (except foam/shampoo), Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) within the past 120 days; QL (180 GM per 30 days)
DIPROLENE (AUGMENTED) TOPICAL OINTMENT 0.05 % (betamethasone dipropionate/propylene glycol)	Tier 3	
<i>fluocinolone and shower cap scalp oil 0.01 %</i>	Tier 1	
<i>fluocinolone topical cream 0.01 %, 0.025 %</i>	Tier 1	
<i>fluocinolone topical oil 0.01 %</i>	Tier 1	
<i>fluocinolone topical ointment 0.025 %</i>	Tier 1	
<i>fluocinolone topical solution 0.01 %</i>	Tier 1	
<i>fluocinonide topical cream 0.05 %, 0.1 %</i>	Tier 1	
<i>fluocinonide topical gel 0.05 %</i>	Tier 1	
<i>fluocinonide topical ointment 0.05 %</i>	Tier 1	
<i>fluocinonide topical solution 0.05 %</i>	Tier 1	
fluocinonide/emollient base (Fluocinonide-E Topical Cream 0.05 %)	Tier 1	
<i>fluocinonide-emollient topical cream 0.05 %</i>	Tier 1	
FLUOVIX PLUS TOPICAL KIT 0.1 % (fluocinonide/silicone, adhesive)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLUOVIX TOPICAL KIT 0.1 % (fluocinonide/silicone, adhesive)	Tier 3	
<i>flurandrenolide topical cream 0.05 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days
<i>flurandrenolide topical lotion 0.05 %</i>	Tier 1	
<i>flurandrenolide topical ointment 0.05 %</i>	Tier 1	ST: Requires prior prescription for Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment within the past 120 days; QL (180 GM per 30 days)
<i>fluticasone propionate topical cream 0.05 %</i>	Tier 1	
<i>fluticasone propionate topical lotion 0.05 %</i>	Tier 1	
<i>fluticasone propionate topical ointment 0.005 %</i>	Tier 1	
<i>halcinonide topical cream 0.1 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>halcinonide topical solution 0.1 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days
<i>halobetasol propionate topical cream 0.05 %</i>	Tier 1	
<i>halobetasol propionate topical foam 0.05 %</i>	Tier 3	ST: Requires prior prescription for generic Halobetasol cream/ointment or Clobetasol foam within the past 120 days; QL (100 GM per 1 FILL)
<i>halobetasol propionate topical ointment 0.05 %</i>	Tier 1	
HALOG TOPICAL CREAM 0.1 % (halcinonide)	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HALOG TOPICAL OINTMENT 0.1 % (halcinonide)	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days
HALOG TOPICAL SOLUTION 0.1 % (halcinonide)	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days
<i>hydrocortisone acetate topical cream with perineal applicator 2.5 %</i>	Tier 3	
<i>hydrocortisone butyrate topical cream 0.1 %</i>	Tier 1	
<i>hydrocortisone butyrate topical lotion 0.1 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days; QL (236 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone butyrate topical ointment 0.1 %</i>	Tier 1	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days
<i>hydrocortisone butyrate topical solution 0.1 %</i>	Tier 1	
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	Tier 1	
<i>hydrocortisone topical cream with perineal applicator 1 %, 2.5 %</i>	Tier 1	
<i>hydrocortisone topical lotion 2 %</i>	Tier 1	ST: Requires prior prescription for Hydrocortisone 2.5% lotion within the past 120 days
<i>hydrocortisone topical lotion 2.5 %</i>	Tier 1	
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	Tier 1	
<i>hydrocortisone topical solution 2.5 %</i>	Tier 1	ST: Requires prior prescription for Hydrocortisone 2.5% lotion within the past 120 days
<i>hydrocortisone valerate topical cream 0.2 %</i>	Tier 1	
<i>hydrocortisone valerate topical ointment 0.2 %</i>	Tier 1	ST: Requires prior prescription for Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	Tier 1	
HYDROXYM TOPICAL GEL 2 % (hydrocortisone)	Tier 3	
IMPOYZ TOPICAL CREAM 0.025 % (clobetasol propionate)	Tier 3	ST: Requires prior prescription for Betamethasone 0.05% (ointment, augmented cream), Desoximetasone (cream, gel, ointment), Fluocinonide 0.05% (gel, ointment, solution, cream) within the past 120 days; QL (200 GM per 30 days)
KENALOG TOPICAL AEROSOL 0.147 MG/GRAM (triamcinolone acetonide)	Tier 3	
halobetasol propionate (Lexette Topical Foam 0.05 %)	Tier 3	ST: Requires prior prescription for generic halobetasol cream/ointment or clobetasol foam within the past 120 days; QL (100 GM per 1 FILL)
LOCOID LIPOCREAM TOPICAL CREAM 0.1 % (hydrocortisone butyrate/emollient base)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOCOID TOPICAL LOTION 0.1 % (hydrocortisone butyrate)	Tier 3	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days; QL (236 ML per 30 days)
LUXIQ TOPICAL FOAM 0.12 % (betamethasone valerate)	Tier 3	
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 % (hydrocortisone acetate)	Tier 3	
<i>mometasone topical cream 0.1 %</i>	Tier 1	
<i>mometasone topical ointment 0.1 %</i>	Tier 1	
<i>mometasone topical solution 0.1 %</i>	Tier 1	
OLUX TOPICAL FOAM 0.05 % (clobetasol propionate)	Tier 3	
OLUX-E TOPICAL FOAM 0.05 % (clobetasol propionate/emollient base)	Tier 3	
PANDEL TOPICAL CREAM 0.1 % (hydrocortisone probutate)	Tier 3	ST: Requires prior prescription for Betamethasone (0.05% lotion, 0.1% cream), Desonide 0.05% ointment, Fluticasone 0.05% cream, Hydrocortisone 0.2% cream, or Triamcinolone (0.1% lotion, 0.025% ointment) within the past 120 days; QL (160 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednicarbate topical cream 0.1 %</i>	Tier 1	
<i>prednicarbate topical ointment 0.1 %</i>	Tier 1	
hydrocortisone (Proctocort Topical Cream 1 %)	Tier 3	
hydrocortisone (Procto-Med Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Proctosol Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
hydrocortisone (Proctozone-Hc Topical Cream With Perineal Applicator 2.5 %)	Tier 1	
SCALACORT DK TOPICAL COMBO PACK 2-2-2 % (hydrocortisone/salicylic acid/sulfur/shampoo no.1)	Tier 2	
SCALACORT TOPICAL LOTION 2 % (hydrocortisone)	Tier 3	ST: Requires prior prescription for Hydrocortisone 2.5% lotion within the past 120 days
SERNIVO TOPICAL SPRAY WITH PUMP 0.05 % (betamethasone dipropionate)	Tier 3	ST: Requires prior prescription for Mometasone 0.1% cream/solution or Triamcinolone 0.1 % cream/ointment within the past 120 days
SYNALAR TOPICAL CREAM 0.025 % (fluocinolone acetonide)	Tier 3	
SYNALAR TOPICAL OINTMENT 0.025 % (fluocinolone acetonide)	Tier 3	
SYNALAR TOPICAL SOLUTION 0.01 % (fluocinolone acetonide)	Tier 3	
hydrocortisone (Texacort Topical Solution 2.5 %)	Tier 3	ST: Requires prior prescription for Hydrocortisone 2.5% lotion within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
desoximetasone (Topicort Topical Cream 0.05 %, 0.25 %)	Tier 3	
TOPICORT TOPICAL GEL 0.05 % (desoximetasone)	Tier 3	
TOPICORT TOPICAL OINTMENT 0.05 % (desoximetasone)	Tier 3	
desoximetasone (Topicort Topical Ointment 0.25 %)	Tier 3	
TOPICORT TOPICAL SPRAY, NON-AEROSOL 0.25 % (desoximetasone)	Tier 3	ST: Requires prior prescription for Betamethasone augmented 0.05% (cream, gel, lotion, ointment), Clobetasol (except foam/shampoo), Desoximetasone (cream, gel, ointment), Fluocinonide (cream, gel), or Halobetasol (cream, ointment) within the past 120 days
clobetasol propionate/emollient base (Tovet Emollient Topical Foam 0.05 %)	Tier 3	
<i>triamcinolone acetonide topical aerosol 0.147 mg/gram</i>	Tier 1	
<i>triamcinolone acetonide topical cream 0.025 %, 0.1 %</i>	Tier 1	
<i>triamcinolone acetonide topical cream 0.5 %</i>	Tier 1	QL (454 GM per 30 days)
<i>triamcinolone acetonide topical lotion 0.025 %, 0.1 %</i>	Tier 1	
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	Tier 1	
<i>triamcinolone acetonide topical ointment 0.05 %</i>	Tier 3	QL (430 GM per 30 days)
triamcinolone acetonide (Trianex Topical Ointment 0.05 %)	Tier 3	QL (430 GM per 30 days)
TRIASIL TOPICAL KIT 0.1 %- 4" X 4" (triamcinolone acetonide/gauze bandage/silicone, adhesive)	Tier 3	
triamcinolone acetonide (Triderm Topical Cream 0.5 %)	Tier 1	QL (454 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRAVATE TOPICAL LOTION 0.05 % (halobetasol propionate)	Tier 3	ST: Requires prior prescription for Betamethasone augmented (ointment, gel, lotion), Clobetasol (spray, lotion, gel, ointment, cream, solution), Fluocinonide 0.1% cream, Halobetasol 0.05% (cream, ointment) within the past 120 days; QL (120 ML per 30 days)
VANOS TOPICAL CREAM 0.1 % (fluocinonide)	Tier 3	
VERDESO TOPICAL FOAM 0.05 % (desonide)	Tier 3	ST: Requires prior prescription for Fluocinolone Acetonide 0.01% body oil within the past 120 days
Dermatological - Glucocorticoid Combinations Other - Drugs For The Skin		
ACIOXIA TOPICAL GEL 0.1-0.5 % (triamcinolone acetonide/pentoxifylline)	Tier 3	
CHLOHUX TOPICAL SHAMPOO 0.05-2 % (clobetasol propionate/levocetirizine dihydrochloride)	Tier 3	
CHLOOXIA TOPICAL CREAM 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
CHLOOXIA TOPICAL OINTMENT 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
CHLOOXIA TOPICAL SOLUTION 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
DIOCHLOY TOPICAL SOLUTION 0.05-0.005 % (clobetasol propionate/calcipotriene)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIVINIX TOPICAL CREAM 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
DIVINIX TOPICAL OINTMENT 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
DIVINIX TOPICAL SOLUTION 0.05-4 % (clobetasol propionate/niacinamide)	Tier 3	
DOMELA TOPICAL CREAM 0.01-4 % (fluocinolone acetonide/niacinamide)	Tier 3	
DYNOMA TOPICAL CREAM 0.05-4 % (desoximetasone/niacinamide)	Tier 3	
FLUOXIA TOPICAL CREAM 0.05-4 % (desoximetasone/niacinamide)	Tier 3	
ILEXOR TOPICAL SHAMPOO 0.05-2 % (clobetasol propionate/levocetirizine dihydrochloride)	Tier 3	
PLENURA TOPICAL SOLUTION 0.05-0.005 % (clobetasol propionate/calcipotriene)	Tier 3	
TELIORA TOPICAL GEL 0.1-0.5 % (triamcinolone acetonide/pentoxifylline)	Tier 3	
TETOXIA TOPICAL CREAM 0.01-4 % (fluocinolone acetonide/niacinamide)	Tier 3	
Dermatological - Glucocorticoid-Emollient Combinations - Drugs For The Skin		
BESER KIT TOPICAL KIT, LOTION AND CREAM, EMOLLIENT 0.05 % (fluticasone propionate/emollient combination no.65)	Tier 3	
ELLZIA PAK TOPICAL KIT, OINTMENT AND CREAM 0.1-5 % (triamcinolone acetonide/dimethicone)	Tier 3	
FLUOPAR TOPICAL KIT 0.1-5 % (fluocinonide/dimethicone)	Tier 3	
NOXIPAK TOPICAL KIT 0.01-20 % (fluocinolone acetonide/urea/silicone, adhesive)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCORT TOPICAL LOTION 2 % (hydrocortisone acetate/aloe vera)	Tier 3	
QUINIXIL TOPICAL CREAM 0.1-5 % (mometasone furoate/dimethicone)	Tier 3	
SANADERMRX TOPICAL KIT 0.1-5 % (triamcinolone acetonide/dimethicone/silicone, adhesive)	Tier 3	QL (1 EA per 30 days)
SYNALAR CREAM KIT TOPICAL CREAM 0.025 % (fluocinolone acetonide/emollient combination no.65)	Tier 3	QL (375 GM per 30 days)
SYNALAR OINTMENT KIT TOPICAL COMBO PACK,OINTMENT AND CREAM 0.025 % (fluocinolone acetonide/emollient combination no.65)	Tier 3	QL (375 GM per 30 days)
TOVET KIT TOPICAL COMBO PACK 0.05 % (clobetasol propionate/emollient combination no.65)	Tier 3	
WHYTEDERM TDPAK TOPICAL KIT 0.1-2 % (triamcinolone acetonide/dimethicone/silicone, adhesive)	Tier 3	
WHYTEDERM TRILASIL PAK TOPICAL KIT 0.1-2 % (triamcinolone acetonide/dimethicone/silicone, adhesive)	Tier 3	
Dermatological - Glucocorticoid-Local Anesthetic Combinations - Drugs For The Skin		
ANALPRAM-HC TOPICAL LOTION 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
EPIFOAM TOPICAL FOAM 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	ST: Requires prior prescription for Hydrocortisone/Pramoxine 2.5%-1% cream within the past 120 days
<i>hydrocortisone-pramoxine topical cream 2.35-1 %</i>	Tier 3	
<i>hydrocortisone-pramoxine topical cream 2.5-1 %</i>	Tier 1	
<i>lidocaine hcl-hydrocortison ac topical cream 3-0.5 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVACORT TOPICAL GEL WITH PERINEAL APPLICATOR 2-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 3	
PRAMOSONE TOPICAL CREAM 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	ST: Requires prior prescription for Hydrocortisone/Pramoxine 2.5%-1% cream within the past 120 days
PRAMOSONE TOPICAL LOTION 1-1 %, 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
PRAMOSONE TOPICAL OINTMENT 1-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	ST: Requires prior prescription for Hydrocortisone/Pramoxine 2.5%-1% cream within the past 120 days
PRAMOSONE TOPICAL OINTMENT 2.5-1 % (hydrocortisone acetate/pramoxine HCl)	Tier 2	
Dermatological - Glucocorticoid-Skin Cleanser Combinations - Drugs For The Skin		
CLODAN KIT TOPICAL KIT, SHAMPOO AND CLEANSER 0.05 % (clobetasol propionate/skin cleanser combination no.28)	Tier 3	
HYDROCORTISONE LOTION COMPLETE TOPICAL COMBO PACK 2 % (hydrocortisone/skin cleanser)	Tier 3	
SYNALAR TS TOPICAL KIT 0.01 % (fluocinolone acetonide/skin cleanser comb no.28)	Tier 3	
XILAPAK TOPICAL KIT 0.01 % (fluocinolone acetonide/skin cleanser no.10/silicone, tape)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Immunomodulator - Catechins - Genital Wart/Hpv Tx - Drugs For The Skin		
VEREGEN TOPICAL OINTMENT 15 % (sinecatechins)	Tier 3	ST: Requires prior prescriptions for Imiquimod 5% cream packets and Podofilox 0.5% solution within the past 365 days; QL (30 GM per 1 FILL)
Dermatological - Immunomodulator - Imidazoquinolinamines - Drugs For The Skin		
<i>imiquimod topical cream in metered-dose pump 3.75 %</i>	Tier 3	
<i>imiquimod topical cream in packet 3.75 %</i>	Tier 3	
<i>imiquimod topical cream in packet 5 %</i>	Tier 1	QL (2 EA per 1 day)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP 2.5 % (imiquimod)	Tier 3	
Dermatological - Immunomodulator - Interferons - Drugs For The Skin		
ALFERON N INJECTION SOLUTION 5 MILLION UNIT/ML (interferon alfa-n3)	Tier 3	KP
Dermatological - Immunomodulator Combinations - Drugs For The Skin		
KAZURI TOPICAL GEL 5-0.05-1 % (imiquimod/tretinoin/levocetirizine dihydrochloride)	Tier 3	
KERIDA TOPICAL GEL 5-0.1-30 % (imiquimod/tretinoin/salicylic acid)	Tier 3	
KYNARA TOPICAL GEL 5-1-2 % (imiquimod/levocetirizine dihydrochloride/niacinamide)	Tier 3	
QUIDROXZAR TOPICAL GEL 5-0.1-30 % (imiquimod/tretinoin/salicylic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
QUIHOXAXIA TOPICAL GEL 5-1-2 % (imiquimod/levocetirizine dihydrochloride/niacinamide)	Tier 3	
QUIHOXVAR TOPICAL GEL 5-0.05-1 % (imiquimod/tretinoin/levocetirizine dihydrochloride)	Tier 3	
Dermatological - Insect Repellents - Drugs For The Skin		
CUTTER ALL FAMILY TOPICAL AEROSOL,SPRAY 7 % (diethyltoluamide)	Tier 3	
CUTTER ALL FAMILY TOPICAL TOWELETTE 7.15 % (diethyltoluamide)	Tier 3	
CUTTER BACKWOODS DRY TOPICAL AEROSOL,SPRAY 25 % (diethyltoluamide)	Tier 3	
CUTTER SKINSATIONS TOPICAL AEROSOL,SPRAY 7 % (diethyltoluamide)	Tier 3	
CUTTER SKINSATIONS TOPICAL SPRAY,NON- AEROSOL 7 % (diethyltoluamide)	Tier 3	
OFF ACTIVE TOPICAL AEROSOL,SPRAY 15 % (diethyltoluamide)	Tier 3	
OFF DEEP WOODS TOPICAL TOWELETTE 25 % (diethyltoluamide)	Tier 3	
REPEL SPORTSMEN TOPICAL AEROSOL,SPRAY 29 % (diethyltoluamide)	Tier 3	
REPEL TOPICAL TOWELETTE 30 % (diethyltoluamide)	Tier 3	
SAWYER CONTROLLED RELEASE TOPICAL LOTION,EXTENDED RELEASE 20 % (diethyltoluamide)	Tier 3	
Dermatological - Keratolytic Combinations Other - Drugs For The Skin		
METDRAY TOPICAL GEL 17-2 % (salicylic acid/ibuprofen)	Tier 3	
NENDRUX TOPICAL GEL 40-5 % (salicylic acid/lidocaine)	Tier 3	
PRONAL TOPICAL GEL 10-40 % (lactic acid/urea)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URAMAXIN GT TOPICAL KIT, CREAM AND GEL 45 % (urea/emollient combination no.65)	Tier 3	
WAYZEN TOPICAL GEL 40-5 % (salicylic acid/lidocaine)	Tier 3	
WELERIS TOPICAL GEL 17-2 % (salicylic acid/ibuprofen)	Tier 3	
XIRUN TOPICAL GEL 10-40 % (lactic acid/urea)	Tier 3	
Dermatological - Keratolytic-Antimitotic Combinations - Drugs For The Skin		
SALVAX DUO PLUS TOPICAL FOAM 6-35 % (salicylic acid/urea)	Tier 3	
<i>silver nitrate applicators topical stick 75-25 %</i>	Tier 1	
Dermatological - Keratolytic-Antimitotic Single Agents - Drugs For The Skin		
<i>cantharidin in acetone topical solution 0.7 %</i>	Tier 1	
CEM-UREA TOPICAL GEL 45 % (urea)	Tier 1	
CONDYLOX TOPICAL GEL 0.5 % (podofilox)	Tier 3	ST: Requires prior prescription for Podofilox 0.5% solution within the past 120 days; QL (0.5 GM per 1 day)
HYDRO 35 TOPICAL FOAM 35 % (urea)	Tier 3	
HYDRO 40 TOPICAL FOAM 40 % (urea)	Tier 3	
KERALYT TOPICAL SHAMPOO 6 % (salicylic acid)	Tier 3	
PODOCON TOPICAL LIQUID 25 % (podophyllum resin)	Tier 1	
<i>podofilox topical gel 0.5 %</i>	Tier 1	ST: Requires prior prescription for Podofilox 0.5% solution within the past 120 days; QL (0.5 GM per 1 day)
<i>podofilox topical solution 0.5 %</i>	Tier 1	QL (0.5 ML per 1 day)
RAYASAL TOPICAL CREAM 5.9 % (salicylic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RYNODERM TOPICAL CREAM 37.5 % (urea)	Tier 3	
SALICATE TOPICAL LIQUID 10 % (salicylic acid)	Tier 3	
<i>salicylic acid topical cream 6 %</i>	Tier 1	
<i>salicylic acid topical cream,extended release 6 %</i>	Tier 1	
<i>salicylic acid topical film forming liquid w/appl 27.5 %</i>	Tier 1	
<i>salicylic acid topical film-forming soln er w/ appl 28.5 %</i>	Tier 1	
<i>salicylic acid topical foam 6 %</i>	Tier 1	
<i>salicylic acid topical gel 6 %</i>	Tier 3	
<i>salicylic acid topical liquid 26 %</i>	Tier 1	
<i>salicylic acid topical lotion 6 %</i>	Tier 1	
<i>salicylic acid topical lotion,extended release 6 %</i>	Tier 1	
<i>salicylic acid topical ointment 3 %</i>	Tier 3	
<i>salicylic acid topical shampoo 6 %</i>	Tier 1	
<i>salicylic acid-ceramides no.1 topical kit,cleanser and cream er 6 %</i>	Tier 3	
SALIMEZ FORTE TOPICAL CREAM 10 % (salicylic acid)	Tier 3	
SALIMEZ TOPICAL CREAM 6 % (salicylic acid)	Tier 3	
SALVAX TOPICAL FOAM 6 % (salicylic acid)	Tier 1	
SALYCIM TOPICAL CREAM 6 % (salicylic acid)	Tier 3	
SALYNTRA TOPICAL GEL 6 % (salicylic acid)	Tier 3	
TRI-CHLOR TOPICAL SOLUTION 80 % (trichloroacetic acid)	Tier 3	
<i>trichloroacetic acid topical recon soln 100 %, 20 %, 25 %, 30 %, 35 %, 40 %, 50 %, 75 %, 80 %, 90 %</i>	Tier 3	
ULTRASAL-ER TOPICAL FILM-FORMING SOLN ER W/ APPL 28.5 % (salicylic acid)	Tier 3	
URAMAXIN GT TOPICAL GEL 45 % (urea)	Tier 3	
URAMAXIN TOPICAL CREAM 45 % (urea)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URAMAXIN TOPICAL FOAM 20 % (urea)	Tier 3	
URAMAXIN TOPICAL GEL 45 % (urea)	Tier 3	
URAMAXIN TOPICAL LOTION 45 % (urea)	Tier 3	
UREA NAIL STICK TOPICAL SOLUTION 50 % (urea)	Tier 1	
<i>urea topical cream 39 %, 40 %, 45 %, 47 %, 50 %</i>	Tier 1	
<i>urea topical cream 39.5 %</i>	Tier 3	
<i>urea topical cream 41 %</i>	Tier 3	
<i>urea topical foam 35 %</i>	Tier 1	
<i>urea topical gel 45 %</i>	Tier 1	
<i>urea topical lotion 40 %</i>	Tier 3	
VIRASAL TOPICAL FILM FORMING LIQUID W/APPL 27.5 % (salicylic acid)	Tier 3	
XALIX TOPICAL FILM-FORMING SOLN ER W/ APPL 28 % (salicylic acid)	Tier 3	
XUREA TOPICAL CREAM 39 % (urea)	Tier 3	
YCANTH TOPICAL SOLUTION WITH APPLICATOR 0.7 % (cantharidin)	Tier 3	PA
Dermatological - Keratoplastic Tar Products - Drugs For The Skin		
<i>coal tar topical solution 20 %</i>	Tier 3	
Dermatological - Local Anesthetic Combinations - Drugs For The Skin		
ANODYNE LPT TOPICAL KIT 2.5-2.5 % (lidocaine/prilocaine)	Tier 3	
CETACAINE TOPICAL AEROSOL, SPRAY 2 %-2 %-14 % (200 MG/SEC) (tetracaine/benzocaine/butamben)	Tier 3	
DOLOTRANZ TOPICAL KIT, CREAM AND GEL 4-2.5-2.5 % (lidocaine/prilocaine)	Tier 3	
ELEMAR TOPICAL KIT 5-6 % (lidocaine/menthol)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENZNONUTY TOPICAL OINTMENT 10-10-20 % (lidocaine/tetracaine/benzocaine)	Tier 3	
ILIDERM TOPICAL SPRAY, NON-AEROSOL (lidocaine HCl/palm oil)	Tier 3	
<i>lidocaine-prilocaine topical cream 2.5-2.5 %</i>	Tier 1	
<i>lidocaine-prilocaine topical kit 2.5-2.5 %</i>	Tier 3	
LMR PLUS TOPICAL KIT 5-6 % (lidocaine/menthol)	Tier 3	
MENTHO-CAINE TOPICAL KIT, OINTMENT AND SPRAY 5-8 % (lidocaine/menthol)	Tier 3	
NOBELA TOPICAL OINTMENT 10-10-20 % (lidocaine/tetracaine/benzocaine)	Tier 3	
PAINGO KFT TOPICAL CREAM 2.5-2.5-30-10 % (lidocaine/prilocaine/methyl salicylate/menthol)	Tier 3	
SOLUPAK TOPICAL KIT, OINTMENT AND SPRAY 5-10-3 % (lidocaine/methyl salicylate/menthol)	Tier 3	
SYNTHERMA PLUS TOPICAL KIT 5-6 % (lidocaine/menthol)	Tier 3	
WPR PLUS TOPICAL KIT, CREAM AND GEL 4-30-10 % (lidocaine HCl/methyl salicylate/menthol)	Tier 3	
Dermatological - Local Anesthetic Gas Combinations - Drugs For The Skin		
ACCUCAINE KIT KIT 10 MG/ML (1 %) (lidocaine HCl/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
CRYODOSE TA MEDIUM STREAM SPR TOPICAL AEROSOL, SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
CRYODOSE TA MIST SPRAY TOPICAL AEROSOL, SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
HURRI-FREEZE TOPICAL AEROSOL, SPRAY (vapocoolant device)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAIN EASE MEDIUM STREAM SPRAY TOPICAL AEROSOL,SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
PAIN EASE MIST SPRAY TOPICAL AEROSOL,SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
SPRAY AND STRETCH TOPICAL AEROSOL,SPRAY (norflurane/pentafluoropropane (HFC 245fa))	Tier 3	
Dermatological - Local Anesthetic Gas Single Agents - Drugs For The Skin		
<i>ethyl chloride topical aerosol,spray 100 %</i>	Tier 1	
Dermatological - Mammalian Target Of Rapamycin (Mtor) Inhibitors - Drugs For The Skin		
HYFTOR TOPICAL GEL 0.2 % (sirolimus)	Tier 3	PA
Dermatological - Miscellaneous Combinations - Drugs For The Skin		
KEFUNOVA TOPICAL CREAM 5-0.005 % (fluorouracil/calcipotriene)	Tier 3	
Dermatological - Miscellaneous Single Agents - Drugs For The Skin		
MUSCUSOLICE TOPICAL CREAM, METERED-DOSE APPLICATOR 2 %, 5 % (baclofen)	Tier 3	
NEURAPTINE TOPICAL CREAM, METERED-DOSE APPLICATOR 10 % (gabapentin)	Tier 3	
Dermatological - Nsaid And Local Anesthetic Combination - Drugs For The Skin		
DICLOVIX TOPICAL KIT, PATCH, SOLUTION DROPS 1.5-2.5-4-2 % (diclofenac sodium/lidocaine/methyl salicylate/camphor)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological - Nsaid Combinations - Drugs For The Skin		
CAPSFENAC PAK TOPICAL KIT, CREAM AND SOLUTION 1.5-0.025 % (diclofenac sodium/capsaicin)	Tier 3	
CAPSINAC TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DERMACINRX LEXITRAL TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DICLOFEX DC TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DICLOGEN TOPICAL KIT 1.5-10-4 % (diclofenac sodium/menthol/camphor)	Tier 3	
DICLOPR TOPICAL COMBO PACK,CREAM AND GEL 1-30-10 % (diclofenac sodium/methyl salicylate/menthol)	Tier 3	
DICLOSAICIN TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DICLOTAL TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
DICLOTREX TOPICAL KIT 1.5-10-4 % (diclofenac sodium/menthol/camphor)	Tier 3	
DIMENTHO TOPICAL KIT 1.5-10 % (diclofenac sodium/menthol/kinesiology tape)	Tier 3	
DITHOL TOPICAL COMBO PACK 1.5-10 % (diclofenac sodium/menthol)	Tier 3	
FENOVAR TOPICAL KIT, CREAM AND SOLUTION 1.5-15-10 % (diclofenac sodium/methyl salicylate/menthol)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ICLOFENAC CP TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
INFLAMMA-K TOPICAL KIT, PATCH, SOLUTION DROPS 1.5-10-6-3.1 % (diclofenac sodium/methyl salicylate/menthol/camphor)	Tier 3	
KERAXA TOPICAL GEL 3-2-4 % (diclofenac sodium/hyaluronate sodium/niacinamide)	Tier 3	
ORTHAPHEN TOPICAL KIT, CREAM AND SOLUTION 1.5-15-10 % (diclofenac sodium/methyl salicylate/menthol)	Tier 3	
ROAOXIA TOPICAL GEL 3-2-4 % (diclofenac sodium/hyaluronate sodium/niacinamide)	Tier 3	
SURE RESULT DSS PREMIUM PACK TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
VAROPHEN (DICLOFENAC) TOPICAL KIT, CREAM AND SOLUTION 1.5-15-10 % (diclofenac sodium/methyl salicylate/menthol)	Tier 3	
ZICLOCIN TOPICAL KIT, CREAM AND SOLUTION 1.5-0.025 % (diclofenac sodium/capsaicin)	Tier 3	
ZICLOPRO TOPICAL COMBO PACK,SOLUTION AND CREAM 1.5-0.025 % (diclofenac sodium/capsicum oleoresin)	Tier 3	
Dermatological - Nsaid Single Agents - Drugs For The Skin		
<i>diclofenac epolamine transdermal patch 12 hour 1.3 %</i>	Tier 1	
<i>diclofenac sodium topical drops 1.5 %</i>	Tier 1	
<i>diclofenac sodium topical gel 1 %</i>	Tier 1	
<i>diclofenac sodium topical solution in metered-dose pump 20 mg/gram /actuation(2 %)</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DICLOFONO TOPICAL GEL IN PACKET 1.6 % (diclofenac sodium)	Tier 3	
FLECTOR TRANSDERMAL PATCH 12 HOUR 1.3 % (diclofenac epolamine)	Tier 3	
FROTEK TOPICAL CREAM IN PACKET 10 % (ketoprofen)	Tier 3	
FROTEK TOPICAL CREAM, METERED-DOSE APPLICATOR 10 % (ketoprofen, micronized)	Tier 3	
LEFLUNICLO KIT,GEL AND TABLET 20 MG- 1 % (leflunomide/diclofenac sodium)	Tier 3	
LICART TRANSDERMAL PATCH 24 HOUR 1.3 % (diclofenac epolamine)	Tier 3	ST: Requires prior prescription for generic Flector patch within the past 120 days; QL (1 EA per 1 day)
PROFINAC TOPICAL KIT 1.5 % (diclofenac sodium/kinesiology tape)	Tier 3	
VENNGEL II TOPICAL KIT 1 % (diclofenac sodium)	Tier 3	
VENNGEL ONE TOPICAL KIT 1 % (diclofenac sodium)	Tier 3	
XRYLIX (DICLOFENAC-KINES TAPE) TOPICAL KIT 1.5 % (diclofenac sodium/kinesiology tape)	Tier 3	
Dermatological - Photodynamic Therapy Agents Topical - Drugs For The Skin		
AMELUZ TOPICAL GEL 10 % (aminolevulinic acid HCl)	Tier 3	
LEVULAN TOPICAL SOLUTION 20 % (aminolevulinic acid HCl)	Tier 3	
Dermatological - Protectant Combinations - Drugs For The Skin		
JUVAZIN TOPICAL GEL (dimethicone/dimethicone crosspolymer/trimethylsiloxysilicate)	Tier 3	
NEW SKIN BOTANICALS TOPICAL FILM FORMING LIQUID W/APPL (protectives combination no.7)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEW SKIN KIDS TOPICAL FILM FORMING LIQUID W/APPL (protectives combination no.9)	Tier 3	
NEW SKIN SENSITIVE TOPICAL FILM FORMING LIQUID W/APPL (protectives combination no.8)	Tier 3	
PR CREAM TOPICAL CREAM (protectives combination no.2/ceramides 1,3,6-II)	Tier 1	
PROSILK GEL TOPICAL GEL (protectives combination no.6)	Tier 3	
RADIAPLEXRX TOPICAL GEL (hyaluronate sodium/allantoin/aloe vera extract)	Tier 3	
RECEDO TOPICAL GEL (polydimethylsiloxanes/silicon dioxide)	Tier 3	
SCARSILK GEL TOPICAL GEL (protectives combination no.6)	Tier 3	
SCARTRATE TOPICAL CREAM 5-2.25 % (dimethicone/allantoin)	Tier 3	
WOUNDGELHA MATRIX TOPICAL GEL 2.5 % (hyaluronate sodium/hydroxyethylcellulose/polyethylene glycol)	Tier 3	
Dermatological - Protectants - Drugs For The Skin		
<i>benzoin (bulk) topical tincture</i>	Tier 3	
DERMELLE TOPICAL GEL (dimethicone)	Tier 3	
DERPIXA TOPICAL GEL (dimethicone)	Tier 3	
PHARMABASE BARRIER TOPICAL OINTMENT 9.38 % (zinc oxide)	Tier 3	
SAFRYCYN TOPICAL CREAM 0.2 % (hyaluronate sodium)	Tier 3	
SCARCARE TOPICAL KIT 2 X 5.5 " (gel-matrix pad,silicone-dimethicone-dime-decameoct-oct-vit E)	Tier 3	
STRATAMARK TOPICAL GEL (dimethicone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STRATATRIZ TOPICAL GEL (dimethicone)	Tier 3	
VASELINE WHITE PETROLEUM TOPICAL OINTMENT IN PACKET (petrolatum,white)	Tier 1	
<i>zinc oxide topical ointment 20 %</i>	Tier 3	
<i>zinc oxide topical paste 25 %</i>	Tier 3	
Dermatological - Retinoids (Vitamin A Derivatives) - Topical Cosmetic - Drugs For The Skin		
<i>tazarotene topical cream 0.1 %</i>	Tier 1	
Dermatological - Rosacea Therapy, Systemic - Drugs For The Skin		
<i>doxycycline monohydrate oral capsule,ir - delay rel,biphase 40 mg</i>	Tier 1	
EMROSI ORAL CAPSULE,IR -EXTEND REL,BIPHASE 40 MG (minocycline HCl)	Tier 3	
ORACEA ORAL CAPSULE,IR - DELAY REL,BIPHASE 40 MG (doxycycline monohydrate)	Tier 3	
Dermatological - Rosacea Therapy, Topical - Drugs For The Skin		
AVEIDA TOPICAL GEL 1-1 % (ivermectin/metronidazole)	Tier 3	
AVEIDAOXIA TOPICAL GEL 1-1-4 % (ivermectin/metronidazole/niacinamide)	Tier 3	
<i>azelaic acid topical gel 15 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AZELEX TOPICAL CREAM 20 % (azelaic acid)	Tier 3	ST: Requires prior prescription for one generic topicals: sulfacetamide+/- sulfur, clindamycin+/- benzoyl peroxide, erythromycin+/- benzoyl peroxide, adapalene+/- benzoyl peroxide, or tretinoin within the past 120 days
BAXONIL TOPICAL OINTMENT 1-2 % (metronidazole/mupirocin)	Tier 3	
<i>brimonidine topical gel with pump 0.33 %</i>	Tier 1	
CLEANSING WASH TOPICAL CLEANSER 10-4-10 % (sulfacetamide sodium/sulfur/urea)	Tier 1	
DAZAVEIDAOXIA TOPICAL GEL 0.25-1-1-4 % (brimonidine tartrate/ivermectin/metronidazole/niacinamide)	Tier 3	
DAZOMON TOPICAL GEL 0.25 % (brimonidine tartrate)	Tier 3	
EPSOLAY TOPICAL CREAM 5 % (benzoyl peroxide)	Tier 3	ST: Requires prior prescription for generic topical Metronidazole within the past 120 days; QL (30 GM per 30 days); Age (Min 18 Years)
FINACEA TOPICAL FOAM 15 % (azelaic acid)	Tier 2	
IDARAN TOPICAL OINTMENT 1-2 % (metronidazole/mupirocin)	Tier 3	
<i>ivermectin topical cream 1 %</i>	Tier 1	ST: Requires prior prescription for Finacea gel or foam within the past 120 days
METROCREAM TOPICAL CREAM 0.75 % (metronidazole)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METROGEL TOPICAL GEL 1 % (metronidazole)	Tier 3	
METROLOTION TOPICAL LOTION 0.75 % (metronidazole)	Tier 3	
<i>metronidazole topical cream 0.75 %</i>	Tier 1	
<i>metronidazole topical gel 0.75 %, 1 %</i>	Tier 1	
<i>metronidazole topical gel with pump 1 %</i>	Tier 1	
<i>metronidazole topical lotion 0.75 %</i>	Tier 1	
MIRVASO TOPICAL GEL WITH PUMP 0.33 % (brimonidine tartrate)	Tier 3	
NORITATE TOPICAL CREAM 1 % (metronidazole)	Tier 3	ST: Requires prior prescription for Metronidazole 0.75% gel, lotion, or cream within the past 120 days
REMYDA TOPICAL GEL 0.25 % (brimonidine tartrate)	Tier 3	
RESTIMO TOPICAL GEL 1-1 % (ivermectin/metronidazole)	Tier 3	
RHOFADE TOPICAL CREAM 1 % (oxymetazoline HCl)	Tier 3	
metronidazole (Rosadan Topical Cream 0.75 %)	Tier 1	
metronidazole (Rosadan Topical Gel 0.75 %)	Tier 3	
ROSDAN TOPICAL KIT, CLEANSER AND GEL 0.75 % (metronidazole/skin cleanser combination no.23)	Tier 3	
ROSDAN TOPICAL KIT, CLEANSER AND CREAM 0.75 % (metronidazole/skin cleanser combination no.23)	Tier 3	
ROSITARA TOPICAL GEL 1-1-4 % (ivermectin/metronidazole/niacinamide)	Tier 3	
ROVIS TOPICAL GEL 0.25-1-1-4 % (brimonidine tartrate/ivermectin/metronidazole/niacinamide)	Tier 3	
SOOLANTRA TOPICAL CREAM 1 % (ivermectin)	Tier 3	ST: Requires prior prescription for Finacea gel or foam within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfacetamide sod-sulfur-urea topical cleanser 10-5-10 %</i>	Tier 1	QL (1419 ML per 1 FILL)
SUMADAN XLT TOPICAL COMBO PACK,CLEANSER AND CREAM 9 %-4.5 % -SPF 25 (sulfacetamide sodium/sulfur/avobenzone/octinoxate/octyl sal)	Tier 3	
ZILXI TOPICAL FOAM 1.5 % (minocycline HCl)	Tier 3	ST: Requires prior prescription for generic topical Metronidazole within the past 120 days; QL (30 GM per 30 days)
Dermatological - Soap And/Or Cleanser Combinations - Drugs For The Skin		
CETAPHIL GENTLE SKIN CLEANSER TOPICAL CLEANSER (skin cleanser combination no.42)	Tier 3	
GENTLE SKIN CLEANSER TOPICAL CLEANSER (skin cleanser combination no.43)	Tier 3	
GENTLE SKIN CLEANSER(WITH SLS) TOPICAL CLEANSER (skin cleanser combination no.10)	Tier 3	
TECNU TOPICAL CLEANSER (skin cleanser combination no.41)	Tier 3	
Dermatological - Sunscreens - Drugs For The Skin		
CERAVE AM TOPICAL LOTION 30 SPF (homosalate/meradimate/octinoxate/octocrylene/zinc oxide)	Tier 3	
Dermatological - Tissue/Wound Adhesives - Fibrin Sealants - Drugs For The Skin		
ARTISS TOPICAL SYRINGE 2.5 TO 6.5 UNIT/ML (10ML), 2.5 TO 6.5 UNIT/ML (2 ML), 2.5 TO 6.5 UNIT/ML (4 ML) (thrombin(hum plas)/fibrinogen/aprotinin,syn/calcium chloride)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TISSEEL VHSD (APROTININ, SYN) TOPICAL KIT 10 ML, 2 ML, 4 ML (thrombin(hum plas)/fibrinogen/aprotinin,syn/calcium chloride)	Tier 3	
TISSEEL VHSD (APROTININ, SYN) TOPICAL SYRINGE 10 ML, 2 ML, 4 ML (thrombin(hum plas)/fibrinogen/aprotinin,syn/calcium chloride)	Tier 3	
Dermatological - Topical Local Anesthetic Amides - Drugs For The Skin		
ANASTIA TOPICAL LOTION 2.75 % (lidocaine HCl)	Tier 3	
ASTERO TOPICAL GEL WITH PUMP 4 % (lidocaine HCl)	Tier 3	
lidocaine (Dermacinx Lidocan Topical Adhesive Patch,Medicated 5 %)	Tier 1	QL (90 EA per 30 days)
DERMACINRX LIDOGEL TOPICAL GEL 2.8 % (lidocaine HCl)	Tier 3	
DERMACINRX LIDOREX TOPICAL GEL 2.8 % (lidocaine HCl)	Tier 3	
DERMALID TOPICAL COMBO PACK 5 % (lidocaine/elastic bandage)	Tier 3	
lidocaine HCl (Glydo Mucous Membrane Jelly In Applicator 2 %)	Tier 1	
L.E.T. (LIDO-EPINEPH-TETRA) TOPICAL GEL 4-0.05-0.5 % (lidocaine HCl/racepinephrine HCl/tetracaine HCl)	Tier 1	
L.E.T. (LIDO-EPINEPH-TETRA) TOPICAL SOLUTION 4-0.05-0.5 % (lidocaine HCl/racepinephrine HCl/tetracaine HCl)	Tier 1	
L.E.T.(LIDO-EPINEPH BIT-TETRA) TOPICAL GEL 4-0.09-0.5 % (lidocaine HCl/epinephrine bitartrate/tetracaine HCl)	Tier 1	
L.E.T.(LIDO-EPINEPH BIT-TETRA) TOPICAL GEL 4-0.18-0.5 % (lidocaine HCl/epinephrine bitartrate/tetracaine HCl)	Tier 3	
LDO PLUS TOPICAL GEL WITH PUMP 4 % (lidocaine HCl)	Tier 3	
<i>lidocaine hcl mucous membrane jelly 2 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine hcl mucous membrane jelly in applicator 2 %</i>	Tier 1	
<i>lidocaine hcl topical cream 3 %</i>	Tier 1	
<i>lidocaine topical adhesive patch,medicated 5 %</i>	Tier 1	QL (90 EA per 30 days)
<i>lidocaine topical ointment 5 %</i>	Tier 1	QL (240 GM per 30 days)
<i>lidocaine-racepinep-tetracaine topical solution 4-0.05-0.5 %</i>	Tier 1	
<i>lidocaine-tetracaine topical cream 7-7 %</i>	Tier 3	
lidocaine (Lidocan Iii Topical Adhesive Patch,Medicated 5 %)	Tier 1	QL (90 EA per 30 days)
lidocaine (Lidocan Iv Topical Adhesive Patch,Medicated 5 %)	Tier 1	QL (90 EA per 30 days)
lidocaine (Lidocan V Topical Adhesive Patch,Medicated 5 %)	Tier 1	QL (90 EA per 30 days)
LIDODERM TOPICAL ADHESIVE PATCH,MEDICATED 5 % (lidocaine)	Tier 3	QL (90 EA per 30 days)
LIDOPIN TOPICAL CREAM 3 %, 3.25 % (lidocaine HCl)	Tier 3	
LIDOPURE PATCH TOPICAL COMBO PACK 5 % (lidocaine/kinesiology tape)	Tier 3	
LIDORX TOPICAL GEL WITH PUMP 3 % (lidocaine HCl)	Tier 3	
LIDTOPIC MAX TOPICAL CREAM, METERED-DOSE APPLICATOR 10 % (lidocaine)	Tier 3	
LIDTOPIC TOPICAL CREAM, METERED-DOSE APPLICATOR 7.5 % (lidocaine)	Tier 3	
MOXICAINE TOPICAL KIT 5 % (lidocaine)	Tier 3	
NOLIRA TOPICAL CREAM 23-7 % (lidocaine/tetracaine)	Tier 3	
NUMBONEX TOPICAL LOTION 2.75 % (lidocaine HCl)	Tier 3	
NYNUTEY TOPICAL CREAM 23-7 % (lidocaine/tetracaine)	Tier 3	
PROXIVOL TOPICAL GEL 2 % (lidocaine HCl/collagen)	Tier 3	
REGENECARE TOPICAL GEL 2 % (lidocaine HCl/collagen)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REGENECARE WITH ALOE TOPICAL GEL 2 % (vitamin E/lidocaine/aloe vera/collagen)	Tier 3	
TRANZAREL TOPICAL GEL 4 % (lidocaine)	Tier 3	
XYLIDERM TOPICAL KIT 5 % (lidocaine/kinesiology tape)	Tier 3	
ZILACAINE PATCH TOPICAL COMBO PACK 5 % (lidocaine/silicone, adhesive)	Tier 3	
ZILOVAL TOPICAL KIT 5 % (lidocaine)	Tier 3	
ZTLIDO TOPICAL ADHESIVE PATCH,MEDICATED 1.8 % (lidocaine)	Tier 3	ST: Requires prior prescription for Lidoderm 5% patch within the past 120 days; QL (90 EA per 30 days)
Dermatological - Topical Local Anesthetic Esters - Drugs For The Skin		
ANACAINE TOPICAL OINTMENT 10 % (benzocaine)	Tier 3	
Dermatological - Topical Local Anesthetic Others - Drugs For The Skin		
DYCLOPRO TOPICAL SOLUTION 0.5 % (dyclonine HCl)	Tier 3	
PRAKETAMIDE TOPICAL CREAM, METERED-DOSE APPLICATOR 5 % (ketamine HCl)	Tier 3	
Dermatological - Topical Local Anesthetics And Combinations - Drugs For The Skin		
DERMACINRX PHN PAK TOPICAL KIT, PATCH, MEDICATED, CREAM 5 % (lidocaine/emollient combination no.102)	Tier 3	
DERMACINRX ZRM PAK TOPICAL KIT, PATCH, MEDICATED, CREAM 5-5 % (lidocaine/dimethicone)	Tier 3	
PRILO PATCH TOPICAL KIT, PATCH, MEDICATED, CREAM 5-2.5-2.5 % (lidocaine/prilocaine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Dermatological Antipruritics - Antihistamines - Drugs For The Skin		
<i>doxepin topical cream 5 %</i>	Tier 3	ST: Requires prior prescription for a topical corticosteroid within the past 120 days
Dermatological Antipruritics Other - Drugs For The Skin		
LEVICYN ANTIPRURITIC TOPICAL GEL (sod Mg fluo/sodium phos/NaCl/hypochlorous acid/sod hypochlor)	Tier 3	
Dermatological Irritants-Counter-Irritant Combinations - Drugs For The Skin		
CHEST RUB (WITH PINE OIL) TOPICAL OINTMENT (eucalyptus oil/lavender oil/pine needle oil/beeswax)	Tier 3	
Dermatological Irritants-Counter-Irritant Single Agents - Drugs For The Skin		
<i>methyl salicylate oil</i>	Tier 3	
<i>methyl salicylate topical liquid</i>	Tier 3	
QUTENZA TOPICAL KIT 8 % (capsaicin/skin cleanser)	Tier 3	PA
WINTERGREEN OIL OIL (methyl salicylate)	Tier 3	
Human Cellular Regenerative Tissue Matrix - Drugs For The Skin		
EPIFIX AMNIOTIC MEMBRANE TOPICAL SHEET 14 MM, 2 X 3 CM, 4 X 4 CM, 7 X 7 CM (human regenerative tissue matrix)	Tier 3	
GRAFIX CORE TOPICAL SHEET 1.5 X 2 CM, 14 MM, 16 MM, 2 X 3 CM, 3 X 4 CM, 5 X 5 CM (human regenerative tissue matrix)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GRAFIX PRIME TOPICAL SHEET 1.5 X 2 CM, 14 MM, 16 MM, 2 X 3 CM, 3 X 4 CM, 5 X 5 CM (human regenerative tissue matrix)	Tier 3	
GRAFIX XC TOPICAL SHEET 7.5 X 15 CM (human regenerative tissue matrix)	Tier 3	
STRAVIX TOPICAL SHEET 2 X 4 CM, 3 X 6 CM (human regenerative tissue matrix)	Tier 3	
TRUSKIN TOPICAL SHEET 2 X 4 CM, 4 X 8 CM (human regenerative tissue matrix)	Tier 3	
Nail Protectives - Drugs For The Skin		
GENADUR (WITH LEXINAL) KIT 2,500 MCG (biotin/carbitol/equisetum xt/ethanol/hydroxypropyl chito/msm)	Tier 3	
GENADUR TOPICAL LIQUID (carbitol/equisetum ext/ethanol/hydroxypropyl chitosan/msm)	Tier 3	
Ovine (Sheep) Skin Dressings, Non-Living - Drugs For The Skin		
KERAMATRIX TOPICAL SHEET 2 X 2 ", 3/4 X 1 ", 4 X 4 " (tissue matrix, keratin-based, ovine derived)	Tier 3	
Porcine Skin Dressings, Non-Living - Drugs For The Skin		
MIRO3D FIBERS TOPICAL POWDER 100 MG, 500 MG, 700 MG (extracellular matrix (ecm), porcine derived)	Tier 3	
MIRO3D TOPICAL SHEET 10 X 5 X 2 CM, 2 X 2 X 2 CM, 3 X 3 X 2 CM, 4 X 4 X 2 CM, 5 X 5 X 2 CM, 7 X 5 X 2 CM (extracellular matrix (ecm), porcine derived)	Tier 3	
MIRODERM FENESTRATED PLUS TOPICAL SHEET 3 X 3 CM, 5 X 5 CM, 8 X 15 CM, 8 X 8 CM (extracellular matrix (ECM),porcine derived,fenestrated)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIRODERM FENESTRATED TOPICAL SHEET 2 X 2 CM, 2 X 3 CM, 3 X 3 CM, 4 X 4 CM, 5 X 5 CM, 8 X 15 CM, 8 X 8 CM (extracellular matrix (ECM), porcine derived, fenestrated)	Tier 3	
MIRODRY WOUND MATRIX TOPICAL SHEET 10 X 5 CM, 2 X 2 CM, 3 X 3 CM, 4 X 4 CM, 5 X 5 CM, 5 X 7 CM (extracellular matrix (ecm), porcine derived)	Tier 3	
MIROTRACT TOPICAL SHEET 3 MM X 5 CM, 3 MM X 9 CM, 5 MM X 5 CM, 5 MM X 9 CM (extracellular matrix (ecm), porcine derived)	Tier 3	
XCELLISTEM TOPICAL POWDER 250 MG (extracellular matrix (ecm), porcine derived)	Tier 3	
Scabicide And Pediculicide Combinations - Drugs For The Skin		
NIX LICE PREVENTION TOPICAL SPRAY, NON-AEROSOL 0.06-0.35-0.6 % (rosemary oil/lemongrass/citronella oil)	Tier 3	
Scabicide And Pediculicide Single Agents - Drugs For The Skin		
crotamiton (Crotan Topical Lotion 10 %)	Tier 3	
ELIMITE TOPICAL CREAM 5 % (permethrin)	Tier 3	
EURAX TOPICAL CREAM 10 % (crotamiton)	Tier 3	
EURAX TOPICAL LOTION 10 % (crotamiton)	Tier 3	
LICE-BEDBUG-MITE BEDDING AEROSOL, SPRAY 0.5 % (permethrin)	Tier 3	
<i>malathion topical lotion 0.5 %</i>	Tier 1	
NATROBA TOPICAL SUSPENSION 0.9 % (spinosad)	Tier 3	
OVIDE TOPICAL LOTION 0.5 % (malathion)	Tier 3	
<i>permethrin topical cream 5 %</i>	Tier 1	
crotamiton (Pruradik Topical Lotion 10 %)	Tier 3	
<i>spinosad topical suspension 0.9 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULESFIA TOPICAL LOTION 5 % (benzyl alcohol)	Tier 3	
Skin Replacement, Live Tissue Dressings - Drugs For The Skin		
APLIGRAF TOPICAL DISK (cultured skin substitute,human and bovine)	Tier 3	
OASIS ULTRA FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX MESHED TOPICAL SHEET 5 X 7 CM, 7 X 10 CM, 7 X 20 CM (porcine acell submucosa,meshed)	Tier 3	
Wound Care - Cleanser Combinations - Drugs For The Skin		
ATRAPRO DERMAL SPRAY TOPICAL SPRAY, NON-AEROSOL 0.003-0.004 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
DELUXO TOPICAL SPRAY, NON-AEROSOL 0.018 %-0.004 % -0.06 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
EPICYN TOPICAL SPRAY, NON-AEROSOL (hypochlorous acid/sodium chloride/sodium phosphate)	Tier 3	
HYCLODEX TOPICAL SPRAY, NON-AEROSOL 0.012 %-0.002 % -0.046 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
HYPOCYN ANTIPRURITIC TOPICAL SPRAY GEL 0.012 % (hypochlorous acid/sodhypochlor/sod chlor/sodmagfluo/e.water)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYPOCYN DERMAL TOPICAL SPRAY, NON-AEROSOL 0.012 %-0.002 %-0.046 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
LEVICYN DERMAL TOPICAL SPRAY, NON-AEROSOL 0.009 % (hypochlorous acid/sod chlor/sod sulfate/sod phosphate, mono)	Tier 3	
MICROCYN TOPICAL SPRAY, NON-AEROSOL 0.003 %-0.004 %-0.023 % (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
RENOVAR IRRIGATION IRRIGATION SOLUTION (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
RENOVAR TOPICAL SOLUTION (hypochlorous acid/sodium hypochlorite/sod chlorid/elec.water)	Tier 3	
Wound Care - Cleansers - Drugs For The Skin		
SIMPLY SALINE WOUND WASH TOPICAL AEROSOL, SPRAY 0.9 % (sodium chloride)	Tier 3	
VASHE IRRIGATION IRRIGATION SOLUTION 0.033 % (sodium chloride irrigating solution/hypochlorous acid)	Tier 3	
Wound Care - Dressings - Drugs For The Skin		
ACESO AG TOPICAL BANDAGE 4 X 4 " (silver/silicone/foam bandage)	Tier 3	
ACTICOAT 7 DRESSING TOPICAL BANDAGE 2 X 2 ", 4 X 5 ", 6 X 6 " (silver)	Tier 3	
ACTICOAT DRESSING TOPICAL BANDAGE 16 X 16 ", 2 X 2 ", 4 X 4 ", 4 X 48 ", 4 X 8 ", 5 X 5 ", 8 X 16 " (silver)	Tier 3	
ACTICOAT FLEX 3 DRESSING TOPICAL BANDAGE 16 X 16 ", 2 X 2 ", 4 X 4 ", 4 X 48 ", 4 X 8 ", 8 X 16 " (silver)	Tier 3	
ACTICOAT FLEX 7 DRESSING TOPICAL BANDAGE 1 X 24 ", 16 X 16 ", 2 X 2 ", 4 X 5 ", 6 X 6 ", 8 X 16 " (silver)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLEVYN ADHESIVE DRESSING TOPICAL BANDAGE 7 X 7 " (foam bandage)	Tier 3	
ALLEVYN AG ADHESIVE TOPICAL BANDAGE 5 %- 3" X 3", 5 %- 5" X 5", 5 %- 7" X 7" (silver sulfadiazine/foam bandage)	Tier 3	
ALLEVYN LIFE DRESSING TOPICAL BANDAGE 4 X 4 " (foam bandage)	Tier 3	
BIOSTEP AG TOPICAL BANDAGE 2 X 2 ", 4 X 4 " (dressing, collagen/silver/sod alginate/carboxymethylcellulose)	Tier 3	
BIOSTEP TOPICAL BANDAGE 2 X 2 ", 4 X 4 " (dressing, collagen/sodium alginate/carboxymethylcellulose)	Tier 3	
CARRASYN HYDROGEL WOUND DRESS TOPICAL GEL (gel dressing)	Tier 3	
COLLATYL TOPICAL GEL 1 % (collagen, hydrolysate (bovine)/silver oxide)	Tier 3	
CURAFIL GEL WOUND TOPICAL GEL (gel dressing)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL SPONGE 0.2 %- 2" X 2" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL STRIP 0.2 %- 1/2" X 3 FEET (polyhexamethylene biguanide/gauze bandage)	Tier 3	
DYNAFOAM AG TOPICAL BANDAGE 4 X 4 " (silver/foam bandage)	Tier 3	
DYNAGINATE AG TOPICAL BANDAGE 12 ", 2 X 2 ", 4 X 5 ", 4 X 8 " (silver/calcium alginate)	Tier 3	
KERAGEL TOPICAL GEL (gel dressing)	Tier 3	
KERAGELT TOPICAL GEL (gel dressing)	Tier 3	
KERLIX AMD TOPICAL BANDAGE 0.2 %- 4.5" X 4.1 YARD (polyhexamethylene biguanide/gauze bandage)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERLIX AMD TOPICAL SPONGE 0.2 %- 6" X 6.75" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
L-MESITRAN SOFT TOPICAL GEL 40 % (honey)	Tier 3	
MEDIHONEY (CAL ALGINATE-HONEY) TOPICAL BANDAGE 2 X 2 ", 3/4 X 12 ", 4 X 5 " (calcium alginate/honey)	Tier 3	
MEDIHONEY (HONEY) TOPICAL GEL 80 % (honey)	Tier 3	
MEDIHONEY (HONEY) TOPICAL PASTE 100 % (honey)	Tier 3	
OCM TOPICAL OINTMENT IN PACKET (collagen, hydrolyzed/cod liver oil)	Tier 3	
OMEZA TOPICAL OINTMENT IN PACKET (collagen, hydrolyzed/cod liver oil)	Tier 3	
REPLICARE DRESSING TOPICAL BANDAGE 1 1/2 X 2 1/2 " (hydrocolloid dressing)	Tier 3	
REPLICARE THIN TOPICAL BANDAGE 2 X 2 3/4 ", 3 1/2 X 5 1/2 ", 6 X 8 " (hydrocolloid dressing)	Tier 3	
REPLICARE ULTRA DRESSING TOPICAL BANDAGE 4 X 4 ", 7 X 8 " (hydrocolloid dressing)	Tier 3	
RESTORE CALCIUM ALGINATE TOPICAL BANDAGE 4 X 4 3/4 " (silver/calcium alginate)	Tier 3	
RESTORE TOPICAL BANDAGE 1 X 12 ", 2 X 2 " (silver/calcium alginate)	Tier 3	
SILIGENTLE AG TOPICAL BANDAGE 2 X 2 ", 4 X 4 ", 4 X 5 ", 6 X 6 " (silver/silicone/foam bandage)	Tier 3	
SPECTRAGEL TOPICAL GEL (gel dressing)	Tier 3	
STRATACTX TOPICAL GEL (gel dressing)	Tier 3	
STRATAGRT TOPICAL GEL (gel dressing)	Tier 3	
STRATAXRT TOPICAL GEL (gel dressing)	Tier 3	
THERAHONEY TOPICAL BANDAGE 4 X 5 " (honey)	Tier 3	
ZENPHOR TOPICAL BANDAGE 2 X 4.7 " (gel dressing)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZENPHOR TOPICAL GEL (gel dressing)	Tier 3	
Wound Care - Growth Factor Agents - Drugs For The Skin		
REGRANEX TOPICAL GEL 0.01 % (becaplermin)	Tier 2	
Wound Care Combinations Other - Drugs For The Skin		
<i>balsam peru-castor oil topical ointment</i>	Tier 3	
<i>balsam peru-castor oil topical ointment in packet</i>	Tier 3	
BPCO TOPICAL OINTMENT (balsam peru/castor oil)	Tier 3	
DERMACINRX CLORHEXACIN TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
DERMACINRX SURGICAL PHARMAPAK TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
DERMAWERX SURGICAL PLUS PAK TOPICAL KIT 2-4-5 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	
DERMULCERA TOPICAL OINTMENT (balsam peru/castor oil)	Tier 3	
FILSUVEZ TOPICAL GEL 10 % (birch bark extract)	Tier 3	PA
LEVICYN ANTIPRURITIC TOPICAL GEL (sod Mg fluo/sodium phos/NaCl/hypochlorous acid/sod hypochlor)	Tier 3	
VENELEX TOPICAL OINTMENT (balsam peru/castor oil)	Tier 3	
VENELEX TOPICAL OINTMENT IN PACKET (balsam peru/castor oil)	Tier 3	
WHYTEDERM SURGIPAK TOPICAL KIT 2-4-2 % (mupirocin/chlorhexidine glucon/dimethicone/silicone adhesive)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Drugs To Treat Erectile Dysfunction - Drugs For The Urinary System		
Erectile Dysfunction (Ed) Drugs-Sel.Cgmp Phosphodiesterase Type5 Inhib - Drugs For Erectile Dysfunction		
CIALIS ORAL TABLET 10 MG, 20 MG (tadalafil)	Tier 3	PA
CIALIS ORAL TABLET 5 MG (tadalafil)	Tier 3	PA; QL (1 EA per 1 day)
<i>tadalafil oral tablet 10 mg</i>	Tier 1	PA
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	Tier 1	PA; QL (1 EA per 1 day)
<i>tadalafil oral tablet 20 mg</i>	Tier 1	PA; QL (2 EA per 1 day)
Electrolyte Balance-Nutritional Products		
Electrolyte Depleters - Sodium-Hydrogen Exchanger 3 (Nhe3) Inhibitors		
XPHOZAH ORAL TABLET 20 MG, 30 MG (tenapanor HCl)	Tier 3	ST: Requires prior prescriptions for Velphoro and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (2 EA per 1 day)
Electrolyte Balance-Nutritional Products - Drugs For Nutrition		
Amino Acid - Carnitine Derivatives - Drugs For Nutrition		
CARNITEX ORAL CAPSULE 340 MG (levocarnitine tartrate)	Tier 3	
L-CARNITINE (TARTRATE) ORAL CAPSULE 500 MG (levocarnitine tartrate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
L-CARNITINE ORAL CAPSULE 500 MG (levocarnitine)	Tier 3	
<i>levocarnitine oral tablet 330 mg</i>	Tier 1	
<i>levocarnitine tartrate oral capsule 250 mg, 500 mg</i>	Tier 3	
Amino Acid-Amino Acid Combinations, Oral - Drugs For Nutrition		
XYMOBOLX ORAL POWDER (amino acids)	Tier 3	
Amino Acids, Single Ingredient, Oral (Non-Injectable) - Drugs For Nutrition		
<i>arginine (l-arginine) oral capsule 500 mg</i>	Tier 3	
<i>arginine hcl (l-arginine) oral capsule 500 mg</i>	Tier 3	
CITRULLINE 1000 ORAL POWDER IN PACKET 1 GRAM/4 GRAM (citrulline)	Tier 3	
ENDARI ORAL POWDER IN PACKET 5 GRAM (glutamine)	Tier 3	PA
<i>glutamine (sickle cell) oral powder in packet 5 gram</i>	Tier 3	PA
<i>glutamine oral powder 100 %</i>	Tier 3	
ISOLEUCINE 1000 ORAL POWDER IN PACKET 1 GRAM/4 GRAM (isoleucine supplement in carbohydrate base)	Tier 3	
ISOLEUCINE AMINO ACID SUPPLMNT ORAL POWDER IN PACKET 50 MG/4 GRAM (isoleucine supplement in carbohydrate base)	Tier 3	
<i>l-cystine oral packet 0.5-15 g-kcal/4 g</i>	Tier 3	
<i>lysine hcl oral capsule 500 mg</i>	Tier 3	
<i>lysine hcl oral tablet 500 mg</i>	Tier 3	
METHIONINE ORAL POWDER IN PACKET 100 MG/4 GRAM (methionine supplement in carbohydrate base)	Tier 3	
N.O.MAX ER ORAL TABLET EXTENDED RELEASE 660 MG (arginine oxoglurate)	Tier 3	
<i>phenylalanine oral powder in packet 50 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VALINE 1000 ORAL POWDER IN PACKET 1 GRAM/4 GRAM (valine supplement in carbohydrate base)	Tier 3	
VALINE AMINO ACID SUPPLEMENT ORAL PACKET 50 MG/4 GRAM (valine supplement in carbohydrate base)	Tier 3	
B-Complex Vitamin Combinations - Drugs For Nutrition		
B ACTIV ORAL CAPSULE 680 MCG DFE (vitamin B complex/methyltetrahydrofolate glucosamine)	Tier 3	
<i>b complex-vitamin c-folic acid oral tablet 400 mcg</i>	Tier 3	
B-100 COMPLEX ORAL TABLET EXTENDED RELEASE 100 MG (vitamin B complex 100 combination no.2)	Tier 3	
B-50 COMPLEX WITH INOSITOL ORAL CAPSULE 400 MCG-25 MG- 50 MG (vitamin B complex/folic acid/choline bitartrate/inositol)	Tier 3	
<i>b-complex with vitamin c oral tablet</i>	Tier 3	
BIOPETIT ORAL LIQUID 790 MG/15 ML (vitamin B complex/lysine)	Tier 3	
COMPLETE LIVER CLEANSE ORAL CAPSULE 16.7 MG-66.7 MCG-110 MG (vitamin B complex/vit C/folic acid/amino acid/herbal no.351)	Tier 3	
FOLIKA-BC ORAL TABLET 1 MG-60 MG- 300 MCG (vitamin B complex/folic acid/ascorbic acid/biotin)	Tier 3	
MULTIVITAMIN-ZINC-STRESS ORAL TABLET 500 MG-400 MCG- 23.9 MG-3 MG (B comp/C/folic acid/zinc sulfate/cupric sulfate/vitamin E ac)	Tier 3	
NEPHRO VITAMINS ORAL TABLET 0.8 MG (folic acid/vitamin B complex and vitamin C)	Tier 3	
NEPHRON FA ORAL TABLET 66 MG IRON- 1,000 MCG (vit B complex and vit C no.24/ferrous fumarate/folic acid)	Tier 3	
NEPHRO-VITE ORAL TABLET 0.8 MG (folic acid/vitamin B complex and vitamin C)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PUREVITA SUPER B-COMPLEX ORAL CAPSULE 400 MCG (vitamin B complex/folic acid)	Tier 3	
STRESS B WITH ZINC ORAL TABLET (multivitamin, stress formula/zinc)	Tier 3	
SUPER B-50 COMPLEX ORAL CAPSULE 400 MCG-20 MG- 50 MG (vitamin B complex/folic acid/choline bitartrate/inositol)	Tier 3	
TM-VITE RX ORAL TABLET 1,000 MCG (vitamin B complex and vitamin C combination no.22/folic acid)	Tier 3	
ULTRA B-100 COMPLEX (FOODBASE) ORAL TABLET 400 MCG-100MCG- 100 MCG (vit B complex/folic acid/choline bit/inositol/alfalfa/herbs)	Tier 3	
<i>vit b comp-folic-choline-inosi oral tablet extended release 400 mcg-10 mg- 10 mg</i>	Tier 3	
VITAMIN B COMPLEX-ELECTROLYTES ORAL TABLET 0.4 MG (vitamin B complex/folic acid)	Tier 3	
WESCAPS ORAL CAPSULE 1 MG (vitamin B complex and vitamin C no.20/folic acid)	Tier 3	
B-Complex Vitamins - Drugs For Nutrition		
B COMPLEX 100 INJECTION SOLUTION 100-2-100-2-2 MG/ML (thiamine HCl/riboflavin/niacinamide/dexpanthenol/pyridoxine)	Tier 1	KP
B-COMPLEX INJECTION INJECTION SOLUTION 100-2-100-2-2 MG/ML (thiamine HCl/riboflavin/niacinamide/dexpanthenol/pyridoxine)	Tier 1	KP
<i>vitamin b complex oral capsule</i>	Tier 3	
<i>vitamin b complex oral tablet</i>	Tier 3	
<i>vitamin b complex oral tablet, disintegrating</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bioflavonoid Combinations - Drugs For Nutrition		
ACTIFLOVIT ORAL TABLET 200-100 MG (bioflavonoid, lemon/vitamin B comp and C)	Tier 3	
BIO C 1:1 ORAL CAPSULE 500-500 MG (ascorbic acid/bioflavonoids)	Tier 3	
DIOVASC ORAL CAPSULE 500 MG (hesperidin/diosmin)	Tier 3	
LIPO-FLAVONOID ORAL TABLET 500 MG (vit B complex and C/choline/inositol/bioflavonoid,lemon)	Tier 3	
Dietary Product - Dietary Supplements - Drugs For Nutrition		
<i>inositol oral capsule 500 mg</i>	Tier 3	
Dietary Product - Infant Formulas - Drugs For Nutrition		
PHENEX-1 ORAL POWDER 15 GRAM-480 KCAL/100 GRAM (infant formula for PKU, iron, no.2)	Tier 3	
Dietary Product - Sweeteners - Drugs For Nutrition		
<i>saccharin powder</i>	Tier 3	
Diluents - Insulin Diluting Solutions - Drugs For Nutrition		
DILUTING MEDIUM FOR NOVOLOG INJECTION SOLUTION (diluent,insulin aspart combination no.1)	Tier 3	KP
Diluents - Sodium Chloride - Drugs For Nutrition		
<i>sodium chlor 0.9% bacteriostat injection solution 0.9 %</i>	Tier 1	KP
<i>sodium chloride 0.9 % injection solution</i>	Tier 1	KP
<i>sodium chloride injection syringe 0.9 %</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Electrolyte Depleters - Ion Exchange Resin - Drugs For Nutrition		
sodium polystyrene sulfonate/sorbitol solution (Kionex (With Sorbitol) Oral Suspension 15-20 Gram/60 MI)	Tier 1	
LOKELMA ORAL POWDER IN PACKET 10 GRAM, 5 GRAM (sodium zirconium cyclosilicate)	Tier 2	
<i>sodium polystyrene sulfonate oral powder 15 gram</i>	Tier 1	
sodium polystyrene sulfonate/sorbitol solution (Sps (With Sorbitol) Oral Suspension 15-20 Gram/60 MI)	Tier 1	
SPS (WITH SORBITOL) RECTAL ENEMA 30-40 GRAM/120 ML (sodium polystyrene sulfonate/sorbitol solution)	Tier 3	
VELTASSA ORAL POWDER IN PACKET 1 GRAM, 16.8 GRAM, 8.4 GRAM (patiomer calcium sorbitex)	Tier 3	PA
Geriatric Vitamins - Drugs For Nutrition		
ELDERTONIC ORAL LIQUID 3.6 MG-0.75 MG /15 ML (vitamin B complex/zinc sulfate/manganese sulfate)	Tier 3	
Irrigation Solutions - Drugs For Nutrition		
<i>lactated ringers irrigation solution</i>	Tier 3	
PHYSIOLYTE IRRIGATION SOLUTION 140-5-3-98 MEQ/L (physiological irrigating solution no.1)	Tier 3	
PHYSIOSOL IRRIGATION IRRIGATION SOLUTION 140-5-3-98 MEQ/L (physiological irrigating solution no.1)	Tier 3	
<i>ringer's irrigation solution</i>	Tier 1	
<i>sodium chloride irrigation solution 0.9 %</i>	Tier 1	
<i>sodium chloride tablet, soluble 1,000 mg</i>	Tier 3	
<i>water for irrigation, sterile irrigation solution</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Minerals And Electrolytes - Calcium Replacement - Drugs For Nutrition		
<i>calcium acetate oral tablet 667 mg</i>	Tier 3	
<i>calcium carb, citrate, malate oral capsule 250 mg calcium</i>	Tier 3	
<i>calcium carbonate oral tablet 500 mg calcium (1,250 mg), 600 mg calcium (1,500 mg)</i>	Tier 3	
<i>calcium citrate oral tablet 200 mg (950 mg)</i>	Tier 3	
OSSOPAN MD ORAL CAPSULE 200 MG CALCIUM- 1.25 MCG (calcium combination no.35/vitamin D3/magnesium malate)	Tier 3	
OSSOPAN-1100 ORAL CAPSULE 275 MG CALCIUM (1,100 MG) (hydroxyapatite)	Tier 3	
OYSTER SHELL CALCIUM 500 ORAL TABLET 500 MG CALCIUM (1,250 MG) (calcium carbonate)	Tier 3	
Minerals And Electrolytes - Calcium Replacement Combinations - Drugs For Nutrition		
BONEUP (CALCIUM ASCORBATE) ORAL CAPSULE 166.6 MG-4.15 MCG-83.3 MG (calcium/vit D3/magnesium oxide/ascorbate cal/vit K2/minerals)	Tier 3	
BONEUP ORAL CAPSULE 333 MG-8.3 MCG-116.7 MG (calcium/vit D3/magnesium oxide/vit C/vit K2/minerals)	Tier 3	
<i>ca-d3-mag ox-zinc-cop-mang-bor oral tablet 600 mg calcium- 20 mcg-50 mg</i>	Tier 3	
<i>ca-d3-mag-zinc-cop-mang-bor oral tablet 600-200-40-7.5 mg-unit-mg-mg</i>	Tier 3	
<i>calc carb-mag ox-d3-zinc gluc oral tablet 333 mg-133 mg-1.67 mcg-5 mg</i>	Tier 3	
<i>calc-d3-magnes-b6-zn-cu-mangan oral tablet 250 mg-400 unit -40 mg-5 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcium carb-d3-mag ox-zinc ox oral tablet 333 mg-133 unit -133 mg-5 mg</i>	Tier 3	
<i>calcium carb-mag ox-zinc sulf oral tablet 334-134-5 mg</i>	Tier 3	
<i>calcium no.38-d3-mag-boron oral liquid 500 mg-12.5 mcg - 20 mg/15 ml</i>	Tier 3	
<i>calcium phos-d3-magnesium-zinc oral tablet,chewable 100 mg-25 mcg- 17 mg-1.67 mg</i>	Tier 3	
<i>calcium-d3-zinc-copper-mangan oral tablet 325 mg-12.5 mcg -2.75 mg</i>	Tier 3	
<i>calcium-vitamin d3-vitamin k oral tablet,chewable 650 mg-12.5 mcg-40 mcg</i>	Tier 3	
CALTRATE-D3 PLUS MINERALS ORAL TABLET 600 MG-20 MCG- 50 MG-1 MG (calcium carb/D3/mag oxide/cupric sulf/mang sulf/zinc oxide)	Tier 3	
CALTRATE-D3 PLUS MINERALS ORAL TABLET,CHEWABLE 600 MG-20 MCG- 40 MG-0.25 MG (calcium carb/D3/mag oxide/cupric sulf/mang sulf/zinc oxide)	Tier 3	
JOINT HEALTH-BONE STRENGTH ORAL TABLET 600 MG-25 MCG- 50 MG (calcium carb/vit D3/mag oxide/copper/manganese/zinc/collag)	Tier 3	
KIDS BONES-MUSCLES ORAL TABLET,CHEWABLE 162 MG CALCIUM- 10 MCG-21 MG (calcium phosphate, tribasic/vitamin D3/mag citrate/vit K1)	Tier 3	
LIQUICAL PLUS ORAL LIQUID 84 MG-24 MG- 10 MCG/5 ML (calcium citrate/magnesium citrate/vitamin D3/zinc citrate)	Tier 3	
MYLK ORAL CAPSULE 200 MG-6.25 MCG -50 MG (calcium no.43/vitamin D3/mag oxide/omega-3/dha/epa/fish oil)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTIMAG PLUS CALCIUM ORAL POWDER 600 MG CALCIUM- 300 MG/SCOOP (calcium malate/magnesium amino acid chelate, malate)	Tier 3	
OSAPLEX MK-7 ORAL CAPSULE 275 MG-12.5 MCG -22.5 MCG (hydroxyapatite/vitamin D3/vitamin K2/choline/silicon)	Tier 3	
OSAPLEX ORAL CAPSULE 275 MG-25 MCG /60 MG-3 MG (hydroxyapatite/vitamin D3/choline/silicon)	Tier 3	
OSTEOPRIME PLUS CALC-MAGNESIUM ORAL TABLET 200 MG-5 MCG-75 MG-200 MCG DFE (calcium no.39/vit D3/magnesium/folate/vit K1/vit K2/minerals)	Tier 3	
ULTRA BONEUP ORAL TABLET 200 MG-8.3 MCG- 83.3 MG-8.3 MG (calcium/vit D3/magnesium oxide/collagen/vit C/vit K2/mineral)	Tier 3	
VEGETARIAN BONEUP ORAL TABLET 166.6 MG-4.15 MCG-83.3 MG (calcium/vit D2/magnesium oxide/ascorbate calcium/vit K2/min)	Tier 3	
Minerals And Electrolytes - Calcium Replacement/Vitamin D Combinations - Drugs For Nutrition		
ALIVE CALCIUM-VITAMIN D3 ORAL TABLET,CHEWABLE 260 MG CALCIUM- 25 MCG-50 MG (calcium phosphate, tribasic/vitamin D3/herbal complex no.293)	Tier 3	
<i>calcium carbonate-vitamin d3 oral capsule 600 mg-5 mcg (200 unit)</i>	Tier 3	
<i>calcium carbonate-vitamin d3 oral tablet 1,000 mg-20 mcg (800 unit)</i>	Tier 3	
<i>calcium carbonate-vitamin d3 oral tablet 250 mg-3.125 mcg (125 unit), 500 mg-10 mcg (400 unit), 500 mg-15 mcg (600 unit), 500 mg-3.125 mcg (125 unit), 500 mg-5 mcg (200 unit), 600 mg-10 mcg (400 unit), 600 mg-20 mcg (800 unit), 600 mg-5 mcg (200 unit)</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>calcium carbonate-vitamin d3 oral tablet,chewable 500 mg-10 mcg (400 unit)</i>	Tier 3	
<i>calcium carbonate-vitamin d3 oral tablet,chewable 500 mg-2.5 mcg (100 unit)</i>	Tier 3	
<i>calcium citrate-vitamin d3 oral tablet 200 mg-6.25 mcg (250 unit), 315 mg-5 mcg (200 unit), 315 mg-6.25 mcg (250 unit)</i>	Tier 3	
<i>calcium phosphate-vitamin d3 oral tablet,chewable 250 mg-10 mcg (400 unit)</i>	Tier 3	
CALTRATE 600 PLUS D ORAL TABLET,CHEWABLE 600 MG-20 MCG (800 UNIT) (calcium carbonate/cholecalciferol (vitamin D3))	Tier 3	
CALTRATE GUMMY BITES ORAL TABLET,CHEWABLE 250 MG-10 MCG (400 UNIT) (calcium phosphate, tribasic/cholecalciferol (vitamin D3))	Tier 3	
OYSTER SHELL CALCIUM-VIT D3 ORAL TABLET 500 MG-5 MCG (200 UNIT) (calcium carbonate/cholecalciferol (vitamin D3))	Tier 3	
YOGURT PLUS CALCIUM GUMMIES ORAL TABLET,CHEWABLE 250 MG-2.5 MCG (100 UNIT) (calcium phosphate, tribasic/cholecalciferol (vitamin D3))	Tier 3	
Minerals And Electrolytes - Electrolytes And Dextrose - Drugs For Nutrition		
ELLIOTTS B (PF) INTRATHECAL SOLUTION 73-19-8-3 MG/10 ML (chemo therapy diluent,e-lytes and dextrose, buffered no.1/PF)	Tier 3	KP
Minerals And Electrolytes - Iodine - Drugs For Nutrition		
LUGOLS ORAL SOLUTION 5 % (potassium iodide/iodine)	Tier 3	
<i>potassium iodide oral solution 1 gram/ml</i>	Tier 1	
SSKI ORAL SOLUTION 1 GRAM/ML (potassium iodide)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STRONG IODINE ORAL SOLUTION 5 % (potassium iodide/iodine)	Tier 1	
XYMODINE ORAL CAPSULE 7,500-5,000 MCG (potassium iodide/iodine)	Tier 3	
Minerals And Electrolytes - Iron - Drugs For Nutrition		
ACCRUFER ORAL CAPSULE 30 MG (ferric maltol)	Tier 3	
AURYXIA ORAL TABLET 210 MG IRON (ferric citrate)	Tier 3	ST: Requires prior prescriptions for Velphoro and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (12 EA per 1 day)
FERGON ORAL TABLET 225 MG (27 MG IRON) (ferrous gluconate)	Tier 3	
FERRETTS IPS ORAL CAPSULE 18 MG (iron succinyl-protein complex)	Tier 3	
<i>ferric citrate oral tablet 210 mg iron</i>	Tier 1	ST: Requires prior prescriptions for Velphoro and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (12 EA per 1 day)
<i>ferric glycinate oral liquid 18 mg iron/15 ml</i>	Tier 3	
<i>ferrous fumarate oral tablet 324 mg (106 mg iron)</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>ferrous gluconate oral tablet 324 mg (37.5 mg iron), 324 mg (38 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral drops 15 mg iron (75 mg)/ml</i>	Tier 3	
<i>ferrous sulfate oral elixir 220 mg (44 mg iron)/5 ml</i>	Tier 3	
<i>ferrous sulfate oral liquid 300 mg (60 mg iron)/5 ml</i>	Tier 3	
<i>ferrous sulfate oral solution 220 mg (44 mg iron)/5 ml</i>	Tier 3	
<i>ferrous sulfate oral tablet 325 mg (65 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral tablet extended release 142 mg (45 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral tablet, delayed release (drlec) 324 mg (65 mg iron)</i>	Tier 3	
<i>ferrous sulfate oral tablet, delayed release (drlec) 325 mg (65 mg iron)</i>	Tier 3	
FE-VITE ORAL DROPS 15 MG IRON (75 MG)/ML (ferrous sulfate)	Tier 3	
HEMATEX ORAL LIQUID 100 MG IRON/5 ML (iron polysaccharide complex)	Tier 3	
IRON (FERROUS SULFATE) ORAL TABLET 325 MG (65 MG IRON) (ferrous sulfate)	Tier 3	
<i>iron bisglycinate chelate oral capsule 28 mg iron, 29 mg iron</i>	Tier 3	
NEONATAL FE ORAL TABLET 90 MG-120 MG-12 MCG-1,000 MCG (iron, carbonyl/ascorbic acid/cyanocobalamin/folic acid)	Tier 3	
NU-IRON ORAL CAPSULE 150 MG IRON (iron polysaccharide complex)	Tier 3	
<i>polysaccharide iron complex oral capsule 150 mg iron</i>	Tier 3	
SLOW FE ORAL TABLET EXTENDED RELEASE 137 MG (45 MG IRON) (ferrous sulfate)	Tier 3	
SLOW RELEASE IRON ORAL TABLET EXTENDED RELEASE 142 MG (45 MG IRON), 143 MG (45 MG IRON) (ferrous sulfate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRIFERIC HEMODIALYSIS POWDER IN PACKET 272 MG IRON (ferric pyrophosphate citrate)	Tier 3	
TRIFERIC HEMODIALYSIS SOLUTION 27.2 MG IRON/5 ML (ferric pyrophosphate citrate)	Tier 3	
Minerals And Electrolytes - Iron Combinations - Drugs For Nutrition		
BENTIVITE BX ORAL TABLET 35 MG IRON- 1 MG (ferrous sulfate/folic acid)	Tier 3	
CITRANATAL BLOOM ORAL TABLET 90-1-12-50 MG-MG-MCG-MG (iron carbonyl,gluc/folic acid/vit B12/vit C/docusate sodium)	Tier 3	
FERIVA 21-7 ORAL TABLET 75 MG IRON-175 MG-1,667 MCGDFE, 75 MG IRON-175 MG-12 MCG-1 MG (iron asp gly/ascorbic acid/vit B12/folate no.1/zinc/succinic)	Tier 3	
FERIVA FA (WITH SUMALATE) ORAL CAPSULE 110 MG-175 MG- 1 MG-12 MCG (iron bisgly,aspart,fumarate/vit C/folate/B12/biotin/cupric)	Tier 3	
GENTLE IRON ORAL CAPSULE 28 MG IRON-60MG -400 MCG-8 MCG (iron bis-glycinate chelate/ascorbic acid/folic acid/vit B12)	Tier 3	
HEMATOGEN FORTE ORAL CAPSULE 460-60-0.01-1 MG (ferrous fumarate/ascorbic acid/cyanocobalamin/folic acid)	Tier 3	
HEMATOGEN ORAL CAPSULE 66 MG IRON- 250 MG-10 MCG (ferrous fumarate/ascorbic acid/cyanocobalamin)	Tier 3	
HEMATRON-AF ORAL TABLET 150 MG-1,020 MCG DFE-500 MG, 150 MG-1,700 MCG DFE-500 MG (iron,carbonyl/levomefolate calcium/vit C/vit E/B12/B7/copper)	Tier 3	
HEMAX ORAL TABLET 150 MG-1,020 MCG DFE-500 MG (iron,carbonyl/levomefolate calcium/vit C/vit E/B12/B7/copper)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRON FOLATE PLUS ORAL CAPSULE 125 MG IRON- 1 MG (iron fumarate,polysac cplex/folic acid/vit B comp and C no.9)	Tier 3	
<i>iron,carbonyl-vitamin c oral tablet 100-250 mg</i>	Tier 3	
<i>iron,carbonyl-vitamin c oral tablet 65 mg iron- 125 mg</i>	Tier 3	
MAXFE (FOLATE) ORAL TABLET 160 MG-1,700 MCG DFE-60 MCG (iron carb,glycinate/folate/B12/mag ascorbate/biotin/zinc)	Tier 3	
NIFEREX (FERROUS ASPARTO GLYC) ORAL TABLET 75 MG IRON-175 MG-1,700 MCGDFE (iron asparto gly/vit C/vit B12/folate no.6/zinc/succinic)	Tier 3	
NOVAFERRUM YAY IRON ORAL TABLET,CHEWABLE 18 MG IRON- 30 MG (iron polysaccharide complex/ascorbic acid)	Tier 3	
PROTECT IRON LIQUID ORAL LIQUID 100 MG IRON-250 MG/5 ML (iron polysaccharide complex/ascorbic acid/vitamin B complex)	Tier 3	
TULIVITE ORAL TABLET 35 MG IRON- 1 MG (ferrous sulfate/folic acid)	Tier 3	
VITABEX IRON ORAL CAPSULE 65 MG IRON- 50 MG-1 MG DFE (iron bisglycinate/C/methylfolate/B12/L. acidoph,plant/inulin)	Tier 3	
VITRON-C ORAL TABLET,DELAYED RELEASE (DR/EC) 65 MG IRON- 125 MG (iron,carbonyl/ascorbic acid)	Tier 3	
Minerals And Electrolytes - Magnesium - Drugs For Nutrition		
LC-655 ORAL CAPSULE 118 MG MAGNESIUM (magnesium glycinate)	Tier 3	
<i>magnesium chloride oral tablet 64 mg magnesium</i>	Tier 3	
<i>magnesium citrate oral capsule 100 mg, 125 mg</i>	Tier 3	
<i>magnesium citrate oral tablet,chewable 83.3 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>magnesium citrate,mag oxide oral capsule 250 mg</i>	Tier 3	
MAGNESIUM COMPLEX ORAL TABLET 300 MG MAGNESIUM (magnesium carb,citrate,oxide)	Tier 3	
<i>magnesium gluconate oral tablet 12.5 mg magne- sium (250 mg), 30 mg (550 mg)</i>	Tier 3	
<i>magnesium glycinate oral capsule 100 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral capsule 400 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral tablet 250 mg magnesium, 300 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral tablet 400 mg (241.3 mg magnesium), 420 mg, 500 mg magnesium</i>	Tier 3	
<i>magnesium oxide oral tablet,chewable 200 mg magnesium</i>	Tier 3	
OPTIMAG 125 ORAL CAPSULE 125 MG MAGNESIUM (magnesium amino acid chelate, magnesium malate)	Tier 3	
OPTIMAG NEURO ORAL CAPSULE 66.7 MG (magnesium amino acid chelate, malate, threonate)	Tier 3	
OPTIMAG NEURO ORAL POWDER 200 MG MAGNESIUM/SCOOP (magnesium amino acid chelate, malate, threonate)	Tier 3	
PUREVITA MAGNESIUM OXIDE ORAL TABLET 400 MG (241.3 MG MAGNESIUM) (magnesium oxide)	Tier 3	
SLOWMAG MUSCLE RECOVERY ORAL TABLET,CHEWABLE 85 MG (magnesium citrate)	Tier 3	
Minerals And Electrolytes - Magnesium Combinations - Drugs For Nutrition		
<i>magnesium citrate-lemon balm oral tablet,chewable 66.6-25 mg</i>	Tier 3	
MAGNESIUM OPTIMIZER ORAL TABLET 50-25-175-1 MG (magnesium malate/potassium citrate/taurine/pyridoxal)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Minerals And Electrolytes - Multiple Minerals - Drugs For Nutrition		
MINREX ORAL CAPSULE 25-100 MG (minerals/potassium glycinate/betaine hydrochloride)	Tier 3	
Minerals And Electrolytes - Oral Electrolytes - Drugs For Nutrition		
BIOLYTE ORAL LIQUID (electrolytes/dextrose/multivit/amino/ginger/milk thistle)	Tier 3	
BIOLYTE ORAL POWDER IN PACKET (electrolytes/dextrose/multivit/amino/ginger/milk thistle)	Tier 3	
CERASPORT ENDURANCE ORAL POWDER IN PACKET 400 MG-160 MG/42 GRAM (sodium chloride/potassium chloride/sodium citrate/rice/whey)	Tier 3	
CERASPORT EX1 ORAL POWDER 200 MG-100 MG- 20 KCAL/6 GRAM (sodium chloride/potassium chloride/sodium citrate/rice syrup)	Tier 3	
CERASPORT PLUS ORAL POWDER IN PACKET 230 MG- 85 MG- 120 KCAL/31GRAM (sodium chloride/potassium chloride/sodium citrate/rice syrup)	Tier 3	
<i>electrolytes-dextrose oral packet</i>	Tier 3	
<i>electrolytes-dextrose oral solution</i>	Tier 3	
ENSURE RAPID HYDRATION ORAL POWDER IN PACKET 30 MEQ-10 MEQ- 25 MEQ-11 GRAM (sodium/potassium/chloride/dextrose)	Tier 3	
HYDRALYTE ORAL SOLUTION (electrolytes/dextrose)	Tier 3	
HYDRALYTE PLUS ORAL POWDER EFFERVESCENT IN PACKET 1,000-300 MG (electrolytes/dextrose/ascorbic acid/elderberry fruit)	Tier 3	
HYDRATING ELECTROLYTE ORAL PACKET (electrolytes/dextrose)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYDRATING ELECTROLYTE SF ORAL POWDER IN PACKET (electrolytes,oral/multivitamin/amino acids)	Tier 3	
HYDRATION MULTIPLI SUGAR FREE ORAL PACKET (electrolytes)	Tier 3	
HYDRATION MULTIPLIER IMMUNE ORAL POWDER IN PACKET 504 MG (electrolytes,oral/dextrose/vitamin B complex/ascorbic acid)	Tier 3	
KINDERLYTE HERBAL IMMUNITY ORAL POWDER IN PACKET 270 MG-25 MCG- 140 MG-50 MG (electrolytes/dextr/vit C/vit D3/turmeric rt xt/elderberry fr)	Tier 3	
ORALYTE ORAL SOLUTION (electrolytes/dextrose)	Tier 3	
PEDIALYTE ELECTROLYTE ORAL POWDER IN PACKET 11.25-5-8.75 MEQ (sodium/potassium/chloride/dextrose)	Tier 3	
PEDIALYTE ELECTROLYTE WATER ORAL SOLUTION (electrolytes)	Tier 3	
PEDIALYTE SPARKLING RUSH ORAL POWDER EFFERVESCENT IN PACKET 28.3 MEQ-18.2 MEQ-16.6 MEQ (sodium/potassium/chloride/dextrose)	Tier 3	
PEDIATRIC ELECTROLYTE ORAL SOLUTION (electrolytes/dextrose)	Tier 3	
Minerals And Electrolytes - Phosphate - Drugs For Nutrition		
PHOSPHOROUS SUPPLEMENT ORAL POWDER IN PACKET 280-160-250 MG (sodium phosphate/potassium phosphates, monobasic and dibasic)	Tier 3	
<i>potassium, sodium phosphates oral powder in packet 280-160-250 mg</i>	Tier 3	
WES-PHOS 250 NEUTRAL ORAL TABLET 250 MG (sodium phosphate,dibasic/pot phos,monob/sod phosphate mono)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Minerals And Electrolytes - Potassium Combinations - Drugs For Nutrition		
<i>mag citrate-potassium citrate oral capsule 70-99 mg</i>	Tier 3	
Minerals And Electrolytes - Potassium, Oral - Drugs For Nutrition		
EFFER-K ORAL TABLET, EFFERVESCENT 10 MEQ, 20 MEQ (potassium bicarbonate/citric acid)	Tier 3	
EFFER-K ORAL TABLET, EFFERVESCENT 25 MEQ (potassium bicarbonate/citric acid)	Tier 1	
potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	Tier 3	
KLOR-CON 8 ORAL TABLET EXTENDED RELEASE 8 MEQ (potassium chloride)	Tier 3	
potassium chloride (Klor-Con M10 Oral Tablet,Er Particles/Crystals 10 Meq)	Tier 1	
potassium chloride (Klor-Con M15 Oral Tablet,Er Particles/Crystals 15 Meq)	Tier 1	
potassium chloride (Klor-Con M20 Oral Tablet,Er Particles/Crystals 20 Meq)	Tier 1	
potassium chloride (Klor-Con Oral Packet 20 Meq)	Tier 3	
KLOR-CON/EF ORAL TABLET, EFFERVESCENT 25 MEQ (potassium bicarbonate/citric acid)	Tier 3	
POKONZA ORAL PACKET 10 MEQ (potassium chloride)	Tier 3	
<i>potassium aa (bisglycinate) oral capsule 99 mg</i>	Tier 3	
<i>potassium chloride oral capsule, extended release 10 meq, 8 meq</i>	Tier 1	
<i>potassium chloride oral liquid 20 meq/15 ml, 40 meq/15 ml</i>	Tier 1	
<i>potassium chloride oral packet 20 meq</i>	Tier 1	
<i>potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>potassium chloride oral tablet extended release 15 meq</i>	Tier 1	
<i>potassium chloride oral tablet,er particles/crystals 10 meq, 15 meq, 20 meq</i>	Tier 1	
<i>potassium gluconate oral tablet 595 mg (99 mg)</i>	Tier 3	
Minerals And Electrolytes - Sodium Chloride, Oral - Drugs For Nutrition		
<i>sodium chloride tablet,soluble 1,000 mg</i>	Tier 3	
Minerals And Electrolytes - Trace Minerals - Drugs For Nutrition		
BORON COMPLEX ORAL CAPSULE 3 MG (boron aspartate)	Tier 3	
<i>chromium nicotinate oral capsule 200 mcg</i>	Tier 3	
<i>chromium picolinate oral tablet 1,000 mcg</i>	Tier 3	
<i>chromium picolinate oral tablet 200 mcg</i>	Tier 3	
<i>copper gluconate oral tablet 2 mg</i>	Tier 3	
<i>selenium oral capsule 200 mcg</i>	Tier 3	
<i>selenium oral tablet 200 mcg, 50 mcg</i>	Tier 3	
<i>selenomethionine oral capsule 200 mcg</i>	Tier 3	
Minerals And Electrolytes - Zinc - Drugs For Nutrition		
IS-ZC 50 ORAL TABLET 50 MG (zinc citrate, zinc oxide)	Tier 3	
PEPCIX ORAL TABLET,CHEWABLE 16 MG (polaprezinc (zinc carnosine))	Tier 3	
<i>zinc amino acid chelate oral tablet 50 mg</i>	Tier 3	
<i>zinc citrate oral tablet,chewable 11 mg, 16.7 mg</i>	Tier 3	
<i>zinc gluconate oral tablet 50 mg</i>	Tier 3	
<i>zinc glycinate oral capsule 20 mg</i>	Tier 3	
<i>zinc glycinate oral tablet,chewable 7.5 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>zinc sulfate oral capsule 50 mg zinc (220 mg)</i>	Tier 3	
<i>zinc sulfate oral tablet 50 mg zinc (220 mg)</i>	Tier 3	
Minerals And Electrolytes - Zinc Combinations - Drugs For Nutrition		
ZINC BALANCE ORAL CAPSULE 15-1 MG (zinc methionine sulfate/copper gluconate)	Tier 3	
<i>zinc gluc, oxide-ascorbic acid oral tablet,disintegrating 15-60 mg</i>	Tier 3	
Multivitamin And Mineral Combinations - Drugs For Nutrition		
ABC COMPLETE SENIOR WOMEN'S ORAL TABLET 8 MG IRON- 400 MCG-50 MCG (multivit-calc-min/ferrous fumarate/folic acid/vit K1/lutein)	Tier 3	
ACTIVNUTRIENTS (NO IRON) ORAL CAPSULE 170 MCG DFE (multivit with minerals/methyltetrahydrofolate glucosamine)	Tier 3	
ACTIVNUTRIENTS CHEWABLE ORAL TABLET,CHEWABLE 0.75 MG- 85 MCG DFE (multivitamin-minerals no.98/ferric glycinate/m-hydrofolate)	Tier 3	
ACTIVNUTRIENTS MULTIVITAMIN ORAL POWDER 340 MCG DFE- 15 MCG/3 GRAM (multivit with minerals/methyltetrahydrofolate glucosa/vit K2)	Tier 3	
ACTIVNUTRIENTS ORAL CAPSULE 1.25 MG IRON- 170 MCG DFE (multivit with min/iron bis-gly/methyltetrahydrofolate gluc)	Tier 3	
ACTIVNUTRIENTS PERFORMANCE ORAL CAPSULE 72.25 MCG DFE- 22.5 MG (multivit-min/folate no.11/milk thistle seed extract/herbs)	Tier 3	
ACTIVNUTRIENTS(NO COPPER-IRON) ORAL CAPSULE 170 MCG DFE (multivit with minerals/leucovorin calc,m-folate glucosamine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADULT 50 PLUS EYE HEALTH ORAL CAPSULE 250-5-1 MG (vit C,E,copper,zinc 11/omega-3/dha/epa/fish/lutein/zeaxanth)	Tier 3	
ADULT MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 120 MCG, 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
ADULTS 50 PLUS ORAL TABLET 0.4 MG-300 MCG- 250 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
ADULTS MULTIVITAMIN ORAL TABLET 18 MG IRON-400 MCG-25 MCG (multivitamin with minerals/ferrous fumarate/folic acid/vit K)	Tier 3	
ALIVE ADULT ULTRA POTENCY ORAL TABLET 18 MG IRON- 400 MCG-120 MCG (multivit-min/ferrous fumarate/folic acid/vit K1/herb no.354)	Tier 3	
ALIVE COMPLETE PREMIUM PRENATL ORAL CAPSULE 13.5 MG IRON- 200 MCG-100 MG (mv-mins no.108/iron fumarate/folic acid/dha/Schiz algal oil)	Tier 3	
ALIVE DAILY ENERGY ORAL TABLET 18 MG IRON- 240 MCG-40 MCG (multivit-min/iron/folic/K1/resveratrol/lutein/herbal no.293)	Tier 3	
ALIVE DIABETIC MULTIVITAMIN ORAL TABLET 120-100 MCG (multivit with minerals/folic acid/lutein/herbal comp no.329)	Tier 3	
ALIVE ENERGY 50 PLUS ORAL TABLET 240-45-900-250 MCG (multivit-min/folic acid/K1/resveratrol/lutein/herbal no.293)	Tier 3	
ALIVE MAX POTENCY ORAL LIQUID 300-80 MCG/30 ML (multivitamin-minerals/folic/vitamin K/herbal no.332)	Tier 3	
ALIVE MAX6 POTENCY COMPLETE ORAL CAPSULE 3 MG IRON- 66.67 MCG DFE (multivit-min/iron/methyltetrahydrofolate/vit K/herb no.335)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALIVE MEN 50 PLUS ULTRA-LUTEIN ORAL TABLET 240-120 MCG (multivit with minerals/folic acid/vitamin K1/herbal no.328)	Tier 3	
ALIVE MEN'S 50 PLUS MULTIVIT ORAL TABLET,CHEWABLE 120 MCG-150 MCG -50 MG (multivit with minerals/folic/lutein/herbal complex no.293)	Tier 3	
ALIVE MEN'S 50 PLUS MV (VIT K) ORAL TABLET 240-120-300 MCG (multivit with minerals/folic/vit K/lutein/herbal complex 293)	Tier 3	
ALIVE MEN'S 50 PLUS ULTRA ORAL TABLET 800 MCG DFE- 120 MCG (multivit-min/methyltetrahydrofolate/vit K/herbal no.328)	Tier 3	
ALIVE MEN'S ENERGY ORAL TABLET 240-120-100 MCG (multivit with minerals/folic/vit K/lutein/herbal complex 293)	Tier 3	
ALIVE MEN'S GUMMY ORAL TABLET,CHEWABLE 120 MCG- 50 MG (multivit with minerals/folic acid/herbal complex no.293)	Tier 3	
ALIVE MEN'S MAX3 POTENCY ORAL TABLET 133.3 MCG DFE- 40 MCG (multivit-min/methyltetrahydrofolate/vit K/herbal no.330)	Tier 3	
ALIVE MEN'S ULTRA POTENCY ORAL TABLET 400 MCG DFE- 120 MCG (multivitamin-min/methyltetrahydrofolate/vitamin K/herbal 334)	Tier 3	
ALIVE PREMIUM ADULT ORAL TABLET,CHEWABLE 80 MCG- 66.7 MG (multivit with minerals/folic acid/herbal complex no.293)	Tier 3	
ALIVE PREMIUM PRENATAL ORAL TABLET,CHEWABLE 120 MCG-25 MG- 66.7 MG (multivitamin-minerals no.45/folic acid/dha/herbal no.293)	Tier 3	
ALIVE WOMEN'S 50 PLUS COMPLETE ORAL TABLET 240-120-300 MCG (multivit-minerals/folic acid/vitamin K1/lutein/herbs)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALIVE WOMEN'S 50 PLUS GUMMY ORAL TABLET,CHEWABLE 120 MCG-150 MCG -37.5 MG (multivit with minerals/folic/lutein/herbal complex no.293)	Tier 3	
ALIVE WOMEN'S ENERGY ORAL TABLET 18 MG IRON-240 MCG-120 MCG (multivit,calcium,minerals/iron/folic acid/vit K/herb no.293)	Tier 3	
ALIVE WOMEN'S GUMMY VITAMIN ORAL TABLET,CHEWABLE 120 MCG- 37.5 MG (multivit with minerals/folic acid/herbal complex no.293)	Tier 3	
ALIVE WOMEN'S MULTIVITAMIN ORAL TABLET 4.5 MG IRON- 120 MCG-60 MCG (multivit-min/ferrous fumarate/folic acid/vit K1/herb no.352)	Tier 3	
ALIVE WOMEN'S ULTRA POTENCY ORAL TABLET 18 MG-800 MCG DFE-150 MCG (multivit-min/iron/methyltetrahydrofolate/vit K/herb 333)	Tier 3	
ALPHA BETIC ORAL TABLET 240 MCG- 100 MG (multivitamin with minerals/folic acid/alpha lipoic acid)	Tier 3	
ANTIOXIDANT FORMULA (SELENIUM) ORAL TABLET 8,333-167-133 UNIT-MG-UNIT (beta-carotene/ascorbic acid/vitE ac/selenium yeast)	Tier 3	
BARIATRIC MULTIVITAMINS ORAL CAPSULE 45 MG IRON-800 MCG DFE-120 MCG (multivit-min/ferrous fumarate/methyltetrahydrofolate/vit K1)	Tier 3	
BOOSTNOW IMMUNE SUPPORT ORAL CAPSULE 166.6-83.3-33.3 MG (multivit-min/yeast/astragalus root xt/ginger root xt/herbs)	Tier 3	
BOOSTNOW IMMUNE SUPPORT ORAL POWDER 499.99-249.99 MG/SCOOP (multivit-min/yeast/astragalus root xt/ginger root xt/herbs)	Tier 3	
CENTRUM ADULT 50 PLUS ORAL TABLET,CHEWABLE 80 MCG (multivitamin with minerals/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CENTRUM ADULTS ORAL TABLET,CHEWABLE 12 MCG (multivitamin with minerals/folic acid)	Tier 3	
CENTRUM CHEWABLES ORAL TABLET,CHEWABLE 8 MG-400 MCG- 80 MCG (multivitamin with minerals/iron,carbonyl/folic acid/vit K1)	Tier 3	
CENTRUM MENOPAUSE MULTIVITAMIN ORAL TABLET 400 MCG-30 MCG- 30 MG (multivitamin with minerals/folic acid/vitamin K1/genistein)	Tier 3	
CENTRUM MINIS ADULTS 50 PLUS ORAL TABLET 200-15-150-125 MCG (multivitamin-mineral/folic acid/phytonadione/lycopene/lutein)	Tier 3	
CENTRUM MINIS MEN 50 PLUS ORAL TABLET 150-30-300-150 MCG (multivitamin-mineral/folic acid/phytonadione/lycopene/lutein)	Tier 3	
CENTRUM MINIS WOMEN 50 PLUS ORAL TABLET 4 MG IRON-200 MCG-25 MCG (multivitamin with minerals/iron/folic acid/vitamin K/lutein)	Tier 3	
CENTRUM MULTI MENTAL FOCUS ORAL TABLET,CHEWABLE 80 MCG- 25 MG (multivitamin with minerals/folic acid/caffeine)	Tier 3	
CENTRUM MULTI PLUS BEAUTY ORAL TABLET,CHEWABLE 80-1,250 MCG (multivitamin with minerals/folic acid/biotin)	Tier 3	
CENTRUM MULTI PLUS OMEGA-3 ORAL TABLET,CHEWABLE 80 MCG-12.5 MCG -23.5 MG (multivitamin with min/folic acid/D3/omega-3/dha/epa/fish oil)	Tier 3	
CENTRUM MULTIGUMMIES MEN ORAL TABLET,CHEWABLE 12 MCG, 42 MCG, 80 MCG (multivitamin with minerals/folic acid)	Tier 3	
CENTRUM MULTIGUMMIES WOMEN ORAL TABLET,CHEWABLE 42 MCG, 80 MCG (multivitamin with minerals/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CENTRUM ORAL LIQUID 9 MG IRON/15 ML (multivitamin with minerals/ferrous gluconate)	Tier 3	
CENTRUM POSTNATAL ORAL TABLET,CHEWABLE 115 MCG-35 MG- 25 MG-5 MG (multivit-min no.114/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
CENTRUM PRENATAL ORAL TABLET,CHEWABLE 180 MCG-35 MG- 25 MG-5 MG (multivitamin-min no.115/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
CENTRUM SILVER ORAL TABLET 0.4 MG-300 MCG- 250 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
CENTRUM WOMEN IMMUNE MINIS ORAL TABLET 9 MG IRON- 200 MCG-25 MCG (multivitamin with minerals/ferrous fumarate/folic acid/vit K)	Tier 3	
CENTURY ADULT FORMULA ORAL TABLET 18 MG IRON-400 MCG-25 MCG (multivitamin with minerals/ferrous fumarate/folic acid/vit K)	Tier 3	
CENTURY MATURE ORAL TABLET 0.4 MG-300 MCG- 250 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
CERTAVITE SENIOR ORAL TABLET 0.4 MG-300 MCG- 250 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
CITRANATAL MEDLEY ORAL CAPSULE 27 MG IRON-1 MG -200 MG (mv with minerals no.102/iron carbonyl,fumarate/folic ac/dha)	Tier 3	
COMPLETE MV ADULT 50 PLUS ORAL TABLET 0.4 MG- 300 MCG- 250 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
CULTURELLE PROBIOTIC-MULTIVIT ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM (multivitamin with minerals/B. coagulans/B. subtilis/inulin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAILY GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
DAVIMET WITH IRON ORAL TABLET,CHEWABLE 11 MG IRON- 1,700 MCG DFE (multivitamin combination no.62/iron chelate/levomefolate)	Tier 3	
DAYAVITE ORAL TABLET 1-75-10 MG (multivitamin with minerals no.90/folic acid/ALA/coQ10)	Tier 3	
DERMACINRX DEXATRAN ORAL CAPSULE 18 MG IRON- 1 MG (multivitamin-minerals no.73/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX FOLIFLEX ORAL TABLET 9 MG IRON- 500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX FOLITIN-Z ORAL TABLET 9 MG IRON- 500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX MULTITAM ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX RIBOTIN-E ORAL TABLET 9 MG IRON- 500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VENEXA FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VENEXA ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX VENTRIXYL FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VENTRIXYL ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMACINRX VITRAMYN ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX VITRANOL FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VITRANOL ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX VITREXATE FE ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX VITREXATE ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
DERMACINRX ZINTREXYL-C ORAL TABLET 9 MG IRON- 500 MCG (multivitamin with minerals no.89/ferrous fumarate/folic acid)	Tier 3	
DIABETIC MULTIVITAMIN ORAL TABLET,CHEWABLE 120 MCG (multivitamin with minerals/folic acid)	Tier 3	
DIATROL ORAL TABLET 1,700 MCG DFE- 90 MCG (multivitamin-minerals no.105/levomefolate calcium/vit K1)	Tier 3	
ELITE-OB ORAL TABLET 50 MG IRON- 1.25 MG (multivitamin with minerals no.69/iron,carbonyl/folic acid)	Tier 3	
EYE HEALTH PLUS LUTEIN ORAL TABLET 300 MCG-200 MG-27 MG-2 MG (beta-carotene(A) w-C and E/lutein/minerals)	Tier 3	
EYE MULTIVITAMIN ORAL TABLET 2,148 MCG-113 MG-45 MG-17.4MG (beta-carotene/ascorbic acid/vitE ac/zinc oxide/cupric oxide)	Tier 3	
FINAZOL ORAL TABLET 18 MG IRON- 1,700 MCG DFE (multivitamin with min no.109/ferrous fumarate/levomefolate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLAGENT DHA ORAL CAPSULE 28 MG-1,000MCG- 35 MG-200 MG (multivit-min 96/iron,carbonyl/folic/omega-3/dha/epa/fish oil)	Tier 3	
FOLAMAX ORAL TABLET 20 MG IRON- 1,670 MCG DFE (multivit with minerals no.83/iron bis-glycinate/folate no.10)	Tier 3	
FOLAMED DHA ORAL CAPSULE 28 MG-1,000MCG- 35 MG-200 MG (multivit-min 96/iron,carbonyl/folic/omega-3/dha/epa/fish oil)	Tier 3	
FOLAPRIME ORAL TABLET 20 MG IRON- 1,670 MCG DFE (multivit with minerals no.83/iron bis-glycinate/folate no.10)	Tier 3	
FOLIVANE-OB ORAL CAPSULE 85-1 MG (mv-mins no.74/ferrous fumarate/iron ps cplx/folic acid)	Tier 3	
GENADEK STEP 1 ORAL CAPSULE 200 MCG-1,000 MCG-10 MG (multivit with minerals no.81/folic acid/vit K1/ubidecarenone)	Tier 3	
GENADEK STEP 2 ORAL CAPSULE 200 MCG-1,000 MCG-10 MG (multivit with minerals no.82/folic acid/vit K1/ubidecarenone)	Tier 3	
HAIR, SKIN AND NAILS (HERBS) ORAL CAPSULE 120-1,250-60 MCG (multivit-min/folic acid/biotin/vit K1/collagen/herbal no.353)	Tier 3	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL CAPSULE 133.3 MCG- 1,666.7 MCG (multivitamin with minerals/folic acid/biotin)	Tier 3	
HAIR,SKIN AND NAILS(FA-BIOTIN) ORAL TABLET 100-1,500 MCG, 66.7-1,666.7 MCG (multivitamin with minerals/folic acid/biotin)	Tier 3	
IMMUNERX ORAL CAPSULE 250 MCG (multivitamin with minerals no.88/folic acid)	Tier 3	
KEYFOLIC ORAL TABLET 20 MG IRON- 1,670 MCG DFE (multivit with minerals no.83/iron bis-glycinate/folate no.10)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LIQUID MULTIVITAMIN ORAL LIQUID 9 MG IRON/ 15 ML (15 ML) (multivitamin with minerals/ferrous gluconate)	Tier 3	
LIVITA FOR ADULT ORAL LIQUID 1,700 MCG DFE- 500 MG/15 ML (multivitamin-minerals no.103/levomefolate calcium/inulin)	Tier 3	
LUTEIN PLUS WITH ZEAXANTHIN ORAL TABLET 1,500 MCG-60 MG -20 MG-15 MG (betacarotene/vit C/vit E/zinc ox/cupric ox/lutein/zeaxanthin)	Tier 3	
MEN 50 PLUS MULTIVITAMIN ORAL TABLET 300-60-600-300 MCG (multivitamin-mineral/folic acid/phytonadione/lycopene/lutein)	Tier 3	
MEN'S 50 PLUS MULTIVITAMIN ORAL TABLET 400-20-370 MCG (multivitamin with minerals/folic acid/vitamin K1/lycopene)	Tier 3	
MEN'S DAILY GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
MEN'S DAILY MULTIVITAMIN ORAL TABLET 8 MG IRON-200 MCG-600 MCG (multivits with calcium and minerals/iron/folic acid/lycopene)	Tier 3	
MEN'S MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
MEN'S MULTIVITAMIN ORAL TABLET 200-60-600 MCG (multivitamin with minerals/folic acid/vitamin K1/lycopene)	Tier 3	
MULTI PRO ORAL CAPSULE 32 MG IRON-1 MG -315 MG (multivit-mins no.85/iron/folic acid/dha/Lactobacillus casei)	Tier 3	
MULTIA DAILY MULTIVITAMIN ORAL CAPSULE 4.5 MG IRON- 500 MCG (mv-mn/iron,carbonyl/folic/om3/fish/lycopene/lutein/zeaxanth)	Tier 3	
MULTITOL-M ORAL TABLET 2,040 MCG DFE (multivitamin with minerals no.106/levomefolate calcium)	Tier 3	
<i>multivit with min-folic acid oral tablet 0.4 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>multivit with min-folic acid oral tablet,chewable 120 mcg, 200 mcg</i>	Tier 3	
<i>multivit,calc,min-fa-k1-lycop oral tablet 240 mcg-30 mcg-300 mcg</i>	Tier 3	
MULTIVITAMIN GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
MULTIVITAMIN WOMEN 50 PLUS ORAL TABLET 8 MG IRON-400 MCG-50 MCG (multivitamin with minerals/iron/folic acid/vitamin K/lutein)	Tier 3	
<i>multivit-min-ferrous fumarate oral tablet 15 mg iron</i>	Tier 3	
<i>multivit-min-ferrous gluconate oral liquid 9 mg iron/15 ml</i>	Tier 3	
MVW MODULATOR FORMUL MULTIVIT ORAL CAPSULE 6,000 MCG-400MG -37.5 MCG (vitamin A/ascorbic acid/vitamin D3/vit E mixed/vit K1/zinc)	Tier 3	
MVW MODULATR FORM MINI MULTIVIT ORAL CAPSULE 3,000 MCG-200MG -18.75 MCG (vitamin A/ascorbic acid/vitamin D3/vit E mixed/vit K1/zinc)	Tier 3	
NANOVM ADULT ORAL POWDER 1 MG-50 MCG DFE - 15.5 MCG (multivit-min/sodium feredetate/levomefolate/vit K1/vit K2)	Tier 3	
NEOVITE ORAL TABLET 1-100-1 MG (multivit-minerals no.67/folic acid/alpha lipoic acid/lutein)	Tier 3	
NICOTINAMIDE (WITH CHROMIUM) ORAL TABLET 500 MCG- 750 MG (levomefolate calc/niacinamide/copper/zinc/selenium/chromium)	Tier 3	
OB COMPLETE ORAL TABLET 50 MG IRON- 1.25 MG (multivitamin with minerals no.69/iron,carbonyl/folic acid)	Tier 3	
ONE A DAY MEN COMPLETE ORAL TABLET 240-25-300 MCG (multivitamin,calcium,minerals/folic acid/vitamin D3/lycopene)	Tier 3	
ONE DAILY ESSENTIAL ORAL TABLET 0.5 MG (multivitamin with minerals/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONE DAILY MEN'S 50 PLUS W-D3 ORAL TABLET 400-20-370 MCG (multivitamin with minerals/folic acid/vitamin K1/lycopene)	Tier 3	
ONE DAILY MEN'S HEALTH ORAL TABLET 240 MCG-30 MCG- 300 MCG (multivitamin,calcium,minerals/folic acid/vitamin K1/lycopene)	Tier 3	
ONE DAILY MULTI-VIT W-MINERAL ORAL TABLET 4.5 MG IRON (multivitamin with minerals/ferrous sulfate)	Tier 3	
ONE DAILY MULTIVITAMIN-IRON ORAL TABLET 18 MG IRON (multivitamin/ferrous sulfate)	Tier 3	
ONE DAILY WOMEN 50 PLUS(VIT K) ORAL TABLET 400 MCG-500 MG CALCIUM-20 MCG (multivit with minerals/folic acid/calcium carbonate/vit K1)	Tier 3	
ONE DAILY WOMEN'S ORAL TABLET 18 MG IRON-400 MCG-25 MCG (multivitamin with minerals/ferrous fumarate/folic acid/vit K)	Tier 3	
ONE-A-DAY MEN VITACRAVES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
ONE-A-DAY MEN'S 50 PLUS ORAL TABLET 400-370 MCG (multivitamin with minerals/folic acid/lycopene)	Tier 3	
ONE-A-DAY MEN'S COMPLETE ORAL TABLET 240 MCG-30 MCG- 300 MCG (multivitamin,calcium,minerals/folic acid/vitamin K1/lycopene)	Tier 3	
ONE-A-DAY WOMEN VITACRAVES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
ONE-A-DAY WOMEN'S 50 PLUS ORAL TABLET 0.4 MG (multivitamin with minerals/folic acid)	Tier 3	
ONE-A-DAY WOMEN'S COMPLETE ORAL TABLET 18 MG IRON- 400 MCG (multivitamin with minerals/ferrous fumarate/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONE-DAILY MULTI ORAL CAPSULE 800 MCG-1 MG- 500 MCG-500 MCG (multivitamin-minerals/folic acid/co Q10/lycopene/lutein)	Tier 3	
PNV-OMEGA ORAL CAPSULE 28-1-300 MG (multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)	Tier 3	
PRENATAL GUMMIES(ZINC CHELATE) ORAL TABLET,CHEWABLE 180 MCG-35 MG- 25 MG-5 MG (multivitamin-min no.110/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
PRESERVISION AREDS 2 PLUS MV ORAL CAPSULE 200 MCG-15 MCG- 5 MG-1 MG (multivitamin-minerals/folic acid/vit K/lutein/zeaxanthin)	Tier 3	
PROFOLA ORAL TABLET 20 MG IRON- 1,670 MCG DFE (multivit with minerals no.83/iron bis-glycinate/folate no.10)	Tier 3	
REMEDIENT ORAL CAPSULE 3.6 MG- 1,000 MCG (multivitamin with minerals/iron succinyl-protein/folic acid)	Tier 3	
SPECTRAVITE ADULT 50 PLUS ORAL TABLET 0.4 MG-300 MCG- 250 MCG (multivitamin with minerals/folic acid/lycopene/lutein)	Tier 3	
SPECTRAVITE MEN 50 PLUS ORAL TABLET 300-60-600-300 MCG (multivitamin-mineral/folic acid/phytonadione/lycopene/lutein)	Tier 3	
SPECTRAVITE MEN'S ORAL TABLET 8 MG IRON- 200 MCG-600 MCG (multivits with calcium and minerals/iron/folic acid/lycopene)	Tier 3	
SPECTRAVITE WOMEN 50 PLUS ORAL TABLET 8 MG IRON-400 MCG-50 MCG (multivitamin with minerals/iron/folic acid/vitamin K/lutein)	Tier 3	
SUPERIOR MEN'S MULTI ORAL TABLET 400 MCG DFE-30 MCG-30 MG (multivit-min/levomefolate calc/K2/saw palm/ginkgo leaf/herbs)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUPERIOR WOMEN'S MULTI ORAL TABLET 2.5 MG IRON-400 MCG DFE-30 MCG (multivit-min/iron gly/levomefolate calc/K2/ginkgo leaf/herbs)	Tier 3	
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 15 MG IRON- 400 MCG (multivitamin/ferrous sulfate/folic acid)	Tier 3	
TARON-C DHA ORAL CAPSULE 35-1-200 MG (mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)	Tier 3	
THERA-M ORAL TABLET 9 MG IRON-400 MCG (multivits with calcium and minerals/iron fumarate/folic acid)	Tier 3	
THERAPEUTIC-M ORAL TABLET 9 MG IRON-400 MCG (multivits with calcium and minerals/iron fumarate/folic acid)	Tier 3	
THERA-VITE MAX-M ORAL TABLET 9 MG IRON-400 MCG (multivits with calcium and minerals/iron fumarate/folic acid)	Tier 3	
VISION OPTIMIZER ORAL CAPSULE 66.6MG-3.33MCG-3.33 MG-0.66 MG (vitamin B complex/vit C/selenium/lutein/zeaxanthin/herb 253)	Tier 3	
VISTA ADVANCED AREDS2 ORAL CAPSULE 250-137.5-12.5 MG (vit C/vit E/zinc/copper/selen/lutein/zeaxanthin/glutathione)	Tier 3	
VITAFUSION PRENATAL ORAL TABLET,CHEWABLE 180 MCG-32.5 MG (25 MG-7.5 MG) (mv-min no.110/folic acid/om-3/dha/other omega-3s/fish oil)	Tier 3	
VITAJoy ADULT MULTI ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
VITREXYL ORAL TABLET 1,000 MCG (multivitamin with minerals no.86/folic acid)	Tier 3	
VITREXYL PLUS IRON ORAL TABLET 27 MG IRON- 1 MG (multivitamin with minerals no.86/ferrous fumarate/folic acid)	Tier 3	
WELLFOLA ORAL TABLET 20 MG IRON- 1,670 MCG DFE (multivit with minerals no.83/iron bis-glycinate/folate no.10)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WESCAP-C DHA ORAL CAPSULE 35-1-200 MG (mv-min 75/ferrous fum/iron ps cplx/folic ac/omega-3/dha/epa)	Tier 3	
WOMEN'S 50 PLUS ADVANCED ORAL TABLET 400-20 MCG (multivitamin,calcium,minerals/folic acid/phytonadione(vit K))	Tier 3	
WOMENS DAILY GUMMIES ORAL TABLET,CHEWABLE 200 MCG (multivitamin with minerals/folic acid)	Tier 3	
WOMEN'S DAILY MULTIVITAMIN ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
WOMEN'S MULTIVITAMIN COLLAGEN ORAL TABLET,CHEWABLE 200 MCG- 25 MG (multivitamin with minerals/folic acid/collagen, hydrolyzed)	Tier 3	
ZATEAN-PN PLUS ORAL CAPSULE 28-1-300 MG (multivitamin-minerals no.71/iron fumarat/folic acid no.1/dha)	Tier 3	
Multivitamins - Drugs For Nutrition		
ADEK GUMMIES PLUS ZINC ORAL TABLET,CHEWABLE 2,400 MCG-18.75 MCG-67MG-400MCG (vitamin A/cholecalciferol (vit D3)/vit E/vit K1/zinc ascorb)	Tier 3	
ALTRIXA ORAL TABLET 1,000 MCG (multivitamin combination no.61/folic acid)	Tier 3	
CENTRUM ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
CENTRUM WOMEN ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
CENTURY ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
CERTAVITE-ANTIOXIDANT ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
DAILY MULTIVITAMIN-MINERALS ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DAILY-VITE (WITH FOLIC ACID) ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
DAVIMET-M ORAL TABLET,CHEWABLE 1,700 MCG DFE (multivitamin combination no.35/levomefolate calcium)	Tier 3	
DERMACINRX DAVIMET ORAL TABLET,CHEWABLE 1,000 MCG (multivitamin combination no.58/folic acid)	Tier 3	
DERMACINRX MULTIVITAMIN ORAL TABLET,CHEWABLE 1,700 MCG DFE (multivitamin combination no.35/levomefolate calcium)	Tier 3	
ENBRACE HR ORAL CAPSULE,IR - DELAY REL,BIPHASE 1.5 MG IRON- 8.73 MG-6.4 MG (multivit no.41/iron cysteine glycinate/folate no.8/phosph-dha)	Tier 3	
FOLET ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG-225 MG (multivitamin no.39/iron bisgl,carb/methylfolate/docusate/dha)	Tier 3	
HI-D ADEK GUMMIES PLUS ZINC ORAL TABLET,CHEWABLE 2,400 MCG-62.5 MCG-67 MG (vitamin A/cholecalciferol (vit D3)/vit E/vit K1/zinc ascorb)	Tier 3	
HIGH POTENCY MULTIVIT (W-IRON) ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
HIGH POTENCY MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
MICRONEX ORAL CAPSULE 400 MCG (multivitamin combination no.63/folic acid)	Tier 3	
MINI MULTIVITAMINS-IRON ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
<i>multivitamin oral tablet</i>	Tier 3	
NESTABS ONE ORAL CAPSULE 38-1-225 MG (multivit 42/iron b-g che,carbonyl/methyltetrahydrofolate/dha)	Tier 3	
OBSTETRIX ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG-225 MG (multivitamin no.39/iron bisgl,carb/methylfolate/docusate/dha)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OBSTETRIX ONE ORAL CAPSULE 38 MG-1,700 MCG DFE-225 MG (multivitamin comb no.42/iron,carbonyl/levomefolate/dha)	Tier 3	
ONE DAILY MULTIVITAMIN ORAL TABLET (multivitamin)	Tier 3	
ONE DAILY MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
ONEVITE DAILY MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
PNV-DHA ORAL CAPSULE 27 MG IRON-1 MG -300 MG (multivitamin combination no.47/ferrous fum/folate no.1/dha)	Tier 3	
PRENATAL-U ORAL CAPSULE 106.5-1 MG (multivitamin combination no.51/ferrous fumarate/folic acid)	Tier 3	
PRENATE AM ORAL TABLET 1-500 MG (multivit no.38/methyltetrahydrofolate glucos,folic acid/ginger)	Tier 3	
PRENATE CHEWABLE ORAL TABLET,CHEWABLE 1 MG (multivitamin no.36/methyltetrahydrofolate gluc,folic acid)	Tier 3	
PRENATE DHA ORAL CAPSULE 28 MG IRON-1 MG -300 MG (multivitamin no.45/iron fumarate/folate comb no.6/dha)	Tier 3	
PRENATE ESSENTIAL ORAL CAPSULE 29 MG IRON-1 MG -300 MG (multivitamin no.46/iron fumarate/folate comb. no.6/dha)	Tier 3	
PRENATE ESSENTIAL(IRON-ASP-GL) ORAL CAPSULE 18 MG IRON- 1 MG-300 MG (multivitamin no.40/iron asparto glycinate/folate no.1/dha)	Tier 3	
PREV-RX ORAL TABLET 1,000-25-20 MCG (folic acid/vit B12/D3/vit E succ/calcium/phosphatidylcholine)	Tier 3	
SPECTRAVITE ADULT ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
SPECTRAVITE WOMEN ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAB-A-VITE MULTIVITAMIN W-IRON ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
TAB-A-VITE ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
TARON-PREX PRENATAL-DHA ORAL CAPSULE 30 MG IRON-1.2 MG-55 MG-265 MG (multivitamin no.53/ferrous fum/folic acid/docusate/dha)	Tier 1	
THEREMS MULTIVITAMIN ORAL TABLET 400 MCG (multivitamin with folic acid)	Tier 3	
TRIVIA COMPLETE ORAL CAPSULE 400 MCG (multivitamin combination no.63/folic acid)	Tier 3	
WESCAP-PN DHA ORAL CAPSULE 27 MG IRON-1 MG - 300 MG (multivitamin combination no.47/ferrous fum/folate no.1/dha)	Tier 3	
WOMEN'S DAILY MULTIVITAMIN ORAL TABLET 18-400 MG-MCG (multivitamin/ferrous fumarate/folic acid)	Tier 3	
ZATEAN-PN DHA ORAL CAPSULE 27 MG IRON-1 MG - 300 MG (multivitamin combination no.47/ferrous fum/folate no.1/dha)	Tier 3	
Nutritional Product - Glutaric Aciduria Type 1 Specific Formulation - Drugs For Nutrition		
GLUTAREX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy, glutaric aciduria type 1)	Tier 3	
Nutritional Product - Isovaleric Acidemia Specific Formulation - Drugs For Nutrition		
I-VALEX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy for isovaleric acidemia with iron)	Tier 3	
Nutritional Product - Lipid Others - Drugs For Nutrition		
DOJOLVI ORAL LIQUID 8.3 KCAL/ML (triheptanoin)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MCT OIL ORAL OIL 14 GRAM-120 KCAL/15 ML (medium chain triglycerides)	Tier 3	
<i>medium chain triglycerides oral oil 14 gram-130 kcal/15 ml</i>	Tier 3	
Nutritional Product - Medical Condition Specific Formulation - Drugs For Nutrition		
ENDARI ORAL POWDER IN PACKET 5 GRAM (glutamine)	Tier 3	PA
<i>glutamine (sickle cell) oral powder in packet 5 gram</i>	Tier 3	PA
<i>ribose oral powder 10 kcal /2 gram (scoop)</i>	Tier 3	
Nutritional Product - Methionine-Free Specific Formulation - Drugs For Nutrition		
HCU GEL POWDER ORAL POWDER IN PACKET 41.7 GRAM-338 KCAL/100 GRAM (nutritional therapy, metabolic disorder, methionine-free)	Tier 3	
HCU MAXAMUM ORAL POWDER 40 GRAM-305 KCAL/100 GRAM (nutritional therapy, metabolic disorder, methionine-free)	Tier 3	
HOMINEX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy, metabolic disorder, methionine-free)	Tier 3	
Nutritional Product - Msud Specific Formulation - Drugs For Nutrition		
ISOLEUCINE 1000 ORAL POWDER IN PACKET 1 GRAM/4 GRAM (isoleucine supplement in carbohydrate base)	Tier 3	
ISOLEUCINE AMINO ACID SUPPLMNT ORAL POWDER IN PACKET 50 MG/4 GRAM (isoleucine supplement in carbohydrate base)	Tier 3	
KETONEX-2 ORAL POWDER 30-410 GRAM-KCAL (nutritional therapy for MSUD with iron)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METHIONINE ORAL POWDER IN PACKET 100 MG/4 GRAM (methionine supplement in carbohydrate base)	Tier 3	
MSUD GEL POWDER ORAL POWDER IN PACKET 41.7 GRAM-338 KCAL/100 GRAM (nutritional therapy for MSUD with iron)	Tier 3	
Nutritional Product - Nutritional Therapy - Drugs For Nutrition		
ALFAMINO JUNIOR ORAL POWDER 14 GRAM-480 KCAL/100 GRAM (nutritional therapy for impaired digestive function)	Tier 3	
BOOST GLUCOSE CONTROL ORAL LIQUID 0.07-0.8 GRAM-KCAL/ML (nutritional tx. glucose intolerance,lactose-free,soy/fiber)	Tier 3	
ELECARE JR ORAL POWDER 14.4 GRAM-493 KCAL/100 GRAM (nutritional therapy for impaired digestive function)	Tier 3	
ENSURE CLEAR THERAPEUTIC ORAL LIQUID 0.035-1 GRAM-KCAL/ML (nutritional therapy for impaired digestive function)	Tier 3	
ENSURE SURGERY ORAL LIQUID 0.08-1.4 GRAM-KCAL/ML (nutritional therapy, compromised immune system, regular)	Tier 3	
ENSURE SURGERY PERIOP BUNDLE ORAL LIQUID 0.08 GRAM- 1.4 KCAL/ML (nut.tx.compromised immune system, reg-maltodextrin-fructose)	Tier 3	
FRUITIVITS ORAL POWDER IN PACKET (nut.tx. metabolic disorder,reg/multivit with iron, minerals)	Tier 3	
GLUCERNA 1.5 CAL ORAL LIQUID 0.08-1.5 GRAM-KCAL/ML (nutritional tx. glucose intolerance,lactose-free,soy/fiber)	Tier 3	
GLUCERNA HUNGER SMART ORAL LIQUID (nutritional therapy, glucose intolerance,lactose-free,soy)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCERNA SNACK BAR ORAL BAR 11 GRAM-160 KCAL/40 GRAM (nutritional therapy, glucose intolerance,soy)	Tier 3	
GLUTAREX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy, glutaric aciduria type 1)	Tier 3	
IMPACT ADVANCED RECOVERY ORAL LIQUID 0.1 GRAM-1.12 KCAL/ML (nutritional therapy, compromised immune system, regular)	Tier 3	
MCT PRO-CAL ORAL PACKET (nutritional therapy for impaired digestive function)	Tier 3	
NEOCATE JUNIOR WITH PREBIOTICS ORAL POWDER 14.8 GRAM-472 KCAL/100 GRAM (nut.tx.impaired digest fxn/fiber)	Tier 3	
NEPRO CARB STEADY ORAL LIQUID 0.08 GRAM-1.8 KCAL/ML (nutritional therapy, impaired renal function,lactose-reduced)	Tier 3	
OPTICLEANSE GHI ORAL POWDER IN PACKET 26 GRAM-210 KCAL, 26 GRAM-230 KCAL (nutritional therapy for impaired digestive function)	Tier 3	
PEPTAMEN JUNIOR PHGG ORAL LIQUID 0.036 GRAM-1.2 KCAL/ML (nutritional therapy for impaired digestive function)	Tier 3	
PROVIMIN ORAL POWDER 73 GRAM-313 KCAL/100 GRAM (nutritional supplement)	Tier 3	
RENAMENT ORAL POWDER IN PACKET 10 GRAM- 210 KCAL (nutritional therapy, impaired renal function)	Tier 3	
RESTORE FUSION RENAL SUPPORT ORAL POWDER 2 GRAM-100 KCAL /21 GRAM (nutritional therapy, impaired renal function,lactose-free)	Tier 3	
RESTORE RENAL SUPPORT ORAL POWDER 2 GRAM-100 KCAL /21 GRAM (nutritional therapy, impaired renal function,lactose-free)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUPLINA CARB STEADY ORAL LIQUID 0.04 GRAM-1.8 KCAL/ML (nutritional therapy, impaired renal function,lactose-reduced)	Tier 3	
VITAL AF 1.2 CAL ORAL LIQUID 0.08 GRAM- 1.2 KCAL/ML (nut.tx.impaired digest fxn/fiber)	Tier 3	
VITAL PEPTIDE 1.5 CAL ORAL LIQUID 0.07 GRAM- 1.5 KCAL/ML (nut.tx.impaired digest fxn/fiber)	Tier 3	
VIVONEX PEDIATRIC ORAL POWDER 12 GRAM-412 KCAL/100 GRAM (nutritional therapy for impaired digestive function)	Tier 3	
Nutritional Product - Phenylketonuria (Pku) Specific Formulation - Drugs For Nutrition		
GLYTACTIN BETTERMILK 5-5 ORAL POWDER 38 GRAM-400 KCAL/100 GRAM (nutritional therapy for PKU no.64)	Tier 3	
NEOPHE ORAL POWDER 60 GRAM-345 KCAL/100 GRAM (nutritional therapy for phenylketonuria (PKU), no.38)	Tier 3	
PHENEX-1 ORAL POWDER 15 GRAM-480 KCAL/100 GRAM (infant formula for PKU, iron, no.2)	Tier 3	
PHENEX-2 ORAL POWDER 30-410 GRAM-KCAL/100 G (nutritional therapy for phenylketonuria (PKU) with iron no.1)	Tier 3	
Nutritional Product - Propionic Acidemia Specific Formulation - Drugs For Nutrition		
MMA-PA GEL ORAL POWDER IN PACKET 41.7 GRAM-338 KCAL/100 GRAM (nutritional therapy for propionic acidemia with iron)	Tier 3	
PROPIMEX-2 ORAL POWDER 30-410 GRAM-KCAL (nutritional therapy for propionic acidemia with iron)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nutritional Product - Protein Replacements - Drugs For Nutrition		
GI PROTECT ORAL POWDER 2 GRAM-25 KCAL /SCOOP (whey protein concentrate)	Tier 3	
IGG 2000 CWP ORAL CAPSULE 500 MG (whey protein concentrate)	Tier 3	
IGG 2000 CWP ORAL POWDER 4 GRAM-20 KCAL /5 GRAM (whey protein concentrate)	Tier 3	
IGG PURE ORAL POWDER 8 GRAM-40 KCAL /SCOOP (whey protein concentrate)	Tier 3	
JUVEN (WITH COLLAGEN) ORAL POWDER IN PACKET 7-7-1.5 GRAM (arginine/glutamine/calcium HMB/collagen/multivitamin-mineral)	Tier 3	
NEW ZEALAND WHEY PROTEIN ORAL POWDER 15 GRAM-70 KCAL/16.9 GRAM (whey protein isolate)	Tier 3	
PROCEL SINGLES ORAL POWDER IN PACKET 5 GRAM-26 KCAL (whey protein concentrate)	Tier 3	
PROSOURCE ORAL PACKET 7.5 GRAM (calcium caseinate/whey)	Tier 3	
Nutritional Product - Tyrosinemia Specific Formulation - Drugs For Nutrition		
TYREX-2 ORAL POWDER 30 GRAM-410 KCAL/100 GRAM (nutritional therapy for tyrosinemia with iron)	Tier 3	
Nutritional Product - Urea Cycle Disorder Specific Formulation - Drugs For Nutrition		
CYCLINEX-2 ORAL POWDER 15 GRAM-440 KCAL/100 GRAM (nutritional therapy, urea cycle disorder)	Tier 3	
EAA UCD ORAL POWDER IN PACKET 40 GRAM-310 KCAL/100 GRAM (nutritional therapy, urea cycle disorder)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Pediatric Vitamins - Drugs For Nutrition		
CHILDREN'S MULTIVITAMIN ORAL TABLET,CHEWABLE (pediatric multivitamin no.42)	Tier 3	
INFANT-TODDLER MULTIVIT ORAL DROPS 250 MCG-50 MG- 10 MCG/ML (pediatric multivitamin no.192)	Tier 3	
INFANT-TODDLER MULTIVITAMIN ORAL DROPS 250 MCG-50 MG- 10 MCG-5 MG/ML (pediatric multivitamin no.212)	Tier 3	
LITTLE ANIMALS ORAL TABLET,CHEWABLE (pediatric multivitamin no.28)	Tier 3	
<i>pediatric multivitamin no.171 oral drops 750 unit-35 mg- 400 unit/ml</i>	Tier 3	
PEDIATRIC POLY-VITE ORAL DROPS 250 MCG-50 MG- 10 MCG-5 MG/ML (pediatric multivitamin no.197)	Tier 3	
PEDIATRIC TRI-VITE ORAL DROPS 750 UNIT-35 MG - 400 UNIT/ML (vitamin A palmitate/ascorbic acid/cholecalciferol (vit D3))	Tier 3	
POLY-VITA DROPS ORAL DROPS 750 UNIT-35 MG- 400 UNIT/ML (pediatric multivitamin no.171)	Tier 3	
<i>vit a palmitate-vit c-vit d3 oral drops 250 mcg-50 mg- 10 mcg/ml, 750 unit-35 mg -400 unit/ml</i>	Tier 3	
Pediatric Vitamins And Mineral Combinations - Drugs For Nutrition		
ALIVE KIDS CHEWABLE ORAL TABLET,CHEWABLE 75-15 MG (pediatric multivit no.235/herbal no.293/bioflavonoids,cit)	Tier 3	
ALIVE KIDS MULTIVITAMIN ORAL TABLET,CHEWABLE 50 MG (pediatric multivitamin no.252/herbal complex no.293)	Tier 3	
CENTRUM KIDS MULTIGUMMY ORAL TABLET,CHEWABLE (pediatric multivitamin no.258)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHILDREN'S MULTIVITAMIN GUMMY ORAL TABLET,CHEWABLE (pediatric multivitamin no.209)	Tier 3	
CHILDREN'S MULTIVITAMIN ORAL TABLET,CHEWABLE (pediatric multivitamin no.42)	Tier 3	
CULTURELLE KIDS PROBIOTIC-MV ORAL TABLET,CHEWABLE 5 BILLION CELL (pediatric multivitamin no.193/Lactobacillus rhamnosus GG)	Tier 3	
CULTURELLE KIDS PRO-MV-LUTEIN ORAL TABLET,CHEWABLE 500 MILLION CELL (pediatric multivitamin no.210/Bacillus subtilis/lutein)	Tier 3	
EMERGEN-C KIDZ DAILY IMMUNE ORAL TABLET,CHEWABLE (pediatric multivitamin no.262)	Tier 3	
EMERGEN-C KIDZ IMMUNE PLUS ORAL TABLET,CHEWABLE (pediatric multivitamin no.261)	Tier 3	
FLINTSTONES COMPLETE (FE SULF) ORAL TABLET,CHEWABLE 10 MG IRON (pediatric multivitamin no.227/ferrous sulfate)	Tier 3	
FLINTSTONES IMMUNITY SUPPORT ORAL TABLET,CHEWABLE 10 MG IRON (pediatric multivitamin no.239/ferrous sulfate)	Tier 3	
FLINTSTONES WITH EXTRA IRON ORAL TABLET,CHEWABLE 18 MG IRON (pediatric multivitamin no.226/ferrous sulfate)	Tier 3	
GENADEK ORAL DROPS 19 MCG-500 MCG /ML (pediatric multivitamin no.196/vitamin D3/vit K1)	Tier 3	
GUMMY DINOS ORAL TABLET,CHEWABLE (pediatric multivitamin no.76)	Tier 3	
HI-D DROP ORAL DROPS 76-1,000 MCG/ML (pediatric multivitamin no.216/vitamin D3/vit K1)	Tier 3	
INFANT-TODDLER MULTIVIT-IRON ORAL DROPS 11 MG IRON/ML (pediatric multivitamin no.207/ferrous sulfate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JUST 4 KIDZ MULTIVIT-PROBIOTIC ORAL TABLET,CHEWABLE 1.25 MG (pediatric multivitamin no.200/Bacillus coagulans)	Tier 3	
KIDS MULTI ZERO ORAL TABLET,CHEWABLE (pediatric multivitamin no.229)	Tier 3	
LIVITA FOR CHILDREN ORAL LIQUID (pediatric multivitamin no.245)	Tier 3	
MVW MODULATR FORMLTN PEDIATRIC ORAL DROPS 2,000 MCG-150 MG-19 MCG/3 ML (vitamin A/ascorbic acid/vitamin D3/vit E mixed/vit K1/zinc)	Tier 3	
<i>pedi multivit no.194-iron sulf oral drops 10 mg iron/ml</i>	Tier 3	
PEDIATRIC POLY-VITE WITH IRON ORAL DROPS 11 MG IRON/ML (pediatric multivitamin no.197/ferrous sulfate)	Tier 3	
POLY-VITA WITH IRON ORAL DROPS 10 MG/ML (pediatric multivitamin no.160/ferrous sulfate)	Tier 3	
Pediatric Vitamins With Fluoride Combinations - Drugs For Nutrition		
DAVIMET WITH FLUORIDE ORAL TABLET,CHEWABLE 0.75 MG FLUORIDE (pediatric multivitamin no.247/sodium fluoride)	Tier 3	
FLORAFOL FE PEDIATRIC ORAL DROPS 0.25MG FLUORIDE -7 MG IRON/ML (pediatric multivitamin no.257/sodium fluoride/iron sulfate)	Tier 3	
FLORAFOL PEDIATRIC MULTIVITAMI ORAL DROPS 0.25 MG FLUORIDE/ML (pediatric multivitamin no.257 with sodium fluoride)	Tier 3	
FLORAFOL PEDIATRIC ORAL TABLET,CHEWABLE 0.5 MG FLUORIDE, 1 MG FLUORIDE (pediatric multivitamin no.251 with sodium fluoride)	Tier 3	
MULTI-VITAMIN WITH FLUORIDE ORAL DROPS 0.25 MG/ML (pediatric multivitamin no.2/sodium fluoride)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MULTI-VITAMIN WITH FLUORIDE ORAL TABLET,CHEWABLE 0.25 MG, 0.5 MG, 1 MG (pediatric multivitamins no.17 with sodium fluoride)	Tier 3	
MULTI-VIT-FLOR ORAL TABLET,CHEWABLE 0.25 MG FLUORIDE, 0.5 MG FLUORIDE, 1 MG FLUORIDE (pediatric multivitamin no.228 with sodium fluoride)	Tier 3	
MULTIVIT-FLUORIDE (METAFOILIN) ORAL TABLET,CHEWABLE 0.25 MG FLUORIDE, 0.5 MG FLUORIDE, 1 MG FLUORIDE (pediatric multivitamin no.219 with sodium fluoride)	Tier 3	
POLY-VI-FLOR (ARCOFOLIN) ORAL TABLET,CHEWABLE 0.25 MG FLUORIDE, 0.5 MG FLUORIDE, 1 MG FLUORIDE (pediatric multivitamin no.175 with fluoride)	Tier 3	
POLY-VI-FLOR DROPS (ARCOFOLIN) ORAL DROPS 0.25 MG FLUORIDE/ML (pediatric multivitamin no.220 with fluoride)	Tier 3	
POLY-VI-FLOR DROPS ORAL DROPS 0.25 MG FLUORIDE/ML (pediatric multivitamin no.220 with fluoride)	Tier 3	
POLY-VI-FLOR IRON DROP(ARCOFO) ORAL DROPS 0.25MG FLUORIDE -7 MG IRON/ML (pediatric multivitamin no.220/sodium fluoride/iron sulfate)	Tier 3	
POLY-VI-FLOR W-IRON(ARCOFOLIN) ORAL TABLET,CHEWABLE 0.5 MG FLUORIDE -10 MG IRON (pediatric multivitamin no.175 with fluoride and iron)	Tier 3	
SOLUVITA MULTIVITAMIN FLUORIDE ORAL DROPS 0.25 MG/ML, 0.5 MG/ML (pediatric multivitamin no.82 with sodium fluoride)	Tier 3	
TRI-VITAMIN (A-D-FOL)-FLUORIDE ORAL DROPS 0.25 MG/ML FLUORIDE (pediatric multivitamin no.265 with sodium fluoride)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prenatal Vitamins And Minerals - Drugs For Nutrition		
BAL-CARE DHA ESSENTIAL ORAL COMBO PACK, TABLET AND CAP, DR 27 MG IRON-1 MG -374 MG (prenatal vit no.100/iron ps cplex,sod EDTA/folic acid/omega3)	Tier 3	
BAL-CARE DHA ORAL COMBO PACK, TABLET AND CAP, DR 27-1-430 MG (prenatal vit no.81/iron ps,sod.feredetate/folic acid/omega-3)	Tier 3	
CADEAU DHA ORAL CAPSULE 29 MG IRON- 1 MG-150 MG (prenatal vitamins no.83/iron fumarate/folate no.6/dha)	Tier 3	
CITRANATAL (DUAL-IRON) ORAL TABLET 27 MG IRON-1 MG -50 MG (prenatal vits no.81/iron carbonyl,gluc/folic acid/docusate)	Tier 3	
CITRANATAL 90 DHA (ALGAL OIL) ORAL COMBO PACK 90 MG IRON-1 MG -50 MG-300 MG (prenatal vit no.72/iron carbony,gluc/folic acid/docusate/dha)	Tier 3	
CITRANATAL ASSURE ORAL COMBO PACK 35 MG IRON-1 MG -50 MG-300 MG (prenatal vit no.73/iron carbony,gluc/folic acid/docusate/dha)	Tier 3	
CITRANATAL DHA (ALGAL OIL) ORAL COMBO PACK 27 MG IRON-1 MG -50 MG-250 MG (prenatal vits no.76/iron carbon,gluc/folic acid/docusate/dha)	Tier 3	
CITRANATAL HARMONY (IRON FUM) ORAL CAPSULE 27 MG IRON-1 MG -50 MG-260 MG (prenatal vitamin no.59/iron carb,fum/folic acid/docusate/dha)	Tier 3	
C-NATE DHA ORAL CAPSULE 28 MG IRON-1 MG -200 MG (prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)	Tier 3	
COMPLETE NATAL DHA ORAL COMBO PACK 29 MG IRON- 1 MG-200 MG (prenatal vitamins no.52/iron/folic acid/omega-3/dha)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMPLETENATE ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vitamins no.14/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX PRENATRIX ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.170/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX PRENATRYL ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.170/ferrous fumarate/folic acid)	Tier 3	
DERMACINRX PRETRATE ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.170/ferrous fumarate/folic acid)	Tier 3	
FOLET ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG- 225 MG (multivitamin no.39/iron bisgl,carb/methylfolate/docusate/dha)	Tier 3	
KOSHER PRENATAL PLUS IRON ORAL TABLET 30 MG IRON- 1 MG (prenatal vitamins no.108/iron,carbonyl/folic acid)	Tier 3	
KPN ORAL TABLET 9 MG IRON- 267 MCG (prenatal vits with calcium no.98/ferrous fumarate/folic acid)	PV	
MARNATAL-F ORAL CAPSULE 60 MG IRON-1 MG (prenatal vits with calcium no.65/iron polysacchar/folic acid)	Tier 3	
MINI PRENATAL ORAL TABLET 6.75 MG IRON- 200 MCG (prenatal vitamins no.49/ferrous fumarate/folic acid)	PV	
M-NATAL PLUS ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
MYNATAL ADVANCE ORAL TABLET 90-1-50 MG (prenatal vit with calcium 15/iron/folic acid/docusate sodium)	Tier 1	
MYNATAL ORAL CAPSULE 65 MG IRON- 1 MG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	Tier 3	
MYNATAL ORAL TABLET 90-1-50 MG (prenatal vitamins with calcium/iron,carb/docusate/folic acid)	Tier 1	
MYNATAL PLUS ORAL TABLET 65 MG IRON- 1 MG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYNATAL-Z ORAL TABLET 65 MG IRON- 1 MG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	Tier 1	
MYNATE 90 PLUS ORAL TABLET EXTENDED RELEASE 90 MG IRON-1 MG (prenatal vitamins with calcium/ferrous fum/docusate/folic ac)	Tier 1	
NEONATAL COMPLETE ORAL TABLET 29-1 MG (prenatal vitamins no.175/ferrous fumarate/folic acid)	Tier 3	
NEONATAL PLUS VITAMIN ORAL TABLET 27 MG IRON-1 MG (prenatal vitamins no.154/ferrous fumarate/folic acid)	Tier 3	
NEONATAL-DHA ORAL COMBO PACK 29-1-200-500 MG (prenatal vit no.175/iron fum/folic acid/dha/Schiz. algal oil)	Tier 3	
NEO-VITAL RX ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.154/ferrous fumarate/folic acid)	Tier 3	
NESTABS ABC ORAL COMBO PACK 32 MG IRON-1 MG - 120 MG-180 MG (prenatal vitamins no.86/iron ps complex/folic acid/dha/epa)	Tier 3	
NESTABS DHA ORAL COMBO PACK 32 MG IRON- 1,000 MCG-230MG (prenatal vits with calcium no.87/iron bisgly/folic acid/dha)	Tier 3	
NEWGEN ORAL TABLET 32-1,000 MG-MCG (prenatal vitamins no.86/iron bis-glycinate/folic acid)	Tier 3	
NEXA PLUS ORAL CAPSULE 29 MG IRON-1.25 MG-55 MG (prenatal vits no.53/iron fum/folic acid/docusate calcium/dha)	Tier 3	
OB COMPLETE ONE ORAL CAPSULE 40-10-1-300 MG (prenatal vit no.85/iron carb,asp.gly/folic acid/dha/fish oil)	Tier 3	
OB COMPLETE PETITE ORAL CAPSULE 35 MG IRON-5 MG IRON-1 MG (prenatal 56/iron carbonyl,asparto glycinate/folic acid/dha)	Tier 3	
OB COMPLETE PREMIER ORAL TABLET 30-20-1 MG (prenatal vits no.83/iron,carbonyl,iron aspart.gly/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OB COMPLETE WITH DHA ORAL CAPSULE 30 MG IRON-10 MG IRON-1 MG (prenatal vit no.30/iron carbonyl,asp glyc/folic acid/omega-3)	Tier 3	
OBSTETRIX DHA ORAL COMBO PACK, TABLET AND CAP, DR 29 MG IRON-1 MG -50 MG (prenatal vits no.12/iron,carb/folic acid/docusate/omega-3)	Tier 1	
OBSTETRIX DHA PRENATAL DUO ORAL COMB PACK, TABLET DR, CAPSULE DR 29 MG IRON- 1,700 MCG DFE (prenatal vitamins no.12/iron carbonyl/levomefolate calc/dha)	Tier 1	
OBSTETRIX EC ORAL TABLET, DELAYED RELEASE (DR/EC) 29 MG IRON- 1,700 MCG DFE (prenatal vitamins no.12/iron,carbonyl/levomefolate calcium)	Tier 3	
OBSTETRIX EC ORAL TABLET, DELAYED RELEASE (DR/EC) 29 MG IRON-1 MG -50 MG (prenatal vitamins no.127/iron,carbonyl/folic acid/docusate)	Tier 3	
OBSTETRIX ONE ORAL CAPSULE 38 MG IRON-1 MG -25 MG-225 MG (multivitamin no.39/iron bisgl,carb/methylfolate/docusate/dha)	Tier 3	
OBTREX DHA ORAL COMBO PACK, TABLET AND CAP, DR 29 MG IRON-1 MG -50 MG (prenatal vits no.12/iron,carb/folic acid/docusate/omega-3)	Tier 3	
ONE DAILY PRENATAL ORAL COMBO PACK 28-800-440 MG-MCG-MG (prenatal vit with calcium 75/iron/folic acid/omega-3/dha/epa)	PV	
ONE-A-DAY PRENATAL-1 ORAL CAPSULE 27 MG IRON-800 MCG-235 MG (prenatal vitamins no.168/iron/folic acid/omega-3/dha/epa)	Tier 3	
<i>pnv no.95-ferrous fumarate-fa oral tablet 28 mg iron- 800 mcg</i>	PV	
PNV-DHA + DOCUSATE ORAL CAPSULE 27-1.25-55-300 MG (prenatal vits,calcium no.66/iron fum/folic acid/docusate/dha)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PNV-SELECT ORAL TABLET 27-1 MG (prenatal vits with calcium no.40/iron fumarate/folate no.1)	Tier 3	
PR NATAL 400 EC ORAL COMBO PACK, TABLET AND CAP, DR 29-1-400 MG (prenatal vit no.19/iron bg HCl, suc-prot/folic acid/omega-3)	Tier 3	
PR NATAL 400 ORAL COMBO PACK 29-1-400 MG (prenatal vit with calcium 53/iron bis, s-p/folic acid/omega-3)	Tier 3	
PR NATAL 430 EC ORAL COMBO PACK, TABLET AND CAP, DR 29-1-430 MG (prenatal vit 55/iron bisgly HCl, suc-prot/folic acid/omega-3)	Tier 3	
PR NATAL 430 ORAL COMBO PACK 29 MG IRON-1 MG - 430 MG (prenatal vit with calcium 54/iron bis, s-p/folic acid/omega-3)	Tier 3	
PREGEN DHA ORAL CAPSULE 28 MG-1,000MCG- 35 MG-200 MG (prenatal vit no.174/iron/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
PRENAISSANCE ORAL CAPSULE 29-1.25-55-325 MG (prenatal vits with calcium no.80/iron fum/folic acid/dss/dha)	Tier 1	
PRENAISSANCE PLUS ORAL CAPSULE 28-1-50-250 MG (prenatal vit with calcium no.69/iron/folic acid/docusate/dha)	Tier 1	
PRENATA ORAL TABLET, CHEWABLE 29 MG IRON- 1 MG (prenatal vitamins no.37/ferrous fumarate/folic acid)	Tier 3	
PRENATABS FA ORAL TABLET 29-1 MG (prenatal vits with calcium no.78/ferrous fumarate/folic acid)	Tier 3	
PRENATABS RX ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamin with calcium no.76/iron, carbonyl/folic acid)	Tier 3	
PRENATAL + DHA ORAL COMBO PACK 28 MG IRON- 975 MCG-200 MG (prenatal vits, calcium no.91/ferrous fumarate/folic acid/dha)	PV	
PRENATAL + DHA ORAL COMBO PACK 28 MG IRON-800 MCG-200 MG (prenatal vit with calcium 95/ferrous fumarate/folic acid/dha)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL 19 (WITH DOCUSATE) ORAL TABLET 29 MG IRON- 1 MG-25 MG (prenatal vits no.115/iron fumarate/folic acid/docusate sod.)	Tier 1	
PRENATAL 19 ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamins no.119/iron fumarate/folic acid)	Tier 3	
PRENATAL 19 ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vits with calcium no.115/iron fumarate/folic acid)	Tier 3	
PRENATAL COMPLETE ORAL TABLET 14 MG IRON- 400 MCG (prenatal vits with calcium no.21/ferrous fumarate/folic acid)	PV	
PRENATAL ESSENTIALS ORAL CAPSULE 6 MG IRON- 272 MCG DFE (prenatal vits no.173/iron bisglycinate/folate no.11)	Tier 3	
PRENATAL FORMULA ORAL TABLET 9 MG IRON- 267 MCG (prenatal vits with calcium no.93/ferrous fumarate/folic acid)	PV	
PRENATAL FORMULA-DHA ORAL CAPSULE 28 MG-800 MCG- 200 MG (prenatal vitamins no.116/iron fumarate/folic acid/dha)	PV	
PRENATAL MULTI ORAL TABLET 27-800 MG-MCG (prenatal vit with calcium no.122/ferrous fumarate/folic acid)	PV	
PRENATAL MULTI-DHA (ALGAL OIL) ORAL CAPSULE 27MG IRON- 800 MCG-250 MG (prenatal vitamins no.40/ferrous fumarate/folic acid/dha)	PV	
PRENATAL MULTI-DHA(WITH VIT K) ORAL CAPSULE 27 MG IRON-800 MCG-260 MG (prenatal vits no.151/iron fum/folic acid/omega3/dha/epa/fish)	PV	
PRENATAL MULTIVITAMINS ORAL TABLET 28 MG IRON- 800 MCG (prenatal vits with calcium 95/ferrous fumarate/folic acid)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL ONE DAILY ORAL TABLET 27 MG IRON- 800 MCG (prenatal vit with calcium no.129/ferrous fumarate/folic acid)	PV	
PRENATAL ORAL TABLET 28 MG IRON- 800 MCG (prenatal vits with calcium 95/ferrous fumarate/folic acid)	PV	
PRENATAL ORAL TABLET 28-800 MG-MCG (prenatal vits with calcium 133/ferrous fumarate/folic acid)	PV	
PRENATAL PLUS (CALCIUM CARB) ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
PRENATAL PLUS DHA ORAL COMBO PACK 27 MG IRON-1 MG -312 MG-250 MG (PNV no.72/ferrous fumarate/folic acid/omega-3/dha)	Tier 3	
PRENATAL PLUS ORAL TABLET 29 MG IRON- 1 MG (prenatal vits with calcium no.72/iron,carbonyl/folic acid)	Tier 3	
PRENATAL PLUS VITAMIN-MINERAL ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.180/ferrous fumarate/folic acid)	Tier 3	
PRENATAL TABLET ORAL TABLET 28 MG IRON- 800 MCG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	PV	
<i>prenatal vit no.179-iron-folic oral tablet 28 mg iron- 800 mcg</i>	PV	
PRENATAL VITAMIN ORAL TABLET 27 MG IRON- 0.8 MG (prenatal vit with calcium no.130/ferrous fumarate/folic acid)	PV	
PRENATAL VITAMIN ORAL TABLET 27 MG IRON- 800 MCG (prenatal vits with calcium no.124/ferrous fumarat/folic acid)	PV	
PRENATAL VITAMIN PLUS LOW IRON ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATAL VITAMIN WITH MINERALS ORAL TABLET 28 MG IRON- 800 MCG (prenatal vitamins with calcium/ferrous fumarate/folic acid)	PV	
<i>prenatal vit-iron fum-folic ac oral tablet 28 mg iron- 800 mcg</i>	PV	
PRENATAL WITH DHA-FOLIC ACID ORAL TABLET,CHEWABLE 400-32.5 MCG-MG (prenatal vitamins no.103/folic acid/omega-3s/dha/fish oil)	PV	
PRENATE ENHANCE ORAL CAPSULE 28 MG IRON- 1 MG-400 MG (prenatal vitamins no.68/iron fumarate/folate no.6/dha)	Tier 3	
PRENATE RESTORE ORAL CAPSULE 27 MG IRON- 1 MG-400 MG (prenatal vitamins no.69/iron fumarate/folate no.6/dha)	Tier 3	
PRIMACARE ORAL CAPSULE 30-1-300 MG (prenatal vits no.118/iron asparto glycinate/folate no.6/dha)	Tier 3	
PROVIDA OB ORAL CAPSULE 40 MG IRON- 1.25 MG (prenatal vits no.65/ferrous fumarate,iron polysac/folic acid)	Tier 3	
SELECT-OB (FOLIC ACID) ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vits no.128/iron polysaccharide complex/folic acid)	Tier 3	
SELECT-OB + DHA ORAL COMBO PACK 29 MG IRON-1 MG -250 MG (prenatal vitamins no.33/iron polysach complex/folic acid/dha)	Tier 3	
SELECT-OB ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vitamins no.13/iron polysaccharides/folate no.1)	Tier 3	
SE-NATAL 19 CHEWABLE ORAL TABLET,CHEWABLE 29 MG IRON- 1 MG (prenatal vits with calcium 118/ferrous fumarate/folic acid)	Tier 3	
SE-NATAL 19 ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamins no.119/iron fumarate/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMILAC PRENATAL ORAL COMBO PACK 27 MG IRON-800 MCG-200 MG (prenatal vits, calcium no.102/ferrous fum/folic acid/dha/lut)	PV	
STUART ONE ORAL CAPSULE 27 MG IRON- 800 MCG-200 MG (prenatal vitamins no.63/iron,carbonyl/folic acid/dha)	PV	
TARON-PREX PRENATAL-DHA ORAL CAPSULE 30 MG IRON-1.2 MG-55 MG-265 MG (multivitamin no.53/ferrous fum/folic acid/docusate/dha)	Tier 1	
THERANATAL COMPLETE ORAL COMBO PACK 27 MG IRON- 1 MG-150 MG (prenatal vitamins no.32/ferrous fumarate/folic acid/dha)	PV	
THERANATAL ONE ORAL CAPSULE 27 MG IRON-1000 MCG-300 MG (prenatal vitamins no.100/iron fumarate/folic acid/dha/epa)	PV	
THERANATAL ORAL TABLET 27 MG IRON- 1 MG (prenatal vitamins no.28/ferrous fumarate/folic acid)	PV	
THERANATAL PLUS ORAL COMBO PACK 27 MG IRON-1 MG-300 MG (prenatal vitamins no.74/ferrous fumarate/folic acid/dha)	PV	
THRIVITE RX ORAL TABLET 29 MG IRON- 1 MG (prenatal vitamin with calcium no.76/iron,carbonyl/folic acid)	Tier 3	
TRICARE ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium 103/ferrous fumarate/folic acid)	Tier 3	
TRINATAL RX 1 ORAL TABLET 60 MG IRON-1 MG (prenatal vitamin 27 with calcium/ferrous fumarate/folic acid)	Tier 3	
TRINATE ORAL TABLET 28 MG IRON- 1 MG (prenatal vits with calcium no.73/ferrous fumarate/folic acid)	Tier 3	
TRISTART DHA ORAL CAPSULE 31 MG IRON- 1 MG-200 MG (prenatal vitamins no.93/iron carbonyl/folate no.9/dha)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA PRENATAL PLUS DHA ORAL CAPSULE 27 MG-800 MCG- 250 MG-200 MG (prenatal vit no.166/iron/folic acid/omega-3/dha/epa/fish oil)	Tier 3	
VITAFOL FE PLUS ORAL CAPSULE 90 MG IRON- 1 MG-200 MG (prenatal vits no.102/iron polysacch/folate no.1/dha)	Tier 3	
VITAFOL FE+ (WITH DOCUSATE) ORAL CAPSULE 90 MG IRON-1 MG -50 MG-200 MG (prenatal vits no.102/iron polysacch/folate no.1/docusate/dha)	Tier 3	
VITAFOL ULTRA ORAL CAPSULE 29 MG IRON- 1 MG-200 MG (prenatal vitamins no.67/iron polysaccharides/folate no.1/dha)	Tier 3	
VITAFOL-OB ORAL TABLET 65-1 MG (prenatal vits with calcium no.10/ferrous fumarate/folic acid)	Tier 3	
VITAFOL-OB+DHA ORAL COMBO PACK 65-1-250 MG (prenatal vits with calcium no.10/ferrous fum/folic acid/dha)	Tier 3	
VITAFOL-ONE ORAL CAPSULE 29 MG IRON- 1 MG-200 MG (prenatal vits no.26/iron polysaccharide cplex/folic acid/dha)	Tier 3	
VITAMEDMD ONE RX ORAL CAPSULE 30 MG IRON-1MG -200 MG (prenatal vitamins no.25/ferrous fumarate/folate no.6/dha)	Tier 3	
VP-CH-PNV ORAL CAPSULE 30 MG IRON-1 MG -50 MG-260 MG (prenatal vits no.34/iron,carb/folic acid/docusate sodium/dha)	Tier 1	
WESNATAL DHA COMPLETE ORAL COMBO PACK 29 MG IRON- 1 MG-200 MG (prenatal vitamins no.52/iron/folic acid/omega-3/dha)	Tier 3	
WESNATE DHA ORAL CAPSULE 28 MG IRON-1 MG -200 MG (prenatal vitamins no.11/ferrous fumarate/folic acid/omega-3)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WESTAB PLUS ORAL TABLET 27 MG IRON- 1 MG (prenatal vits with calcium no.72/ferrous fumarate/folic acid)	Tier 3	
WESTGEL DHA ORAL CAPSULE 31 MG IRON- 1 MG-200 MG (prenatal vitamins no.93/iron carbonyl/folate no.9/dha)	Tier 3	
WOMEN'S PRENATAL PLUS DHA ORAL COMBO PACK 28 MG-975 MCG- 200 MG (prenatal vit with calcium no.61/iron fumarate/folic acid/dha)	PV	
Prenatal Vitamins With Low Or No Iron (Less Than 27 Mg) - Drugs For Nutrition		
ALTRIXA OB ORAL TABLET 15 MG IRON- 1,750 MCG DFE (prenatal vitamins no.181/ferrous fumarate/folate)	Tier 3	
AZESCO ORAL TABLET 13 MG IRON- 1 MG (prenatal vitamins no.147/ferrous gluconate/folic acid)	Tier 3	
MATERVIA ORAL CAPSULE 6.5 MG IRON- 500 MCG (prenatal vitamins no.178/iron bisglycinate/folic acid)	Tier 3	
NATAL PNV ORAL TABLET 6 MG IRON- 833.5 MCG DFE (prenatal vitamins no.164/ferrous gluconate/folate no.6)	Tier 3	
ONE-A-DAY PRENATAL ORAL TABLET,CHEWABLE 400 MCG- 25 MG (prenatal vitamins no.167/folic acid/docosahexaenoic acid)	Tier 3	
PNV TABS 20-1 ORAL TABLET 20 MG IRON- 1 MG (prenatal vitamins no.163/iron bis-glycinate/folate no.10)	Tier 3	
PRENATAL GUMMIES ORAL TABLET,CHEWABLE 400 MCG-35 MG- 25 MG-5 MG (prenatal vitamins no.153/folic acid/omega3/dha/epa/fish oil)	PV	
PRENATAL ORAL TABLET,CHEWABLE 400 MCG (prenatal vitamins no.144/folic acid)	PV	
PRENATE DHA (FERR ASP GLYCIN) ORAL CAPSULE 18 MG IRON-1 MG -300 MG (prenatal vitamins no.78/iron asparto glycin/folate no.1/dha)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRENATE ELITE (IRON ASP GLYC) ORAL TABLET 20 MG IRON- 1 MG (prenatal vits no.114/ferrous aspart glycinate/folate no.1)	Tier 3	
PRENATE ELITE ORAL TABLET 26 MG IRON- 1 MG (prenatal vitamins no.36/ferrous fumarate/folate no.6)	Tier 3	
PRENATE MINI (FERR ASP GLYCIN) ORAL CAPSULE 18-1-350 MG (prenatal vits no.87/iron asp.glycinate,carb/folate no.1/dha)	Tier 3	
PRENATE PIXIE ORAL CAPSULE 10 MG IRON- 1 MG-200 MG (prenatal vitamins no.85/iron asparto glycin/folate no.1/dha)	Tier 3	
PRENATE STAR ORAL TABLET 20 MG IRON- 1 MG (prenatal vitamins no.77/ferrous asparto glycinate/folic acid)	Tier 3	
R-NATAL OB ORAL CAPSULE 20 MG IRON- 1 MG-320 MG (prenatal vitamins no.66/iron,carbonyl/folic acid/dha)	Tier 3	
THERANATAL OVAVITE ORAL COMBO PACK 18-1-125 MG-MG-UNIT (prenatal vitamins no.74/ferrous fumarate/folic acid/coQ10)	PV	
VITAFOL GUMMIES ORAL TABLET,CHEWABLE 3.33 MG IRON- 0.33 MG (prenatal vits no.112/iron phosph/folic acid/omega-3s/dha/epa)	Tier 3	
ZALVIT ORAL TABLET 13 MG IRON- 1 MG (prenatal vitamins no.147/ferrous gluconate/folic acid)	Tier 3	
ZIPHEX ORAL TABLET 13 MG IRON- 1 MG (prenatal vitamins no.147/ferrous gluconate/folic acid)	Tier 3	
Sodium Chloride Flushes - Drugs For Nutrition		
AQUASTAT 0.9% SODIUM CHLORIDE INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 3	KP
AQUASTAT SFR 0.9% SODIUM CHLOR INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 3	KP
BD POSIFLUSH NORMAL SALINE 0.9 INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT 0.9% SODIUM CHLORIDE INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 3	KP
MONOJECT PREFILL ADVANCED NS INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 3	KP
NORMAL SALINE FLUSH INJECTION SYRINGE (sodium chloride 0.9 % (flush))	Tier 1	KP
<i>sodium chlor 0.9% bacteriostat injection solution 0.9 %</i>	Tier 1	KP
<i>sodium chloride 0.9 % (flush) injection syringe</i>	Tier 1	KP
<i>sodium chloride 0.9 % injection solution</i>	Tier 1	KP
Sodium Chloride, Parenteral - Drugs For Nutrition		
<i>sodium chloride 0.45 % intravenous parenteral solution 0.45 %</i>	Tier 1	KP
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	Tier 1	KP
<i>sodium chloride 0.9 % intravenous piggyback</i>	Tier 1	KP
Vitamin C Combinations - Drugs For Nutrition		
EMERGEN-C APPLE CIDER VINEGAR ORAL POWDER EFFERVESCENT IN PACKET 250 MG (ascorbic acid/multivitamin with minerals/herbal drugs)	Tier 3	
EMERGEN-C ASHWAGANDHA ORAL POWDER EFFERVESCENT IN PACKET 250 MG (ascorbic acid/multivitamin with minerals/herbal drugs)	Tier 3	
EMERGEN-C ELDERBERRY ORAL TABLET,CHEWABLE 133.3-16.7 MG, 250-16.7 MG (ascorbic acid/multivit with minerals/elderberry fruit)	Tier 3	
EMERGEN-C ENERGY PLUS ORAL POWDER EFFERVESCENT IN PACKET 250-50 MG (ascorbic acid/vitamin B complex/minerals/cafeine)	Tier 3	
EMERGEN-C IMMUNE PLUS ORAL TABLET,CHEWABLE 250 MG (ascorbic acid/multivit with minerals)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMERGEN-C ORAL TABLET,CHEWABLE 500 MG (ascorbic acid/ascorbate sodium/multivitamin with minerals)	Tier 3	
EMERGEN-C TURMERIC GINGER ORAL POWDER EFFERVESCENT IN PACKET 250-100-150 MG (ascorbic acid/multivit with minerals/turmeric/ginger root)	Tier 3	
EMERGEN-C TURMERIC GINGER ORAL TABLET,CHEWABLE 83.3-33.3-16.6 MG (ascorbic acid/multivit with minerals/turmeric/ginger root)	Tier 3	
SAMBUCUS ELDERBERRY-VITAMIN C ORAL LOZENGE 250-12.5 MG (ascorbic acid/ascorbate sodium/elderberry fruit)	Tier 3	
VITAMIN C FIZZY DRINK ORAL POWDER EFFERVESCENT IN PACKET 1,000 MG (ascorbic acid/multivit with minerals)	Tier 3	
Vitamin D And Folic Acid Combinations - Drugs For Nutrition		
CHOLECAL DF ORAL TABLET 95 MCG (3,800 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX DOTREMINE ORAL TABLET 250 MCG (10,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX FOLDITAM ORAL TABLET 250 MCG (10,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX FOLIXAPURE ORAL TABLET 125 MCG (5,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX FOLIXATE ORAL TABLET 125 MCG- 1,700 MCG DFE (cholecalciferol (vit D3)/levomefolate calcium)	Tier 3	
DERMACINRX FOLTAMIN ORAL TABLET 125 MCG (5,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
DERMACINRX FOLTREXYL ORAL TABLET 125 MCG (5,000 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FOLIC D3 ORAL CAPSULE 94.38 MCG(3,775 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
OSTACHOL ORAL TABLET 95 MCG (3,800 UNIT)-1 MG (cholecalciferol (vit D3)/folic acid)	Tier 3	
Vitamin E Combinations - Drugs For Nutrition		
XCELLENT E ORAL CAPSULE 33.5-125-25 MG (vitamin E/vitamin E mixed/tocotrienol)	Tier 3	
Vitamins - A - Drugs For Nutrition		
A-25 (VIT A PALMITATE) ORAL CAPSULE 7,500 MCG (25,000 UNIT) (vitamin A palmitate)	Tier 3	
<i>beta carotene oral capsule 7,500 mcg (25,000 unit)</i>	Tier 3	
PUREVITA VITAMIN A ORAL DROPS 3,000 MCG/2 ML (vitamin A palmitate)	Tier 3	
<i>vitamin a oral capsule 3,000 mcg (10,000 unit)</i>	Tier 3	
<i>vitamin a palmitate oral capsule 3,000 mcg (10,000 unit)</i>	Tier 3	
Vitamins - B Preparation Combinations - Drugs For Nutrition		
B-COMPLEX PLUS B-12 ORAL TABLET 7 MG-5 MG-4 MG- 25 MCG-10 MG (thiamine HCl/riboflavin/niacinamide/cyanocobalamin/papain)	Tier 3	
<i>cyanocobalamin-methylcobalamin sublingual drops 5,000 mcg/ml</i>	Tier 3	
<i>folic acid-vitamin b6-vit b12 oral tablet 400 mcg-50 mg- 100 mcg</i>	Tier 3	
FOLICORE B COMPLEX ORAL TABLET 1,000 MCG-10 MG -400 MCG (folic acid/pyridoxine HCl (B6)/cyanocobalamin)	Tier 3	
FOLVITA COMPLEX ORAL TABLET 1 MG-10 MG- 400 MCG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KIDS BRAIN BUILDER ORAL TABLET,CHEWABLE 27.5 MG-0.2 MG- 0.25 MCG (choline bitartrate/pyridoxine HCl (vitamin B6)/vit B12)	Tier 3	
METANX FC ORAL CAPSULE 2-3-35 MG (mecobalamin/levomefolate calcium/pyridoxal phosphate)	Tier 3	
METHYL PROTECT ORAL CAPSULE 1,000 MCG-3,400 MCG DFE-10 MG (mecobalamin/folate no.11/pyridoxal/vit B2/betaine)	Tier 3	
MINCORA ORAL TABLET 20 MCG- 1,000 MCG-10 MG (cholecalciferol/folic acid/vit B6/vit B12/acetylcysteine)	Tier 3	
RELCARE ORAL TABLET 20 MCG- 1,000 MCG-10 MG (cholecalciferol/folic acid/vit B6/vit B12/acetylcysteine)	Tier 3	
WESTAB MAX ORAL TABLET 2.5-25-2 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
WESTAB ONE ORAL TABLET 2.5-25-1 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
ZINGIBER ORAL TABLET 1.2 MG-40 MG- 124.1 MG-100 MG (folic acid/pyridoxine HCl/Ca phos dibasic & tribasic/ginger)	Tier 3	
Vitamins - B-1, Thiamine And Derivatives - Drugs For Nutrition		
<i>benfotiamine oral capsule 150 mg</i>	Tier 3	
PUREVITA VITAMIN B1 ORAL DROPS 50 MG/2 ML (thiamine HCl)	Tier 3	
<i>thiamine hcl (vitamin b1) injection solution 100 mg/ml</i>	Tier 1	KP
<i>thiamine hcl (vitamin b1) oral capsule 100 mg</i>	Tier 3	
<i>thiamine hcl (vitamin b1) oral tablet 100 mg, 50 mg</i>	Tier 3	
<i>thiamine mononitrate (vit b1) oral tablet 100 mg</i>	Tier 3	
<i>thiamine mononitrate (vit b1) oral tablet 250 mg, 50 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamins - B-12 And Folic Acid Combinations - Drugs For Nutrition		
LORMATE ORAL CAPSULE 1 MG-1 MG(1,670 MCG DFE)-500 MG (mecobalamin/levomefolate calcium/turmeric root extract)	Tier 3	
<i>me-thfolate glucos-mecobalamin oral tablet,disintegrating 1,000 mcg dfe- 2,500 mcg</i>	Tier 3	
PAXLYTE ORAL CAPSULE 50 MCG-1 MG- 4.25 MG DFE (cobamamide/folic acid/leucovorin/levomefolate/mv-mins no.111)	Tier 3	
<i>vitamin b12-folic acid oral tablet,disintegrating 2,500-400 mcg</i>	Tier 3	
Vitamins - B-12, Cyanocobalamin And Derivatives - Drugs For Nutrition		
ADENO-HYDROXO B12 ORAL TABLET,DISINTEGRATING 2,500 MCG (hydroxocobalamin acetate/cobamamide)	Tier 3	
B12 ACTIVE ORAL TABLET,CHEWABLE 1,000 MCG (mecobalamin)	Tier 3	
B12 SUBLINGUAL LOZENGE 5,000-100 MCG (cyanocobalamin/cobamamide)	Tier 3	
<i>cyanocobalamin (vitamin b-12) injection solution 1,000 mcg/ml</i>	Tier 1	KP
<i>cyanocobalamin (vitamin b-12) nasal spray,non-aerosol 500 mcg/spray</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral liquid 1,000 mcg/15 ml</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral lozenge 500 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral tablet 1,000 mcg, 100 mcg, 250 mcg, 500 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) oral tablet extended release 1,000 mcg, 2,000 mcg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyanocobalamin (vitamin b-12) oral tablet,chewable 1,500 mcg, 5,000 mcg, 500 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) sublingual lozenge 3,000 mcg</i>	Tier 3	
<i>cyanocobalamin (vitamin b-12) sublingual tablet 1,000 mcg, 2,500 mcg, 5,000 mcg</i>	Tier 3	
<i>cyanocobalamin-cobamamide sublingual tablet 5,000-100 mcg</i>	Tier 3	
<i>cyanocobalamin-methylcobalamin sublingual drops 5,000 mcg/ml</i>	Tier 3	
<i>cyanocobalamin (vitamin B-12) (Dodex Injection Solution 1,000 Mcg/ML)</i>	Tier 1	KP
<i>hydroxocobalamin intramuscular solution 1,000 mcg/ml</i>	Tier 1	KP
<i>mecobalamin (vitamin b12) injection recon soln 10,000 mcg</i>	Tier 1	KP
<i>mecobalamin (vitamin b12) oral tablet,chewable 1,000 mcg</i>	Tier 3	
<i>mecobalamin (vitamin b12) oral tablet,chewable 5,000 mcg, 500 mcg</i>	Tier 3	
<i>mecobalamin (vitamin b12) oral tablet,disintegrating 5,000 mcg</i>	Tier 3	
<i>mecobalamin (vitamin b12) sublingual tablet,disintegrating 1,000 mcg</i>	Tier 3	
<i>PUREVITA VITAMIN B12 ORAL DROPS 3,000 MCG/2 ML (mecobalamin)</i>	Tier 3	
Vitamins - B-2, Riboflavin And Derivatives - Drugs For Nutrition		
<i>PUREVITA VITAMIN B2 ORAL DROPS 25 MG/2 ML (riboflavin (vitamin B2))</i>	Tier 3	
<i>riboflavin (vitamin b2) oral capsule 100 mg</i>	Tier 3	
<i>riboflavin (vitamin b2) oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamins - B-3, Niacin And Derivatives - Drugs For Nutrition		
<i>niacin (inositol niacinate) oral capsule 400 mg niacin (500 mg)</i>	Tier 3	
<i>niacin (inositol niacinate) oral capsule 500 mg</i>	Tier 3	
<i>niacin oral capsule 100 mg</i>	Tier 3	
<i>niacin oral tablet 100 mg, 500 mg</i>	Tier 3	
<i>niacin oral tablet extended release 500 mg</i>	Tier 3	
<i>niacinamide oral capsule 500 mg</i>	Tier 3	
<i>niacinamide oral tablet 250 mg, 50 mg</i>	Tier 3	
<i>niacinamide oral tablet 500 mg</i>	Tier 3	
PUREVITA VITAMIN B3 ORAL DROPS 35 MG/2 ML (niacinamide)	Tier 3	
Vitamins - B-5, Pantothenic Acid And Derivatives - Drugs For Nutrition		
<i>calcium pantothenate oral capsule 250 mg</i>	Tier 3	
PUREVITA VITAMIN B5 ORAL DROPS 20 MG/2 ML (calcium pantothenate)	Tier 3	
Vitamins - B-6, Pyridoxine And Derivatives - Drugs For Nutrition		
PUREVITA VITAMIN B6 ORAL DROPS 25 MG/2 ML (pyridoxine HCl (vitamin B6))	Tier 3	
<i>pyridoxine (vitamin b6) injection solution 100 mg/ml</i>	Tier 1	KP
<i>pyridoxine (vitamin b6) oral tablet 10 mg</i>	Tier 3	
<i>pyridoxine (vitamin b6) oral tablet 100 mg, 25 mg, 50 mg, 500 mg</i>	Tier 3	
Vitamins - Bioflavonoids - Drugs For Nutrition		
<i>quercetin oral capsule 500 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vitamins - Biotin - Drugs For Nutrition		
<i>biotin oral capsule 5 mg</i>	Tier 3	
<i>biotin oral tablet 1 mg, 10 mg, 5 mg</i>	Tier 3	
<i>biotin oral tablet,chewable 2,500 mcg</i>	Tier 3	
<i>biotin oral tablet,chewable 5,000 mcg</i>	Tier 3	
<i>biotin oral tablet,disintegrating 10,000 mcg, 5,000 mcg</i>	Tier 3	
HAIR, SKIN AND NAILS (BIOTIN) ORAL TABLET,CHEWABLE 10,000 MCG (biotin)	Tier 3	
VITAJEY BIOTIN ORAL TABLET,CHEWABLE 2,500 MCG (biotin)	Tier 3	
Vitamins - C, Ascorbic Acid And Derivatives - Drugs For Nutrition		
ASCOR INTRAVENOUS SOLUTION 500 MG/ML (ascorbic acid)	Tier 3	KP
<i>ascorbate sodium (vitamin c) oral liquid 1,000 mg/15 ml</i>	Tier 3	
<i>ascorbic acid (vitamin c) injection solution 500 mg/ml</i>	Tier 1	KP
<i>ascorbic acid (vitamin c) oral tablet 1,000 mg, 250 mg, 500 mg</i>	Tier 3	
<i>ascorbic acid (vitamin c) oral tablet,chewable 125 mg, 250 mg, 500 mg</i>	Tier 3	
<i>ascorbic acid(vitamin c)(bulk) granules 100 %</i>	Tier 3	
<i>ascorbic acid-ascorbate sodium oral tablet,chewable 500 mg</i>	Tier 3	
<i>ascorbic acid-zinc oxide oral capsule 90-50 mg</i>	Tier 3	
BUFFERED C POWDER ORAL POWDER IN PACKET 3,000 MG (ascorbic acid/minerals)	Tier 3	
EASY-C IMMUNE HEALTH ORAL TABLET 500 MG (ascorbate calcium/ascorbyl palmitate)	Tier 3	
LIQUID C ORAL LIQUID 500 MG/5 ML (ascorbic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PUREVITA VITAMIN C ORAL DROPS 100 MG/ML (ascorbic acid)	Tier 3	
PUREVITA VITAMIN C ORAL TABLET,CHEWABLE 125 MG (ascorbic acid)	Tier 3	
VITAJEY DAILY C ORAL TABLET,CHEWABLE 125 MG (ascorbic acid)	Tier 3	
VITAMIN C WITH ROSE HIPS ORAL CAPSULE 500 MG (ascorbic acid)	Tier 3	
VITAMIN C WITH ROSE HIPS ORAL TABLET 1,000 MG, 500 MG (ascorbic acid)	Tier 3	
XCELLENT C ORAL CAPSULE 750-7.5 MG (ascorbate calcium, magnesium, potassium/black pepper extract)	Tier 3	
Vitamins - D And K Combinations - Drugs For Nutrition		
DECARA K ORAL CAPSULE 1,250-200 MCG (cholecalciferol (vit D3)/vitamin K2)	Tier 3	
DOSOKAP ORAL TABLET 137.5-200 MCG (cholecalciferol (vit D3)/vitamin K2)	Tier 3	
K2-D3 MAX ORAL CAPSULE 125 MCG (5,000 UNIT)-180 MCG (cholecalciferol (vit D3)/vitamin K2)	Tier 3	
<i>vitamin d2-vitamin k1 oral drops 20-120 mcg/4 drops</i>	Tier 3	
<i>vitamin d3-vitamin k2 oral capsule 125 mcg (5,000 unit)-100 mcg, 125-90 mcg, 250 mcg (10,000 unit)-45 mcg</i>	Tier 3	
Vitamins - D Derivatives - Drugs For Nutrition		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	Tier 1	
<i>calcitriol oral solution 1 mcg/ml</i>	Tier 1	
<i>cholecalciferol (vitamin d3) oral capsule 1,250 mcg (50,000 unit), 10 mcg (400 unit), 125 mcg (5,000 unit), 25 mcg (1,000 unit), 250 mcg (10,000 unit), 50 mcg (2,000 unit)</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cholecalciferol (vitamin d3) oral capsule 62.5 mcg (2,500 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral drops 10 mcg/drop (400 unit/drop), 10 mcg/ml (400 unit/ml), 25 mcg/drop (1000 unit/drop)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral drops 125 mcg/0.5 ml (5k unit/0.5ml)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral syringe 10 mcg/ml (400 unit/ml)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet 1,250 mcg (50,000 unit), 10 mcg (400 unit), 125 mcg (5,000 unit), 25 mcg (1,000 unit), 50 mcg (2,000 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet 250 mcg (10,000 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet,chewable 25 mcg (1,000 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet,chewable 50 mcg (2,000 unit), 62.5 mcg (2,500 unit)</i>	Tier 3	
<i>cholecalciferol (vitamin d3) oral tablet,disintegrating 50 mcg (2,000 unit)</i>	Tier 3	
D3-2000 ORAL CAPSULE 50 MCG (2,000 UNIT) (cholecalciferol (vitamin D3))	Tier 3	
<i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i>	Tier 1	
<i>ergocalciferol (vitamin d2) oral drops 200 mcg/ml (8,000 unit/ml)</i>	Tier 3	
PEDIATRIC D-VITE ORAL DROPS 10 MCG/ML (400 UNIT/ML) (cholecalciferol (vitamin D3))	Tier 3	
PUREVITA VITAMIN D3 ORAL DROPS 10 MCG/2 ML (400 UNIT/2 ML) (cholecalciferol (vitamin D3))	Tier 3	
PUREVITA VITAMIN D3 ORAL TABLET 25 MCG (1,000 UNIT) (cholecalciferol (vitamin D3))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ROCALTROL ORAL SOLUTION 1 MCG/ML (calcitriol)	Tier 3	
ergocalciferol (vitamin D2) (Vitamin D2 Oral Capsule 1,250 Mcg (50,000 Unit))	Tier 1	
WEEKLY-D ORAL CAPSULE 1,250 MCG (50,000 UNIT) (cholecalciferol (vitamin D3))	Tier 3	
Vitamins - E - Drugs For Nutrition		
PUREVITA VITAMIN E ORAL DROPS 180 MG/2 ML (vitamin E)	Tier 3	
<i>vitamin e (dl, acetate) oral capsule 180 mg (400 unit), 45 mg (100 unit), 450 mg (1,000 unit)</i>	Tier 3	
<i>vitamin e (dl, acetate) oral capsule 90 mg (200 unit)</i>	Tier 3	
<i>vitamin e (dl, acetate) oral drops 45 mg/0.25ml 100 unit/0.25ml</i>	Tier 3	
<i>vitamin e acetate (bulk) liquid 125 unit/ml</i>	Tier 3	
Vitamins - Folic Acid And Derivatives - Drugs For Nutrition		
COBALEFOL ORAL CAPSULE 1-1.4-1.6-16.3 MG (folic acid/thiamine/riboflavin/B3/B6/B12/vit C/vit D3/vit E)	Tier 3	
DEPLIN FC ORAL CAPSULE 15 MG (levomefolate calcium)	Tier 3	
FOLETRA ORAL CAPSULE 1-1.4-1.6-16.3 MG (folic acid/thiamine/riboflavin/B3/B6/B12/vit C/vit D3/vit E)	Tier 3	
<i>folic acid injection solution 5 mg/ml</i>	Tier 1	KP
<i>folic acid oral tablet 1 mg</i>	Tier 1	
<i>folic acid oral tablet 400 mcg</i>	Tier 3	
<i>folic acid oral tablet 800 mcg</i>	PV	
HYLAZINC ORAL TABLET 1 MG-1.5 MG- 1.7 MG-50 MG (folic acid/thiamine/riboflavin/niacin/pyridoxine/B12/C/zinc)	Tier 3	
<i>methylnetetrahydrofolate glucos oral capsule 1,700 mcg dfe, 680 mcg dfe, 8,500 mcg dfe</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MI-VITE RX ORAL TABLET 1-1.5-1.7-20-5 MG (folic acid/thiamine/riboflavin/niacin/B5/B6/biotin/B12/vit C)	Tier 3	
PUREVITA FOLIC ACID ORAL DROPS 200 MCG/ML (folic acid)	Tier 3	
PUREVITA FOLIC ACID ORAL TABLET 400 MCG (folic acid)	Tier 3	
Vitamins - Folic Acid Combinations - Drugs For Nutrition		
FOLCYTEINE ORAL TABLET 1 MG-47 MG- 20 MCG-16 MG (folic acid/calcium citrate/vitamin D3/mag citrate/a-cysteine)	Tier 3	
WESTAB MAX ORAL TABLET 2.5-25-2 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
WESTAB ONE ORAL TABLET 2.5-25-1 MG (cyanocobalamin/folic acid/pyridoxine)	Tier 3	
Vitamins - K, Phytonadione And Derivatives - Drugs For Nutrition		
K1-1000 ORAL CAPSULE 1,000 MCG (phytonadione (vit K1))	Tier 3	
<i>phytonadione (vitamin k1) injection solution 10 mg/ml</i>	Tier 1	KP
<i>phytonadione (vitamin k1) injection syringe 1 mg/0.5 ml</i>	Tier 1	KP
<i>phytonadione (vitamin k1) oral tablet 5 mg</i>	Tier 1	
VITAMIN K INJECTION SOLUTION 1 MG/0.5 ML (phytonadione (vit K1))	Tier 1	KP
phytonadione (vit K1) (Vitamin K1 Injection Solution 10 Mg/ML)	Tier 1	KP
<i>vitamin k2 (mk-4) oral tablet 100 mcg</i>	Tier 3	
<i>vitamin k2 oral capsule 100 mcg, 45 mcg</i>	Tier 3	
<i>vitamin k2 oral drops 90 mcg/0.5 ml</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Endocrine		
Antihyperglycemic - Dual SglT1 And SglT2 Inhibitors		
INPEFA ORAL TABLET 200 MG, 400 MG (sotagliflozin)	Tier 3	ST: At least 2 prior prescriptions for Farxiga, Jardiance, Synjardy XR, Synjardy, or Xigduo XR within the past 365 days
Corticotropin-Releasing Factor (Crf) Type 1 Receptor Antagonists		
CRENESSITY ORAL CAPSULE 100 MG, 25 MG, 50 MG (crinecerfont)	Tier 3	PA
CRENESSITY ORAL SOLUTION 50 MG/ML (crinecerfont)	Tier 3	PA
Menopausal Symptoms Suppressant-Neurokinin 3 (Nk3) Receptor Antagonist		
VEOZAH ORAL TABLET 45 MG (fezolinetant)	Tier 3	
Endocrine - Hormones		
Abortifacients Or Cervical Ripening Agents - Prostaglandin Analogs - Drugs For Women		
CERVIDIL VAGINAL INSERT, EXTENDED RELEASE 10 MG (dinoprostone)	Tier 3	
PREPIDIL VAGINAL GEL 0.5 MG/3 G (dinoprostone)	Tier 3	
Abortifacients- Progesterone Receptor Antagonist - Drugs For Women		
MIFEPREX ORAL TABLET 200 MG (mifepristone)	Tier 3	
<i>mifepristone oral tablet 200 mg</i>	PV	
Adrenal Steroid Inhibitors - Hormones		
ISTURISA ORAL TABLET 1 MG, 5 MG (osilodrostat phosphate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RECORLEV ORAL TABLET 150 MG (levoketoconazole)	Tier 3	PA
Adrenocorticotrophic Hormones - Hormones		
ACTHAR INJECTION GEL 80 UNIT/ML (corticotropin)	Tier 3	PA; KP
ACTHAR SELFJECT SUBCUTANEOUS PEN INJECTOR 40 UNIT/0.5 ML, 80 UNIT/ML (corticotropin)	Tier 3	PA; KP
CORTROPHIN GEL INJECTION GEL 80 UNIT/ML (corticotropin)	Tier 3	PA; KP
CORTROPHIN GEL SUBCUTANEOUS SYRINGE 40 UNIT/0.5 ML, 80 UNIT/ML (corticotropin)	Tier 3	PA; KP
Agents To Treat Hypoglycemia (Hyperglycemics) - Drugs For Diabetes		
BAQSIMI NASAL SPRAY, NON-AEROSOL 3 MG/ACTUATION (glucagon)	Tier 2	
<i>diazoxide oral suspension 50 mg/ml</i>	Tier 1	
GLUCAGON (HCL) EMERGENCY KIT INJECTION RECON SOLN 1 MG (glucagon HCl)	Tier 3	KP; ST: Requires prior prescription for Baqsimi or Gvoke within the past 120 days
glucagon (Glucagon Emergency Kit (Human) Injection Recon Soln 1 Mg)	Tier 1	KP; ST: Requires prior prescription for Baqsimi or Gvoke within the past 120 days
<i>glucose oral tablet, chewable 2 gram</i>	Tier 3	
<i>glucose oral tablet, chewable 3.75 gram, 4 gram</i>	Tier 3	
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML (glucagon)	Tier 2	KP
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS AUTO-INJECTOR 0.5 MG/0.1 ML, 1 MG/0.2 ML (glucagon)	Tier 2	KP
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML (glucagon)	Tier 2	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GVOKE PFS 2-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML (glucagon)	Tier 2	KP
GVOKE SUBCUTANEOUS SOLUTION 1 MG/0.2 ML (glucagon)	Tier 2	KP
INSTA-GLUCOSE (WITH DEXTRIN) ORAL GEL 24 GRAM/31 GRAM (dextrose/dextrin/maltose)	Tier 3	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (diazoxide)	Tier 3	
ZEGALOGUE AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 0.6 MG/0.6 ML (dasiglucagon HCl)	Tier 3	KP; ST: Requires prior prescription for Baqsimi or Gvoke within the past 120 days
ZEGALOGUE SYRINGE SUBCUTANEOUS SYRINGE 0.6 MG/0.6 ML (dasiglucagon HCl)	Tier 3	KP; ST: Requires prior prescription for Baqsimi or Gvoke within the past 120 days
Amyloidosis Agents- Transthyretin (Ttr) Stabilizer - Hormones		
ATTRUBY ORAL TABLET 356 MG (acoramidis HCl)	Tier 3	PA
VYNDAMAX ORAL CAPSULE 61 MG (tafamidis)	Tier 3	PA
VYNDALOX ORAL CAPSULE 20 MG (tafamidis meglumine)	Tier 3	PA
Amyloidosis Agents-Ttr Suppression, Antisense Oligonucleotide-Based - Hormones		
WAINUA SUBCUTANEOUS AUTO-INJECTOR 45 MG/0.8 ML (eplontersen sodium)	Tier 3	PA; KP
Androgen - Single Agents - Drugs For Men		
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %) (testosterone)	Tier 3	PA; QL (5 GM per 1 day)
testosterone cypionate (Depo-Testosterone Intramuscular Oil 100 Mg/ML)	Tier 3	PA; KP; QL (10 ML per 28 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JATENZO ORAL CAPSULE 158 MG, 198 MG (testosterone undecanoate)	Tier 3	PA; QL (4 EA per 1 day)
JATENZO ORAL CAPSULE 237 MG (testosterone undecanoate)	Tier 3	PA; QL (2 EA per 1 day)
KYZATREX ORAL CAPSULE 100 MG (testosterone undecanoate)	Tier 3	PA; QL (2 EA per 1 day)
KYZATREX ORAL CAPSULE 150 MG, 200 MG (testosterone undecanoate)	Tier 3	PA; QL (4 EA per 1 day)
METHITEST ORAL TABLET 10 MG (methyltestosterone)	Tier 3	PA
<i>methyltestosterone oral capsule 10 mg</i>	Tier 1	PA
NATESTO NASAL GEL IN METERED-DOSE PUMP 5.5 MG/0.122 GRAM/ACTUATION (testosterone)	Tier 3	PA; QL (22 GM per 30 days)
TESTIM TRANSDERMAL GEL 50 MG/5 GRAM (1 %) (testosterone)	Tier 3	PA; QL (10 GM per 1 day)
TESTOPEL IMPLANT PELLETT 75 MG (testosterone)	Tier 3	KP
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	Tier 1	PA; KP; QL (10 ML per 28 days)
<i>testosterone enanthate intramuscular oil 200 mg/ml</i>	Tier 1	PA; KP; QL (5 ML per 28 days)
<i>testosterone implant pellet 100 mg, 200 mg, 50 mg</i>	Tier 1	KP
<i>testosterone transdermal gel 50 mg/5 gram (1 %)</i>	Tier 1	PA; QL (10 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation</i>	Tier 1	PA; QL (4 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	Tier 1	PA; QL (10 GM per 1 day)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	Tier 1	PA; QL (5 GM per 1 day)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1.62 % (40.5 mg/2.5 gram)</i>	Tier 1	PA; QL (5 GM per 1 day)
<i>testosterone transdermal gel in packet 1 % (50 mg/5 gram)</i>	Tier 1	PA; QL (10 GM per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	Tier 1	PA; QL (1.25 GM per 1 day)
<i>testosterone transdermal solution in metered pump w/app 30 mg/actuation (1.5 ml)</i>	Tier 1	PA; QL (6 ML per 1 day)
TLANDO ORAL CAPSULE 112.5 MG (testosterone undecanoate)	Tier 3	PA; QL (4 EA per 1 day)
VOGELXO TRANSDERMAL GEL 50 MG/5 GRAM (1 %) (testosterone)	Tier 3	PA; QL (10 GM per 1 day)
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP 12.5 MG/ 1.25 GRAM (1 %) (testosterone)	Tier 3	PA; QL (10 GM per 1 day)
VOGELXO TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM) (testosterone)	Tier 3	PA; QL (10 GM per 1 day)
XYOSTED SUBCUTANEOUS AUTO-INJECTOR 100 MG/0.5 ML, 50 MG/0.5 ML, 75 MG/0.5 ML (testosterone enanthate)	Tier 3	PA; KP; QL (2 ML per 28 days)
Antidiuretic And Vasopressor Hormones - Hormones		
DDAVP INJECTION SOLUTION 4 MCG/ML (desmopressin acetate)	Tier 3	KP
DDAVP ORAL TABLET 0.1 MG, 0.2 MG (desmopressin acetate)	Tier 3	
<i>desmopressin injection solution 4 mcg/ml</i>	Tier 1	KP
<i>desmopressin nasal spray with pump 10 mcg/spray (0.1 ml)</i>	Tier 1	
<i>desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)</i>	Tier 1	
<i>desmopressin nasal spray,non-aerosol 150 mcg/spray (0.1 ml)</i>	Tier 3	
<i>desmopressin oral tablet 0.1 mg, 0.2 mg</i>	Tier 1	
NOCDURNA (MEN) SUBLINGUAL TABLET,DISINTEGRATING 55.3 MCG (desmopressin acetate)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOC DURNA (WOMEN) SUBLINGUAL TABLET, DISINTEGRATING 27.7 MCG (desmopressin acetate)	Tier 3	QL (1 EA per 1 day)
Antihyperglycemic - Alpha-Glucosidase Inhibitors - Drugs For Diabetes		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
PRECOSE ORAL TABLET 100 MG, 25 MG, 50 MG (acarbose)	Tier 3	
Antihyperglycemic - Amylin Analog-Type - Drugs For Diabetes		
SYMLINPEN 120 SUBCUTANEOUS PEN INJECTOR 2,700 MCG/2.7 ML (pramlintide acetate)	Tier 3	
SYMLINPEN 60 SUBCUTANEOUS PEN INJECTOR 1,500 MCG/1.5 ML (pramlintide acetate)	Tier 3	
Antihyperglycemic - Dipeptidyl Peptidase-4 (Dpp-4) Inhibitors - Drugs For Diabetes		
<i>alogliptin oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	Tier 1	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (sitagliptin phosphate)	Tier 2	
NESINA ORAL TABLET 12.5 MG, 25 MG (alogliptin benzoate)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
<i>saxagliptin oral tablet 2.5 mg, 5 mg</i>	Tier 1	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sitagliptin oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
TRADJENTA ORAL TABLET 5 MG (linagliptin)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (sitagliptin)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
Antihyperglycemic - Dopamine Receptor Agonists - Drugs For Diabetes		
CYCLOSET ORAL TABLET 0.8 MG (bromocriptine mesylate)	Tier 3	ST: Requires prior prescription for Metformin (Glucophage), Metformin ER, Glyburide/Metformin (Glucovance), or Glipizide/Metformin (Metaglip) within the past 180 days
Antihyperglycemic - Dual Gip And Glp-1 Receptor Agonists - Drugs For Diabetes		
MOUNJARO SUBCUTANEOUS PEN INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML (tirzepatide)	Tier 2	PA; KP
Antihyperglycemic - Glucagon-Like Peptide-1 (Glp-1) Receptor Agonists - Drugs For Diabetes		
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85 ML (exenatide microspheres)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>exenatide subcutaneous pen injector 10 mcg/dose(250 mcg/ml) 2.4 ml, 5 mcg/dose (250 mcg/ml) 1.2 ml</i>	Tier 1	PA
<i>liraglutide subcutaneous pen injector 0.6 mg/0.1 ml (18 mg/3 ml)</i>	Tier 1	PA
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) (semaglutide)	Tier 2	PA; KP
RYBELSUS ORAL TABLET 1.5 MG, 14 MG, 3 MG, 4 MG, 7 MG, 9 MG (semaglutide)	Tier 2	PA
TRULICITY SUBCUTANEOUS PEN INJECTOR 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML (dulaglutide)	Tier 2	PA
VICTOZA 2-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML) (liraglutide)	Tier 2	PA
VICTOZA 3-PAK SUBCUTANEOUS PEN INJECTOR 0.6 MG/0.1 ML (18 MG/3 ML) (liraglutide)	Tier 2	PA
Antihyperglycemic - Glucocorticoid (Cortisol) Receptor Blocker (Gr-li) - Drugs For Diabetes		
KORLYM ORAL TABLET 300 MG (mifepristone)	Tier 3	PA
<i>mifepristone oral tablet 300 mg</i>	Tier 3	PA
Antihyperglycemic - Meglitinide Analogs - Drugs For Diabetes		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	Tier 1	
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antihyperglycemic - Sglt-2 Inhibitor And Biguanide Combinations - Drugs For Diabetes		
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG (canagliflozin/metformin HCl)	Tier 3	ST: At least 2 prior prescriptions for Farxiga, Jardiance, Synjardy XR, Synjardy, or Xigduo XR within the past 365 days
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG (canagliflozin/metformin HCl)	Tier 3	ST: At least 2 prior prescriptions for Farxiga, Jardiance, Synjardy XR, Synjardy, or Xigduo XR within the past 365 days
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 7.5-1,000 MG, 7.5-500 MG (ertugliflozin pidolate/metformin HCl)	Tier 3	ST: At least 2 prior prescriptions for Farxiga, Jardiance, Synjardy XR, Synjardy, or Xigduo XR within the past 365 days
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG (empagliflozin/metformin HCl)	Tier 2	
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 25-1,000 MG, 5-1,000 MG (empagliflozin/metformin HCl)	Tier 2	
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG, 2.5-1,000 MG, 5-1,000 MG, 5-500 MG (dapagliflozin propanediol/metformin HCl)	Tier 2	
Antihyperglycemic - Sglt-2 Inhibitor And Dpp-4 Inhibitor Combinations - Drugs For Diabetes		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (empagliflozin/linagliptin)	Tier 2	
QTERN ORAL TABLET 10-5 MG, 5-5 MG (dapagliflozin propanediol/saxagliptin HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (ertugliflozin pidolate/sitagliptin phosphate)	Tier 3	
Antihyperglycemic - Sodium Glucose Cotransporter-2 (Sglt2) Inhibitors - Drugs For Diabetes		
BRENZAVVY ORAL TABLET 20 MG (bexagliflozin)	Tier 3	ST: At least 2 prior prescriptions for Farxiga, Jardiance, Synjardy XR, Synjardy, or Xigduo XR within the past 365 days
FARXIGA ORAL TABLET 10 MG, 5 MG (dapagliflozin propanediol)	Tier 2	
INVOKANA ORAL TABLET 100 MG, 300 MG (canagliflozin)	Tier 2	
JARDIANCE ORAL TABLET 10 MG, 25 MG (empagliflozin)	Tier 2	
STEGLATRO ORAL TABLET 15 MG, 5 MG (ertugliflozin pidolate)	Tier 2	
Antihyperglycemic - Sulfonylurea And Biguanide Combinations - Drugs For Diabetes		
<i>glipizide-metformin oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	Tier 1	
<i>glyburide-metformin oral tablet 1.25-250 mg, 2.5-500 mg, 5-500 mg</i>	Tier 1	
Antihyperglycemic - Sulfonylurea Derivatives - Drugs For Diabetes		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	
<i>glimepiride oral tablet 3 mg</i>	Tier 3	
<i>glipizide oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>glipizide oral tablet 2.5 mg</i>	Tier 1	
<i>glipizide oral tablet extended release 24hr 10 mg, 2.5 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG (glipizide)	Tier 3	
<i>glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg</i>	Tier 1	
<i>glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg</i>	Tier 1	
Antihyperglycemic - Thiazolidinedione And Biguanide Combinations - Drugs For Diabetes		
ACTOPLUS MET ORAL TABLET 15-850 MG (pioglitazone HCl/metformin HCl)	Tier 3	ST: Requires prior prescription for Metformin, preferred Sulfonylurea, or preferred Metformin/Sulfonylurea combination within the past 120 days
<i>pioglitazone-metformin oral tablet 15-500 mg, 15-850 mg</i>	Tier 1	ST: Requires prior prescription for Metformin, preferred Sulfonylurea, or preferred Metformin/Sulfonylurea combination within the past 120 days
Antihyperglycemic - Thiazolidinedione And Sulfonylurea Combinations - Drugs For Diabetes		
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (pioglitazone HCl/glimepiride)	Tier 3	ST: Requires prior prescription for Metformin, preferred Sulfonylurea, or preferred Metformin/Sulfonylurea combination within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>pioglitazone-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	Tier 1	ST: Requires prior prescription for Metformin, preferred Sulfonylurea, or preferred Metformin/Sulfonylurea combination within the past 120 days
Antihyperglycemic-Dipeptidyl Peptidase-4 Inhibit And Thiazolidinedione - Drugs For Diabetes		
<i>alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg</i>	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
OSENI ORAL TABLET 12.5-30 MG, 25-45 MG (alogliptin benzoate/pioglitazone HCl)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
Antihyperglycemic-Dipeptidyl Peptidase-4(Dpp-4)Inhibitor And Biguanide - Drugs For Diabetes		
<i>alogliptin-metformin oral tablet 12.5-1,000 mg, 12.5-500 mg</i>	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
JANUMET ORAL TABLET 50-1,000 MG, 50-500 MG (sitagliptin phosphate/metformin HCl)	Tier 2	
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-1,000 MG, 50-500 MG (sitagliptin phosphate/metformin HCl)	Tier 2	
JENTADUETO ORAL TABLET 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG (linagliptin/metformin HCl)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG (linagliptin/metformin HCl)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
KAZANO ORAL TABLET 12.5-1,000 MG, 12.5-500 MG (alogliptin benzoate/metformin HCl)	Tier 3	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg, 5-1,000 mg, 5-500 mg</i>	Tier 1	ST: Requires prior prescription for Janumet XR, Janumet, or Januvia within the past 120 days
Antihyperglycemic-Insulin, Long Acting And Glp-1 Receptor Agonist Comb - Drugs For Diabetes		
SOLIQUA 100/33 SUBCUTANEOUS INSULIN PEN 100 UNIT-33 MCG/ML (insulin glargine,human recombinant analog/lixisenatide)	Tier 2	
XULTOPHY 100/3.6 SUBCUTANEOUS INSULIN PEN 100 UNIT-3.6 MG /ML (3 ML) (insulin degludec/liraglutide)	Tier 2	
Antihyperglycemic-Sglit-2 Inhibitor, Dpp-4 Inhibitor And Biguanide Comb - Drugs For Diabetes		
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 12.5-2.5-1,000 MG, 25-5-1,000 MG, 5-2.5-1,000 MG (empagliflozin/linagliptin/metformin HCl)	Tier 2	
Antithyroid Agents, Thionamides - Imidazole Derivatives - Drugs For Thyroid		
<i>methimazole oral tablet 10 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antithyroid Agents, Thionamides - Thiouracil Derivatives - Drugs For Thyroid		
<i>propylthiouracil oral tablet 50 mg</i>	Tier 1	
Bone Formation Stimulating Agents - Natriuretic Peptide - Drugs For Menopause And Bone Loss		
VOXZOGO SUBCUTANEOUS RECON SOLN 0.4 MG, 0.56 MG, 1.2 MG (vosoritide)	Tier 3	PA; KP
Bone Formation Stimulating Agents - Parathyroid Hormone Rel Peptides - Drugs For Menopause And Bone Loss		
TYMLOS SUBCUTANEOUS PEN INJECTOR 80 MCG (3,120 MCG/1.56 ML) (abaloparatide)	Tier 3	PA; KP
Bone Formation Stimulating Agents - Parathyroid Hormone-Type - Drugs For Menopause And Bone Loss		
BONSITY SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (560MCG/2.24ML) (teriparatide)	Tier 3	PA; KP
FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (560MCG/2.24ML) (teriparatide)	Tier 3	PA; KP
<i>teriparatide subcutaneous pen injector 20 mcg/dose (560mcg/2.24ml)</i>	Tier 3	PA; KP
Bone Resorption Inhibitors - Bisphosphonate And Vitamin D Combinations - Drugs For Menopause And Bone Loss		
FOSAMAX PLUS D ORAL TABLET 70 MG- 2,800 UNIT, 70 MG- 5,600 UNIT (alendronate sodium/cholecalciferol (vitamin D3))	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Bone Resorption Inhibitors - Bisphosphonates - Drugs For Menopause And Bone Loss		
ACTONEL ORAL TABLET 150 MG (risedronate sodium)	Tier 3	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 30 days)
ACTONEL ORAL TABLET 35 MG (risedronate sodium)	Tier 3	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 7 days)
<i>alendronate oral solution 70 mg/75 ml</i>	Tier 1	QL (75 ML per 7 days)
<i>alendronate oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	Tier 1	
ATELVIA ORAL TABLET, DELAYED RELEASE (DR/EC) 35 MG (risedronate sodium)	Tier 3	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 7 days)
BINOSTO ORAL TABLET, EFFERVESCENT 70 MG (alendronate sodium)	Tier 3	ST: Requires prior prescriptions for Alendronate and Ibandronate within the past 365 days; QL (4 EA per 28 days)
FOSAMAX ORAL TABLET 70 MG (alendronate sodium)	Tier 3	
<i>ibandronate oral tablet 150 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risedronate oral tablet 150 mg</i>	Tier 1	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 30 days)
<i>risedronate oral tablet 30 mg, 5 mg</i>	Tier 1	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 1 day)
<i>risedronate oral tablet 35 mg</i>	Tier 1	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 7 days)
<i>risedronate oral tablet, delayed release (drlec) 35 mg</i>	Tier 1	ST: Requires prior prescriptions for generic Alendronate and Ibandronate within the past 365 days; QL (1 EA per 7 days)
Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer - Drugs For Menopause And Bone Loss		
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	Tier 3	QL (2 EA per 1 day)
<i>cinacalcet oral tablet 90 mg</i>	Tier 3	QL (4 EA per 1 day)
SENSIPAR ORAL TABLET 30 MG, 60 MG (cinacalcet HCl)	Tier 3	QL (2 EA per 1 day)
SENSIPAR ORAL TABLET 90 MG (cinacalcet HCl)	Tier 3	QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Calcitonins - Drugs For Menopause And Bone Loss		
<i>calcitonin (salmon) injection solution 200 unit/ml</i>	Tier 1	KP
<i>calcitonin (salmon) nasal spray,non-aerosol 200 unit/actuation</i>	Tier 1	
MIACALCIN INJECTION SOLUTION 200 UNIT/ML (calcitonin,salmon,synthetic)	Tier 3	KP
Estrogen And Progestin With Antimineralocorticoid Activity,Combination - Drugs For Women		
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG (drospirenone/estradiol)	Tier 3	
Estrogen And Selective Estrogen Receptor Modulator (Serm) Combinations - Drugs For Women		
DUAVEE ORAL TABLET 0.45-20 MG (estrogens, conjugated/bazedoxifene acetate)	Tier 2	
Estrogen-Androgen - Drugs For Women		
COVARYX H.S. ORAL TABLET 0.625-1.25 MG (estrogens,esterified/methyltestosterone)	Tier 1	
COVARYX ORAL TABLET 1.25-2.5 MG (estrogens,esterified/methyltestosterone)	Tier 1	
EEMT HS ORAL TABLET 0.625-1.25 MG (estrogens,esterified/methyltestosterone)	Tier 1	
EEMT ORAL TABLET 1.25-2.5 MG (estrogens,esterified/methyltestosterone)	Tier 1	
ESTRATEST F.S. ORAL TABLET 1.25-2.5 MG (estrogens,esterified/methyltestosterone)	Tier 1	
<i>estrogens-methyltestosterone oral tablet 0.625-1.25 mg, 1.25-2.5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Estrogen-Progestin - Drugs For Women		
estradiol/norethindrone acetate (Abigale Lo Oral Tablet 0.5-0.1 Mg)	Tier 1	
estradiol/norethindrone acetate (Abigale Oral Tablet 1-0.5 Mg)	Tier 1	
ACTIVEVELLA ORAL TABLET 1-0.5 MG (estradiol/norethindrone acetate)	Tier 3	
BIJUVA ORAL CAPSULE 0.5-100 MG (estradiol/progesterone)	Tier 2	QL (1 EA per 1 day)
BIJUVA ORAL CAPSULE 1-100 MG (estradiol/progesterone)	Tier 2	QL (30 EA per 30 days)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/24 HR (estradiol/levonorgestrel)	Tier 3	ST: Requires prior prescription for Combipatch within the past 120 days; QL (1 EA per 7 days)
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR, 0.05-0.25 MG/24 HR (estradiol/norethindrone acetate)	Tier 2	QL (2 EA per 7 days)
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	Tier 1	
norethindrone acetate/ethinyl estradiol (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg, 1-5 Mg-Mcg)	Tier 1	
norethindrone acetate/ethinyl estradiol (Jinteli Oral Tablet 1-5 Mg-Mcg)	Tier 1	
estradiol/norethindrone acetate (Mimvey Oral Tablet 1-0.5 Mg)	Tier 1	
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	Tier 1	
PREMPHASE ORAL TABLET 0.625 MG (14)/ 0.625MG-5MG(14) (estrogens, conjugated/medroxyprogesterone acetate)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG (estrogens, conjugated/medroxyprogesterone acetate)	Tier 2	
Estrogens - Drugs For Women		
CLIMARA TRANSDERMAL PATCH WEEKLY 0.025 MG/24 HR, 0.0375 MG/24 HR, 0.05 MG/24 HR, 0.06 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR (estradiol)	Tier 3	QL (1 EA per 7 days)
DELESTROGEN INTRAMUSCULAR OIL 20 MG/ML (estradiol valerate)	Tier 3	KP
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (estradiol cypionate)	Tier 3	KP
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%) (estradiol)	Tier 3	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (30 EA per 30 days)
DIVIGEL TRANSDERMAL GEL IN PACKET 1 MG/GRAM (0.1 %) (estradiol)	Tier 3	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (30 GM per 30 days)
DIVIGEL TRANSDERMAL GEL IN PACKET 1.25 MG/1.25 GRAM (0.1 %) (estradiol)	Tier 3	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (37.5 GM per 30 days)
estradiol (Dotti Transdermal Patch Semiweekly 0.025 Mg/24 Hr, 0.0375 Mg/24 Hr, 0.05 Mg/24 Hr, 0.075 Mg/24 Hr, 0.1 Mg/24 Hr)	Tier 1	QL (2 EA per 7 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELESTRIN TRANSDERMAL GEL IN METERED-DOSE PUMP 0.87 GRAM/ACTUATION (estradiol)	Tier 3	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (52 GM per 30 days)
<i>estradiol implant pellet 6 mg</i>	Tier 1	KP
<i>estradiol oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>estradiol transdermal gel in metered-dose pump 1.25 gram/actuation</i>	Tier 1	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days
<i>estradiol transdermal gel in packet 0.25 mg/0.25 gram (0.1 %), 0.5 mg/0.5 gram (0.1 %), 0.75 mg/0.75 gram (0.1%)</i>	Tier 1	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (30 EA per 30 days)
<i>estradiol transdermal gel in packet 1 mg/gram (0.1 %)</i>	Tier 1	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (30 GM per 30 days)
<i>estradiol transdermal gel in packet 1.25 mg/1.25 gram (0.1 %)</i>	Tier 1	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (37.5 GM per 30 days)
<i>estradiol transdermal patch semiweekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	Tier 1	QL (2 EA per 7 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.05 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr, 0.1 mg/24 hr</i>	Tier 1	QL (1 EA per 7 days)
<i>estradiol valerate intramuscular oil 10 mg/ml, 20 mg/ml, 40 mg/ml</i>	Tier 1	KP
ESTROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 1.25 GRAM/ACTUATION (estradiol)	Tier 3	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days
EVAMIST TRANSDERMAL SPRAY, NON-AEROSOL 1.53 MG/SPRAY (1.7%) (estradiol)	Tier 3	ST: Requires prior prescription for generic Climara, Minivelle, or Vivelle-Dot within the past 120 days; QL (16.2 ML per 30 days)
estradiol (Lyllana Transdermal Patch Semiweekly 0.025 Mg/24 Hr, 0.0375 Mg/24 Hr, 0.05 Mg/24 Hr, 0.075 Mg/24 Hr, 0.1 Mg/24 Hr)	Tier 1	QL (2 EA per 7 days)
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (estrogens, esterified)	Tier 3	
MENOSTAR TRANSDERMAL PATCH WEEKLY 14 MCG/24 HR (estradiol)	Tier 3	QL (1 EA per 7 days)
MINIVELLE TRANSDERMAL PATCH SEMIWEEKLY 0.025 MG/24 HR, 0.0375 MG/24 HR, 0.05 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR (estradiol)	Tier 3	QL (2 EA per 7 days)
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (estrogens, conjugated)	Tier 2	
VIVELLE-DOT TRANSDERMAL PATCH SEMIWEEKLY 0.025 MG/24 HR, 0.0375 MG/24 HR, 0.05 MG/24 HR, 0.075 MG/24 HR, 0.1 MG/24 HR (estradiol)	Tier 3	QL (2 EA per 7 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Fertility Enhancer - Luteal Phase Supporting, Progesterone-Type - Drugs For Women		
CRINONE VAGINAL GEL 8 % (progesterone, micronized)	Tier 2	
ENDOMETRIN VAGINAL INSERT 100 MG (progesterone, micronized)	Tier 2	
Fertility Enhancer - Ovulation Stimulant - Synthetic (Non-Fsh) - Drugs For Women		
clomiphene citrate (Clomid Oral Tablet 50 Mg)	Tier 3	
<i>clomiphene citrate oral tablet 50 mg</i>	Tier 1	
Follicle-Stimulating And Luteinizing Hormones - Drugs For Women		
MENOPUR SUBCUTANEOUS RECON SOLN 75 UNIT (menotropins)	Tier 3	KP
Follicle-Stimulating Hormone (Fsh) - Drugs For Women		
FOLLISTIM AQ SUBCUTANEOUS CARTRIDGE 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML (follitropin beta, recombinant)	Tier 3	KP; ST: Requires prior prescription for Gonal-F or Gonal-F-RFF within the past 120 days
GONAL-F RFF REDI-JECT SUBCUTANEOUS PEN INJECTOR 300 UNIT/0.48 ML, 450 UNIT/0.72 ML, 900 UNIT/1.44 ML (follitropin alfa, recombinant)	Tier 3	KP
GONAL-F RFF SUBCUTANEOUS RECON SOLN 75 UNIT (follitropin alfa, recombinant)	Tier 3	KP
GONAL-F SUBCUTANEOUS RECON SOLN 1,050 UNIT, 450 UNIT (follitropin alfa, recombinant)	Tier 3	KP
Glucocorticoid Salt Combinations - Drugs For Inflammation		
BETALOAN SUIK KIT 6 MG/ML (betamethasone acetate and sodium phosph/norflurane/HFC 245fa)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Glucocorticoids - Drugs For Inflammation		
AGAMREE ORAL SUSPENSION 40 MG/ML (vamorolone)	Tier 3	PA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG (hydrocortisone)	Tier 3	PA
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (hydrocortisone)	Tier 3	
<i>cortisone oral tablet 25 mg</i>	Tier 1	
<i>deflazacort oral suspension 22.75 mg/ml</i>	Tier 3	PA
<i>deflazacort oral tablet 18 mg, 30 mg, 36 mg, 6 mg</i>	Tier 3	PA
dexamethasone (Dexabliss Oral Tablets,Dose Pack 1.5 Mg (39 Tabs))	Tier 3	ST: Requires prior prescription for Dexamethasone 1.5mg tablets within the past 120 days
DEXAMETHASONE INTENSOL ORAL DROPS 1 MG/ML (dexamethasone)	Tier 3	
<i>dexamethasone oral elixir 0.5 mg/5 ml</i>	Tier 1	
<i>dexamethasone oral solution 0.5 mg/5 ml</i>	Tier 1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1.5 mg, 4 mg, 6 mg</i>	Tier 1	
<i>dexamethasone oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>dexamethasone oral tablets,dose pack 1.5 mg (21 tabs), 1.5 mg (35 tabs), 1.5 mg (51 tabs)</i>	Tier 3	ST: Requires prior prescription for Dexamethasone 1.5mg tablets within the past 120 days
DEXONTO IONTOPHORETIC SOLUTION 0.4 % (dexamethasone sodium phosphate)	Tier 3	
DMT SUIK KIT 10 MG/ML (dexamethasone/PF/norflurane/pentafluoropropane (HFC 245fa))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMFLAZA ORAL SUSPENSION 22.75 MG/ML (deflazacort)	Tier 3	PA
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG (deflazacort)	Tier 3	PA
EOHILIA ORAL SUSPENSION IN PACKET 2 MG/10 ML (budesonide)	Tier 3	PA
HEMADY ORAL TABLET 20 MG (dexamethasone)	Tier 3	QL (2 EA per 1 day)
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
<i>hydrocortisone sod succinate injection recon soln 100 mg</i>	Tier 1	KP
deflazacort (Jaythari Oral Tablet 18 Mg, 30 Mg, 36 Mg, 6 Mg)	Tier 3	PA
KENALOG INJECTION SUSPENSION 10 MG/ML, 40 MG/ML (triamcinolone acetonide)	Tier 3	KP
KENALOG-80 INJECTION SUSPENSION 80 MG/ML (triamcinolone acetonide)	Tier 3	KP
KHINDIVI ORAL SOLUTION 1 MG/ML (hydrocortisone)	Tier 3	
MEDROL (PAK) ORAL TABLETS,DOSE PACK 4 MG (methylprednisolone)	Tier 3	
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG (methylprednisolone)	Tier 3	
MEDROL ORAL TABLET 2 MG (methylprednisolone)	Tier 2	
MEDROLOAN II SUIK KIT 40 MG/ML (methylprednisolone acetate/norflurane/HFC 245fa)	Tier 3	
MEDROLOAN SUIK KIT 40 MG/ML (methylprednisolone acetate/norflurane/HFC 245fa)	Tier 3	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Tier 1	
<i>methylprednisolone oral tablets,dose pack 4 mg</i>	Tier 1	
ORAPRED ODT ORAL TABLET,DISINTEGRATING 10 MG, 15 MG, 30 MG (prednisolone sodium phosphate)	Tier 3	
PEDIAPRED ORAL SOLUTION 5 MG BASE/5 ML (6.7 MG/5 ML) (prednisolone sodium phosphate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisolone oral solution 15 mg/5 ml</i>	Tier 1	
<i>prednisolone oral tablet 5 mg</i>	Tier 3	ST: At least 2 prior prescriptions for generic Prednisone tablets, generic Methylprednisolone tablets, or Prednisolone 15mg/5mL oral solution within the past 365 days
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 15 mg/5 ml (3 mg/ml), 20 mg/5 ml (4 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	Tier 1	
<i>prednisolone sodium phosphate oral solution 15 mg/5 ml (5 ml), 25 mg/5 ml (5 mg/ml)</i>	Tier 1	
<i>prednisolone sodium phosphate oral tablet, disintegrating 10 mg, 15 mg, 30 mg</i>	Tier 1	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML (prednisone)	Tier 2	
<i>prednisone oral solution 5 mg/5 ml</i>	Tier 1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	Tier 1	
<i>prednisone oral tablets, dose pack 10 mg, 5 mg</i>	Tier 1	
RAYOS ORAL TABLET, DELAYED RELEASE (DR/EC) 1 MG, 2 MG, 5 MG (prednisone)	Tier 3	PA
SOLU-CORTEF ACT-O-VIAL (PF) INJECTION RECON SOLN 1,000 MG/8 ML, 100 MG/2 ML, 250 MG/2 ML, 500 MG/4 ML (hydrocortisone sodium succinate/PF)	Tier 3	KP
dexamethasone (Taperdex Oral Tablets, Dose Pack 1.5 Mg (21 Tabs), 1.5 Mg (49 Tabs))	Tier 3	ST: Requires prior prescription for Dexamethasone 1.5mg tablets within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (27 TABS) (dexamethasone)	Tier 3	ST: Requires prior prescription for Dexamethasone 1.5mg tablets within the past 120 days
TARPEYO ORAL CAPSULE,DELAYED RELEASE(DR/EC) 4 MG (budesonide)	Tier 3	PA
<i>triamcinolone acetonide injection suspension 10 mg/ml, 40 mg/ml</i>	Tier 1	KP
TRILOAN II SUIK KIT 40 MG/ML (triamcinolone/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
TRILOAN SUIK KIT 40 MG/ML (triamcinolone/norflurane and pentafluoropropane (HFC 245fa))	Tier 3	
prednisolone sodium phosphate (Veripred 20 Oral Solution 20 Mg/5 MI (4 Mg/MI))	Tier 3	
ZCORT ORAL TABLETS,DOSE PACK 1.5 MG (25 TABS) (dexamethasone)	Tier 3	ST: Requires prior prescription for Dexamethasone 1.5mg tablets within the past 120 days
Gonadotropin Inhibitor Pituitary Suppressants - Drugs For Women		
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	Tier 1	
Growth Hormone Receptor Antagonists - Drugs For Growth		
SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (pegvisomant)	Tier 3	KP
Growth Hormone Releasing Hormones (Ghrh) - Drugs For Growth		
EGRIFTA SV SUBCUTANEOUS RECON SOLN 2 MG (tesamorelin acetate)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EGRIFTA WR SUBCUTANEOUS KIT 11.6 MG (tesamorelin acetate)	Tier 3	PA; KP
Growth Hormones - Drugs For Growth		
GENOTROPIN MINISUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML, 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML (somatropin)	Tier 3	PA; KP
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG/ML (36 UNIT/ML), 5 MG/ML (15 UNIT/ML) (somatropin)	Tier 3	PA; KP
HUMATROPE INJECTION CARTRIDGE 12 MG (36 UNIT), 24 MG (72 UNIT), 6 MG (18 UNIT) (somatropin)	Tier 3	PA; KP
NGENLA SUBCUTANEOUS PEN INJECTOR 24 MG/1.2 ML (20 MG/ML), 60 MG/1.2 ML (50 MG/ML) (somatropin)	Tier 3	PA; KP
NORDITROPIN FLEXPEN SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 30 MG/3 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) (somatropin)	Tier 3	PA; KP
NUTROPIN AQ NUSPIN SUBCUTANEOUS PEN INJECTOR 10 MG/2 ML (5 MG/ML), 20 MG/2 ML (10 MG/ML), 5 MG/2 ML (2.5 MG/ML) (somatropin)	Tier 3	PA; KP
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) (somatropin)	Tier 3	PA; KP
OMNITROPE SUBCUTANEOUS RECON SOLN 5.8 MG (somatropin)	Tier 3	PA; KP
SAIZEN SAIZENPREP SUBCUTANEOUS CARTRIDGE 8.8 MG/1.51 ML (FINAL CONC.) (somatropin)	Tier 3	PA; KP
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG (somatropin)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (lonapegsomatropin-tcgd)	Tier 3	PA; KP
SOGROYA SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) (somapacitan-beco)	Tier 3	PA; KP
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG, 5 MG (somatropin)	Tier 3	PA; KP
Human Chorionic Gonadotropin (Hcg) - Drugs For Women		
<i>chorionic gonadotropin, human intramuscular recon soln 10,000 unit</i>	Tier 3	KP; ST: Requires prior prescription for Novarel or Ovidrel within the past 120 days
NOVAREL INTRAMUSCULAR RECON SOLN 5,000 UNIT (chorionic gonadotropin, human)	Tier 2	KP
OVIDREL SUBCUTANEOUS SYRINGE 250 MCG/0.5 ML (choriogonadotropin alfa)	Tier 2	KP
PREGNYL INTRAMUSCULAR RECON SOLN 10,000 UNIT (chorionic gonadotropin, human)	Tier 3	KP; ST: Requires prior prescription for Novarel or Ovidrel within the past 120 days
Human Insulins - Fixed Combinations - Drugs For Diabetes		
HUMULIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 2	
HUMULIN 70/30 U-100 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLIN 70/30 U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 2	
NOVOLIN 70-30 FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30) (insulin NPH human isophane/insulin regular, human)	Tier 2	
Human Insulins - Intermediate Acting - Drugs For Diabetes		
HUMULIN N NPH INSULIN KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin NPH human isophane)	Tier 2	
HUMULIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (insulin NPH human isophane)	Tier 2	
NOVOLIN N FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin NPH human isophane)	Tier 2	
NOVOLIN N NPH U-100 INSULIN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (insulin NPH human isophane)	Tier 2	
Human Insulins - Rapid Acting - Drugs For Diabetes		
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT, 8 UNIT (90)/ 12 UNIT (90) (insulin regular, human)	Tier 3	PA
Human Insulins - Short Acting - Drugs For Diabetes		
HUMULIN R REGULAR U-100 INSULIN INJECTION SOLUTION 100 UNIT/ML (insulin regular, human)	Tier 2	
HUMULIN R U-500 (CONC) INSULIN SUBCUTANEOUS SOLUTION 500 UNIT/ML (insulin regular, human)	Tier 2	
HUMULIN R U-500 (CONC) KWIKPEN SUBCUTANEOUS INSULIN PEN 500 UNIT/ML (3 ML) (insulin regular, human)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MYXREDLIN INTRAVENOUS SOLUTION 100 UNIT/100 ML (1 UNIT/ML) (insulin regular, human in 0.9 % sodium chloride)	Tier 3	
NOVOLIN R FLEXPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin regular, human)	Tier 2	
NOVOLIN R REGULAR U100 INSULIN INJECTION SOLUTION 100 UNIT/ML (insulin regular, human)	Tier 2	
Insulin Analogs - Fixed Combinations - Drugs For Diabetes		
HUMALOG MIX 50-50 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (50-50) (insulin lispro protamine and insulin lispro)	Tier 2	
HUMALOG MIX 75-25 KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (75-25) (insulin lispro protamine and insulin lispro)	Tier 3	
HUMALOG MIX 75-25(U-100)INSULN SUBCUTANEOUS SUSPENSION 100 UNIT/ML (75-25) (insulin lispro protamine and insulin lispro)	Tier 2	
<i>insulin asp prt-insulin aspart subcutaneous insulin pen 100 unit/ml (70-30)</i>	Tier 3	ST: Requires prior prescription for Humalog Mix 75-25 within the past 120 days
<i>insulin asp prt-insulin aspart subcutaneous solution 100 unit/ml (70-30)</i>	Tier 3	ST: Requires prior prescription for Humalog Mix 75-25 within the past 120 days
<i>insulin lispro protamin-lispro subcutaneous insulin pen 100 unit/ml (75-25)</i>	Tier 1	
NOVOLOG MIX 70-30 U-100 INSULN SUBCUTANEOUS SOLUTION 100 UNIT/ML (70-30) (insulin aspart protamine human/insulin aspart)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOLOG MIX 70-30FLEXPEN U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (70-30) (insulin aspart protamine human/insulin aspart)	Tier 2	
Insulin Analogs - Long Acting - Drugs For Diabetes		
BASAGLAR KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 3	ST: Requires prior prescription for Glargine-yfgn, Toujeo, or Tresiba within the past 120 days
BASAGLAR TEMPO PEN(U-100)INSLN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 3	ST: At least 2 prior prescriptions for Insulin glargine-yfgn, Toujeo or Tresiba within the past 365 days
<i>insulin glargine-yfgn subcutaneous insulin pen 100 unit/ml (3 ml)</i>	Tier 2	
<i>insulin glargine-yfgn subcutaneous solution 100 unit/ml</i>	Tier 2	
REZVOGLAR KWIKPEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine-aglr)	Tier 3	ST: Requires prior prescription for Glargine-yfgn, Toujeo, or Tresiba within the past 120 days
SEMGLEE(INSULIN GLARGINE-YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glargine-yfgn)	Tier 3	ST: Requires prior prescription for Glargine-yfgn, Toujeo, or Tresiba within the past 120 days
SEMGLEE(INSULIN GLARG-YFGN)PEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin glargine-yfgn)	Tier 3	ST: Requires prior prescription for Glargine-yfgn, Toujeo, or Tresiba within the past 120 days
TOUJEO MAX U-300 SOLOSTAR SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (3 ML) (insulin glargine,human recombinant analog)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOUJEO SOLOSTAR U-300 INSULIN SUBCUTANEOUS INSULIN PEN 300 UNIT/ML (1.5 ML) (insulin glargine,human recombinant analog)	Tier 2	
TRESIBA FLEXTOUCH U-100 SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin degludec)	Tier 2	
TRESIBA FLEXTOUCH U-200 SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML) (insulin degludec)	Tier 2	
TRESIBA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin degludec)	Tier 2	
Insulin Analogs - Rapid Acting - Drugs For Diabetes		
ADMELOG SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin lispro)	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
ADMELOG U-100 INSULIN LISPRO SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin lispro)	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
APIDRA SOLOSTAR U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin glulisine)	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
APIDRA U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin glulisine)	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIASP FLEXTOUCH U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin aspart (niacinamide))	Tier 2	
FIASP PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (3 ML) (insulin aspart (niacinamide))	Tier 2	
FIASP PUMPCART SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (1.6 ML) (insulin aspart (niacinamide)/pump cartridge)	Tier 2	
FIASP U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin aspart (niacinamide))	Tier 2	
HUMALOG JUNIOR KWIKPEN U-100 SUBCUTANEOUS INSULIN PEN, HALF-UNIT 100 UNIT/ML (insulin lispro)	Tier 3	
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin lispro)	Tier 3	
HUMALOG KWIKPEN INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML) (insulin lispro)	Tier 2	
HUMALOG TEMPO PEN(U-100)INSULN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML (insulin lispro)	Tier 3	ST: At least 2 prior prescriptions for Insulin lispro, Novolog, Fiasp, or Lyumjev (non Tempo version) within the past 365 days
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (insulin lispro)	Tier 2	
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin lispro)	Tier 3	
<i>insulin aspart u-100 subcutaneous cartridge 100 unit/ml</i>	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin aspart u-100 subcutaneous insulin pen 100 unit/ml (3 ml)</i>	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
<i>insulin aspart u-100 subcutaneous solution 100 unit/ml</i>	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
<i>insulin lispro subcutaneous insulin pen 100 unit/ml</i>	Tier 1	
<i>insulin lispro subcutaneous insulin pen, half-unit 100 unit/ml</i>	Tier 1	
<i>insulin lispro subcutaneous solution 100 unit/ml</i>	Tier 1	
KIRSTY PEN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin aspart-xjhz)	Tier 3	
KIRSTY SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin aspart-xjhz)	Tier 3	
LYUMJEV KWIKPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (insulin lispro-aabc)	Tier 2	
LYUMJEV KWIKPEN U-200 INSULIN SUBCUTANEOUS INSULIN PEN 200 UNIT/ML (3 ML) (insulin lispro-aabc)	Tier 2	
LYUMJEV TEMPO PEN(U-100)INSULN SUBCUTANEOUS INSULIN PEN, SENSOR 100 UNIT/ML (insulin lispro-aabc)	Tier 3	ST: At least 2 prior prescriptions for Insulin lispro, Novolog, Fiasp, or Lyumjev (non Tempo version) within the past 365 days
LYUMJEV U-100 INSULIN SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin lispro-aabc)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MERIOLOG SOLOSTAR SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin aspart-szjj)	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
MERIOLOG SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin aspart-szjj)	Tier 3	ST: Requires prior prescription for Fiasp, Lyumjev, Novolog, Insulin Lispro, or Humalog U-200 within the past 120 days
NOVOLOG FLEXPEN U-100 INSULIN SUBCUTANEOUS INSULIN PEN 100 UNIT/ML (3 ML) (insulin aspart)	Tier 2	
NOVOLOG PENFILL U-100 INSULIN SUBCUTANEOUS CARTRIDGE 100 UNIT/ML (insulin aspart)	Tier 2	
NOVOLOG U-100 INSULIN ASPART SUBCUTANEOUS SOLUTION 100 UNIT/ML (insulin aspart)	Tier 2	
Insulin Response Enhancers - Biguanides - Drugs For Diabetes		
DM2 COMBO PACK, TABLET AND STRIP 500 MG (metformin HCl/blood sugar diagnostic)	Tier 3	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
<i>metformin oral solution 500 mg/5 ml</i>	Tier 1	
<i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i>	Tier 1	
<i>metformin oral tablet 625 mg, 750 mg</i>	Tier 3	
<i>metformin oral tablet extended release 24 hr 500 mg, 750 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>metformin oral tablet extended release 24hr 1,000 mg, 500 mg</i>	Tier 3	
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg, 500 mg</i>	Tier 3	ST: Requires prior prescription for generic Glucophage XR within the past 120 days
RIOMET ORAL SOLUTION 500 MG/5 ML (metformin HCl)	Tier 3	
Insulin Response Enhancers - Thiazolidinediones (Ppar-Gamma Agonists) - Drugs For Diabetes		
ACTOS ORAL TABLET 15 MG, 30 MG, 45 MG (pioglitazone HCl)	Tier 3	
<i>pioglitazone oral tablet 15 mg, 30 mg, 45 mg</i>	Tier 1	
Insulin-Like Growth Factor-1 (Igf-1) - Hormones		
INCRELEX SUBCUTANEOUS SOLUTION 10 MG/ML (mecasermin)	Tier 3	PA; KP
Leptin Hormone Analogs - Hormones		
MYALEPT SUBCUTANEOUS RECON SOLN 5 MG/ML (FINAL CONC.) (metreleptin)	Tier 3	PA; KP
Lhrh (Gnrh) Agonist Analog Pit Suppres - Central Precocious Puberty - Drugs For Women		
SUPPRELIN LA IMPLANT KIT 50 MG (65 MCG/DAY) (histrelin acetate)	Tier 3	KP
Lhrh (Gnrh) Agonist Analog Pituitary Suppressants - Drugs For Women		
SYNAREL NASAL SPRAY, NON-AEROSOL 2 MG/ML (nafarelin acetate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Lhrh (Gnrh) Antagonist, Estrogen And Progestin Combinations - Drugs For Woman		
MYFEMBREE ORAL TABLET 40-1-0.5 MG (relugolix/estradiol/norethindrone acetate)	Tier 2	
ORIAHNN ORAL CAPSULE, SEQUENTIAL 300-1-0.5MG(AM) /300 MG(PM) (elagolix sodium/estradiol/norethindrone acetate)	Tier 2	
Lhrh (Gnrh) Antagonists - Drugs For Women		
<i>cetorelix subcutaneous kit 0.25 mg</i>	Tier 3	KP
CETROTIDE SUBCUTANEOUS KIT 0.25 MG (cetorelix acetate)	Tier 3	KP
ganirelix acetate (Fyremadel Subcutaneous Syringe 250 Mcg/0.5 ml)	Tier 3	KP
<i>ganirelix subcutaneous syringe 250 mcg/0.5 ml</i>	Tier 3	KP
ORILISSA ORAL TABLET 150 MG, 200 MG (elagolix sodium)	Tier 2	
Menopausal Symptoms Suppressant-Ssri Antidepressant Type - Drugs For Women		
<i>paroxetine mesylate(menop.sym) oral capsule 7.5 mg</i>	Tier 1	ST: Requires prior prescription for Paroxetine HCL or Venlafaxine within the past 120 days; QL (1 EA per 1 day)
Mineralocorticoids - Drugs For Inflammation		
<i>fludrocortisone oral tablet 0.1 mg</i>	Tier 1	
Oxytocic - Ergot Alkaloids - Drugs For Women		
<i>methylergonovine oral tablet 0.2 mg</i>	Tier 1	QL (28 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Parathyroid Hormones And Analogs - Drugs For Menopause And Bone Loss		
YORVIPATH SUBCUTANEOUS PEN INJECTOR 168 MCG/0.56 ML, 294 MCG/0.98 ML, 420 MCG/1.4 ML (palopegteriparatide)	Tier 3	PA; KP
Progestins - Drugs For Women		
norethindrone acetate (Gallifrey Oral Tablet 5 Mg)	Tier 1	
medroxyprogesterone oral tablet 10 mg, 2.5 mg, 5 mg	Tier 1	
norethindrone acetate oral tablet 5 mg	Tier 1	
progesterone intramuscular oil 50 mg/ml	Tier 1	KP
progesterone micronized oral capsule 100 mg, 200 mg	Tier 1	
PROMETRIUM ORAL CAPSULE 100 MG, 200 MG (progesterone, micronized)	Tier 3	
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (medroxyprogesterone acetate)	Tier 3	
Prolactin Inhibitor - Ergot Derivative Dopamine Receptor Agonists - Drugs For Women		
cabergoline oral tablet 0.5 mg	Tier 1	
Selective Estrogen Receptor Modulators (Serms) - Drugs For Menopause And Bone Loss		
EVISTA ORAL TABLET 60 MG (raloxifene HCl)	Tier 3	
raloxifene oral tablet 60 mg	PV	\$0 COPAY IF QUANTITY 1 IN 1 DAY
Somatostatic Agents - Drugs For Growth		
MYCAPSSA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 20 MG (octreotide acetate)	Tier 3	PA
octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)</i>	Tier 3	KP
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML (octreotide acetate)	Tier 3	KP
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML (1 ML), 0.6 MG/ML (1 ML), 0.9 MG/ML (1 ML) (pasireotide diaspertate)	Tier 3	PA; KP
Thyroid Hormones - Animal Source (Porcine) - Drugs For Thyroid		
ADTHYZA ORAL TABLET 120 MG, 15 MG, 60 MG (thyroid,pork)	Tier 3	ST: Requires prior prescription for NP Thyroid tablets within the past 120 days
ADTHYZA ORAL TABLET 130 MG, 16.25 MG, 30 MG, 32.5 MG, 65 MG, 90 MG, 97.5 MG (thyroid,pork)	Tier 3	
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (thyroid,pork)	Tier 3	ST: Requires prior prescription for NP Thyroid tablets within the past 120 days
NIVA THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (thyroid,pork)	Tier 3	ST: Requires prior prescription for NP Thyroid tablets within the past 120 days
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 90 MG (thyroid,pork)	Tier 1	
NP THYROID ORAL TABLET 60 MG (thyroid,pork)	Tier 3	
RENTHYROID ORAL TABLET 120 MG, 15 MG (thyroid,pork)	Tier 3	ST: Requires prior prescription for NP Thyroid tablets within the past 120 days
RENTHYROID ORAL TABLET 30 MG, 90 MG (thyroid,pork)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>thyroid (pork) oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg</i>	Tier 1	
Thyroid Hormones - Synthetic T3 (Triiodothyronine) - Drugs For Thyroid		
CYTOMEL ORAL TABLET 25 MCG, 5 MCG, 50 MCG (liothyronine sodium)	Tier 3	ST: Requires prior prescription for generic Liothyronine tablets within the past 120 days
liothyronine sodium (Liomny Oral Tablet 25 Mcg, 5 Mcg, 50 Mcg)	Tier 1	
<i>liothyronine oral tablet 25 mcg, 5 mcg, 50 mcg</i>	Tier 1	
Thyroid Hormones - Synthetic T4 (Thyroxine) - Drugs For Thyroid		
ERMEZA ORAL SOLUTION 30 MCG/ML (levothyroxine sodium)	Tier 1	PA
EUTHYROX ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 1	QL (2 EA per 1 day)
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 3	ST: Requires prior prescription for generic Levothyroxine tablets within the past 120 days; QL (2 EA per 1 day)
<i>levothyroxine oral capsule 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Tier 1	PA
<i>levothyroxine oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	Tier 1	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 3	ST: Requires prior prescription for generic Levothyroxine tablets within the past 120 days; QL (2 EA per 1 day)
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 3	ST: Requires prior prescription for generic Levothyroxine tablets within the past 120 days; QL (2 EA per 1 day)
THYQUIDITY ORAL SOLUTION 20 MCG/ML (levothyroxine sodium)	Tier 3	ST: Requires prior prescription for generic Levothyroxine tablets within the past 120 days; QL (20 ML per 1 day)
TIROSINT ORAL CAPSULE 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 3	PA
TIROSINT-SOL ORAL SOLUTION 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML (levothyroxine sodium)	Tier 3	PA
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG (levothyroxine sodium)	Tier 3	ST: Requires prior prescription for generic Levothyroxine tablets within the past 120 days; QL (2 EA per 1 day)
Fdb Class Obsolete-Not Used		
Alternative Therapy - Homeopathic Products		
AURUMHEEL ORAL DROPS (homeopathic drugs)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CANTHARIS COMPOSITUM ORAL DROPS (homeopathic drugs)	Tier 3	
CRALONIN ORAL DROPS (homeopathic drugs)	Tier 3	
EYE ORAL TABLET,SOLUBLE (homeopathic drugs)	Tier 3	
LAMIOFLUR ORAL DROPS (homeopathic drugs)	Tier 3	
PLANTAGO-HOMACCORD ORAL DROPS (homeopathic drugs)	Tier 3	
POPULUS COMPOSITUM ORAL DROPS (homeopathic drugs)	Tier 3	
PSORINOHEEL ORAL DROPS (homeopathic drugs)	Tier 3	
RENEEL ORAL TABLET,SOLUBLE (homeopathic drugs)	Tier 3	
SABAL-HOMACCORD ORAL DROPS (homeopathic drugs)	Tier 3	
SYZYGIUM COMPOSITUM ORAL DROPS (homeopathic drugs)	Tier 3	
VERTIGOHEEL ORAL DROPS (homeopathic drugs)	Tier 3	
VERTIGOHEEL ORAL TABLET,SOLUBLE (homeopathic drugs)	Tier 3	
Gastrointestinal Therapy Agents		
Fecal Microbiota Transplantation (Fmt)		
REBYOTA RECTAL ENEMA 150 ML (fecal microbiota, live-jslm)	Tier 3	PA
VOWST ORAL CAPSULE (fecal microbiota spores, live-brpk)	Tier 3	PA
Gastric Acid Secretion Reducer - Potassium-Competitive Acid Blockers		
VOQUEZNA ORAL TABLET 10 MG, 20 MG (vonoprazan fumarate)	Tier 3	PA; QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gastrointestinal Therapy Agents - Drugs For The Stomach		
Antacid - Calcium - Drugs For Ulcers And Stomach Acid		
PRELIEF ORAL TABLET 65 MG (calcium glycerophosphate)	Tier 3	
Antacid - Magnesium - Drugs For Ulcers And Stomach Acid		
<i>magnesium oxide oral tablet 400 mg (241.3 mg magnesium)</i>	Tier 3	
Antidiarrheal - Antiperistaltic Agents - Drugs For Diarrhea		
<i>loperamide oral capsule 2 mg</i>	Tier 1	
<i>opium tincture oral tincture 10 mg/ml (morphine)</i>	Tier 1	
Antidiarrheal - Gastrointestinal Chloride Channel Inhibitors - Drugs For Diarrhea		
MYTESI ORAL TABLET,DELAYED RELEASE (DR/EC) 125 MG (crofelemer)	Tier 2	ST: Requires prior prescription for Antiretrovirals therapy within the past 120 days; QL (2 EA per 1 day)
Antidiarrheal - Tryptophan Hydroxylase Inhibitor - Drugs For Diarrhea		
XERMELO ORAL TABLET 250 MG (telotristat etiprate)	Tier 3	PA
Antidiarrheal Antiperistaltic-Anticholinergic Combinations - Drugs For Diarrhea		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5 ml</i>	Tier 1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOMOTIL ORAL TABLET 2.5-0.025 MG (diphenoxylate HCl/atropine sulfate)	Tier 3	
MOTOFEN ORAL TABLET 1-0.025 MG (difenoxyin HCl/atropine sulfate)	Tier 3	ST: Requires prior prescription for Diphenoxylate/Atropine within the past 120 days; QL (8 EA per 1 day)
Antidiarrheal Gi Adsorbent-Intestinal Flora Modifiers Combinations - Drugs For Diarrhea		
ACIDOPHILUS-PECTIN ORAL CAPSULE 75 MILLION CELL -100 MG (Lactobacillus acidophilus/pectin)	Tier 3	
Antidiarrheal Miscellaneous Combinations - Drugs For Diarrhea		
BANATROL PLUS ORAL POWDER IN PACKET (banana flakes/transgalactooligosaccharides)	Tier 3	
Antidiarrheal Opioid Agents - Drugs For Diarrhea		
<i>opium tincture oral tincture 10 mg/ml (morphine)</i>	Tier 1	
Antiemetic - Anticholinergics - Drugs For Vomiting And Nausea		
<i>scopolamine base transdermal patch 3 day 1 mg over 3 days</i>	Tier 1	
TRANSDERM-SCOP TRANSDERMAL PATCH 3 DAY 1 MG OVER 3 DAYS (scopolamine)	Tier 3	
Antiemetic - Antihistamines - Drugs For Vomiting And Nausea		
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	Tier 1	
<i>meclizine oral tablet 50 mg</i>	Tier 3	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antiemetic - Antihistamine-Vitamin Combinations - Drugs For Vomiting And Nausea		
BONJESTA ORAL TABLET,IR,DELAYED REL,BIPHASIC 20-20 MG (doxylamine succinate/pyridoxine HCl (vitamin B6))	Tier 3	QL (60 EA per 30 days)
DICLEGIS ORAL TABLET,DELAYED RELEASE (DR/EC) 10-10 MG (doxylamine succinate/pyridoxine HCl (vitamin B6))	Tier 3	QL (120 EA per 30 days)
<i>doxylamine-pyridoxine (vit b6) oral tablet, delayed release (drlec) 10-10 mg</i>	Tier 1	QL (120 EA per 30 days)
Antiemetic - Cannabinoid Type - Drugs For Vomiting And Nausea		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (dronabinol)	Tier 3	QL (2 EA per 1 day)
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	Tier 3	QL (60 ML per 30 days)
Antiemetic - Dopamine (D2)/5-Ht3 Antagonists - Drugs For Vomiting And Nausea		
<i>trimethobenzamide oral capsule 300 mg</i>	Tier 1	
Antiemetic - Phenothiazines - Drugs For Vomiting And Nausea		
prochlorperazine maleate (Compazine Oral Tablet 10 Mg, 5 Mg)	Tier 3	
prochlorperazine (Compazine Rectal Suppository 25 Mg)	Tier 3	
prochlorperazine (Compro Rectal Suppository 25 Mg)	Tier 1	
promethazine HCl (Phenergan Injection Solution 25 Mg/ML, 50 Mg/ML)	Tier 3	KP
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prochlorperazine rectal suppository 25 mg</i>	Tier 1	
<i>promethazine injection solution 25 mg/ml, 50 mg/ml</i>	Tier 1	KP
<i>promethazine oral syrup 6.25 mg/5 ml</i>	Tier 1	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
promethazine HCl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg, 50 Mg)	Tier 1	
Antiemetic - Selective Serotonin 5-HT₃ Antagonists - Drugs For Vomiting And Nausea		
<i>granisetron hcl oral tablet 1 mg</i>	Tier 1	ST: Requires prior prescription for Ondansetron tablets or ODT within the past 120 days; QL (8 EA per 30 days)
<i>ondansetron hcl oral solution 4 mg/5 ml</i>	Tier 1	QL (50 ML per 15 days)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	Tier 1	
<i>ondansetron oral tablet, disintegrating 16 mg</i>	Tier 3	
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	Tier 1	
SANCUSO TRANSDERMAL PATCH WEEKLY 3.1 MG/24 HOUR (granisetron)	Tier 3	QL (1 EA per 7 days)
Antiemetic - Substance P-Neurokinin 1 (NK₁) Receptor Antagonists - Drugs For Vomiting And Nausea		
<i>aprepitant oral capsule 125 mg</i>	Tier 1	QL (1 EA per 21 days)
<i>aprepitant oral capsule 40 mg</i>	Tier 1	QL (1 EA per 28 days)
<i>aprepitant oral capsule 80 mg</i>	Tier 1	QL (2 EA per 21 days)
<i>aprepitant oral capsule, dose pack 125 mg (1)- 80 mg (2)</i>	Tier 1	QL (3 EA per 21 days)
EMEND ORAL CAPSULE 80 MG (aprepitant)	Tier 3	QL (2 EA per 21 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMEND ORAL CAPSULE,DOSE PACK 125 MG (1)- 80 MG (2) (aprepitant)	Tier 3	QL (3 EA per 21 days)
EMEND ORAL SUSPENSION FOR RECONSTITUTION 125 MG (25 MG/ ML FINAL CONC.) (aprepitant)	Tier 2	QL (3 EA per 21 days)
VARUBI ORAL TABLET 90 MG (rolapitant HCl)	Tier 3	QL (2 EA per 14 days)
Antiemetic - Substance P-Neurokinin 1 And 5-Ht3 Recept Antagonist Comb - Drugs For Vomiting And Nausea		
AKYNZEO (NETUPITANT) ORAL CAPSULE 300-0.5 MG (netupitant/palonosetron HCl)	Tier 2	QL (1 EA per 28 days)
Bile Acids - Drugs For The Stomach		
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (cholic acid)	Tier 3	PA
Chronic Idiopathic Const. Agents - Guanylate Cyclase-C (Gc-C) Agonists - Drugs For Constipation		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (linaclotide)	Tier 2	QL (1 EA per 1 day)
TRULANCE ORAL TABLET 3 MG (plecanatide)	Tier 2	QL (1 EA per 1 day)
Colonic Acidifier (Ammonia Inhibitor) - Drugs For The Stomach		
lactulose (Enulose Oral Solution 10 Gram/15 Ml)	Tier 1	
lactulose (Generlac Oral Solution 10 Gram/15 Ml)	Tier 1	
<i>lactulose oral solution 10 gram/15 ml</i>	Tier 1	
Digestive Enzyme Mixtures - Drugs For The Stomach		
BEVITROL ORAL CAPSULE 9,000-112,500- 112,500 UNIT (lipase/protease/amylase (porcine))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT (lipase/protease/amylase (porcine))	Tier 2	
GASTRACID ORAL CAPSULE 100-350-300-20 MG (pepsin/glutamic acid/betaine HCl/gentian root extract)	Tier 3	
PANCREAZE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,500-35,500- 61,500 UNIT, 16,800- 56,800- 98,400 UNIT, 2,600-8,800- 15,200 UNIT, 21,000- 54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT, 4,200- 14,200- 24,600 UNIT (lipase/protease/amylase (porcine))	Tier 3	
PANXYME PH ORAL CAPSULE 10.2-10-45 MG (lipase/protease/amylase (porcine))	Tier 3	
PERTZYE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 16,000-57,500- 60,500 UNIT, 24,000-86,250- 90,750 UNIT, 4,000-14,375- 15,125 UNIT, 8,000-28,750- 30,250 UNIT (lipase/protease/amylase (porcine))	Tier 3	ST: Requires prior prescription for Zenpep or Creon within the past 120 days
VIOKACE ORAL TABLET 10,440-39,150- 39,150 UNIT, 20,880-78,300- 78,300 UNIT (lipase/protease/amylase (porcine))	Tier 3	ST: Requires prior prescription for Zenpep or Creon within the past 120 days
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000- 189,600- 252,600 UNIT (lipase/protease/amylase (porcine))	Tier 2	
Digestive Enzymes - Drugs For The Stomach		
DAIRY RELIEF ORAL TABLET 3,000 UNIT, 4,500 UNIT, 9,000 UNIT (lactase)	Tier 3	
<i>lactase oral tablet 3,000 unit, 9,000 unit</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PAPAYA DIGESTIVE ENZYME CMPLX ORAL TABLET,CHEWABLE (enzymes,digestive)	Tier 3	
SUCRAID ORAL SOLUTION 8,500 UNIT/ML (sacrosidase)	Tier 3	PA
Gallstone Solubilizing (Litholysis) Agents - Drugs For The Stomach		
CHENODAL ORAL TABLET 250 MG (chenodiol)	Tier 3	PA
CTEXLI ORAL TABLET 250 MG (chenodiol)	Tier 3	PA
RELTONE ORAL CAPSULE 200 MG, 400 MG (ursodiol)	Tier 3	PA
URSO FORTE ORAL TABLET 500 MG (ursodiol)	Tier 3	
<i>ursodiol oral capsule 200 mg, 400 mg</i>	Tier 3	PA
<i>ursodiol oral capsule 300 mg</i>	Tier 1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	Tier 1	
Gastric Acid Secretion Reducer - Histamine H2-Receptor Antagonists - Drugs For Ulcers And Stomach Acid		
<i>cimetidine hcl oral solution 300 mg/5 ml</i>	Tier 1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	Tier 1	
<i>famotidine oral suspension for reconstitution 40 mg/5 ml (8 mg/ml)</i>	Tier 1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	Tier 1	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	Tier 1	
famotidine (Pepcid Oral Tablet 20 Mg, 40 Mg)	Tier 3	
Gastric Acid Secretion Reducer - Proton Pump Inhibitors (Ppis) - Drugs For Ulcers And Stomach Acid		
ACIPHEX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG (rabeprazole sodium)	Tier 3	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACIPHEX SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 10 MG, 5 MG (rabeprazole sodium)	Tier 3	ST: At least 2 prior prescriptions for Lansoprazole, Omeprazole, or Pantoprazole within the past 365 days; QL (1 EA per 1 day)
DEXILANT ORAL CAPSULE,BIPHASE DELAYED RELEAS 30 MG, 60 MG (dexlansoprazole)	Tier 3	ST: Requires prior prescription for Lansoprazole, Omeprazole, or Pantoprazole within the past 120 days; QL (1 EA per 1 day)
<i>dexlansoprazole oral capsule,biphase delayed releas 30 mg, 60 mg</i>	Tier 1	ST: Requires prior prescription for Lansoprazole, Omeprazole, or Pantoprazole within the past 120 days; QL (1 EA per 1 day)
<i>esomeprazole magnesium oral capsule,delayed release(drlec) 20 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>esomeprazole magnesium oral capsule,delayed release(drlec) 40 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>esomeprazole magnesium oral granules dr for susp in packet 40 mg</i>	Tier 1	QL (2 EA per 1 day)
<i>lansoprazole oral capsule,delayed release(drlec) 15 mg, 30 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lansoprazole oral tablet,disintegrat, delay rel 15 mg, 30 mg</i>	Tier 1	ST: Requires prior prescription for Lansoprazole, Omeprazole, or Pantoprazole Sodium within the past 120 days
NEXIUM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 MG (esomeprazole magnesium)	Tier 3	QL (1 EA per 1 day)
NEXIUM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40 MG (esomeprazole magnesium)	Tier 3	QL (2 EA per 1 day)
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG (esomeprazole magnesium)	Tier 3	QL (1 EA per 1 day)
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 40 MG (esomeprazole magnesium)	Tier 3	QL (2 EA per 1 day)
<i>omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>pantoprazole oral granules dr for susp in packet 40 mg</i>	Tier 1	ST: Requires prior prescription for Omeprazole Magnesium, Omeprazole, Pantoprazole Sodium, Prilosec OTC, or Prilosec within the past 120 days
<i>pantoprazole oral tablet,delayed release (dr/ec) 20 mg, 40 mg</i>	Tier 1	
PREVACID ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 MG (lansoprazole)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREVACID SOLUTAB ORAL TABLET,DISINTEGRAT, DELAY REL 15 MG, 30 MG (lansoprazole)	Tier 3	ST: Requires prior prescription for Lansoprazole, Omeprazole, or Pantoprazole Sodium within the past 120 days
PRILOSEC ORAL SUSP,DELAYED RELEASE FOR RECON 10 MG, 2.5 MG (omeprazole magnesium)	Tier 3	ST: Requires prior prescription for Lansoprazole, Omeprazole, or Pantoprazole within the past 120 days
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET 40 MG (pantoprazole sodium)	Tier 3	ST: Requires prior prescription for Omeprazole Magnesium, Omeprazole, Pantoprazole Sodium, Prilosec OTC, or Prilosec within the past 120 days
PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG, 40 MG (pantoprazole sodium)	Tier 3	
<i>rabeprazole oral capsule, delayed rel sprinkle 10 mg</i>	Tier 1	ST: At least 2 prior prescriptions for Lansoprazole, Omeprazole, or Pantoprazole within the past 365 days; QL (1 EA per 1 day)
<i>rabeprazole oral tablet, delayed release (dr/ec) 20 mg</i>	Tier 1	QL (1 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Gastric Acid Secretion Reducer-Proton Pump Inhibitor And Antacid Comb - Drugs For Ulcers And Stomach Acid		
KONVOMEF ORAL SUSPENSION FOR RECONSTITUTION 2-84 MG/ML (omeprazole/sodium bicarbonate)	Tier 3	PA
<i>omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram, 40-1.1 mg-gram</i>	Tier 1	ST: Requires prior prescription for Lansoprazole, Omeprazole, or Pantoprazole within the past 120 days; QL (1 EA per 1 day)
<i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg, 40-1,680 mg</i>	Tier 1	PA
Gastric Mucosa - Cytoprotective Prostaglandin Analogs - Drugs For Ulcers And Stomach Acid		
CYTOTEC ORAL TABLET 100 MCG, 200 MCG (misoprostol)	Tier 3	
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	Tier 1	
Gastrointestinal - Prokinetic Agents - 5-Ht4 Receptor Agonists - Drugs For The Stomach		
MOTEGRITY ORAL TABLET 1 MG, 2 MG (prucalopride succinate)	Tier 3	QL (1 EA per 1 day)
<i>prucalopride oral tablet 1 mg, 2 mg</i>	Tier 1	QL (1 EA per 1 day)
Gastrointestinal Antiflatulents - Drugs For The Stomach		
<i>activated charcoal oral capsule 260 mg</i>	Tier 3	
<i>activated charcoal oral capsule 280 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BEANAID ORAL CAPSULE 300 UNIT (alpha-D-galactosidase)	Tier 3	
BEANO ORAL TABLET 400 UNIT (alpha-D-galactosidase)	Tier 3	
GAS RELIEF-PREVENTION ORAL CAPSULE 600 UNIT (alpha-D-galactosidase)	Tier 3	
Gastrointestinal Prokinetic Agents - D2 Antagonist/5-Ht4 Agonists - Drugs For The Stomach		
GIMOTI NASAL SPRAY WITH PUMP 15 MG/SPRAY (metoclopramide HCl)	Tier 3	PA
<i>metoclopramide hcl oral solution 5 mg/5 ml</i>	Tier 1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	Tier 1	
REGLAN ORAL TABLET 10 MG, 5 MG (metoclopramide HCl)	Tier 3	
Gi Antispasmodic - Belladonna Alkaloids - Drugs For Stomach Cramps		
ANASPAZ ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 3	
ED-SPAZ ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 1	
<i>hyoscyamine sulfate oral drops 0.125 mg/ml</i>	Tier 1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5 ml</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet extended release 12 hr 0.375 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet,disintegrating 0.125 mg</i>	Tier 1	
<i>hyoscyamine sulfate sublingual tablet 0.125 mg</i>	Tier 1	
HYOSYNE ORAL DROPS 0.125 MG/ML (hyoscyamine sulfate)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HYOSYNE ORAL ELIXIR 0.125 MG/5 ML (hyoscyamine sulfate)	Tier 1	
LEVVID ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG (hyoscyamine sulfate)	Tier 3	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 3	
LEVSIN/SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 3	
<i>methscopolamine oral tablet 2.5 mg, 5 mg</i>	Tier 1	
NULEV ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 3	
OSCIMIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
OSCIMIN SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
SYMAX DUOTAB ORAL TABLET,EXT RELEASE MULTIPHASE 0.125 MG-0.25 MG (0.375 MG) (hyoscyamine sulfate)	Tier 3	
SYMAX FASTABS ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 3	
SYMAX-SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 3	
SYMAX-SR ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG (hyoscyamine sulfate)	Tier 3	
Gi Antispasmodic - Quaternary Ammonium Compounds - Drugs For Stomach Cramps		
DARTISLA ORAL TABLET,DISINTEGRATING 1.7 MG (glycopyrrolate)	Tier 3	ST: Requires prior prescription for Glycopyrrolate 2mg within the past 120 days; QL (4 EA per 1 day); Age (Min 18 Years)
<i>glycopyrrolate (pf) injection syringe 0.6 mg/3 ml (0.2 mg/ml)</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>glycopyrrolate oral tablet 1.5 mg</i>	Tier 3	ST: Requires prior prescription for Glycopyrrolate 1mg or 2mg within the past 120 days; QL (3 EA per 1 day)
GLYRX-PF INJECTION SYRINGE 0.6 MG/3 ML (0.2 MG/ML) (glycopyrrolate/PF)	Tier 3	KP
ROBINUL FORTE ORAL TABLET 2 MG (glycopyrrolate)	Tier 3	
ROBINUL ORAL TABLET 1 MG (glycopyrrolate)	Tier 3	
Gi Antispasmodic - Synthetic Tertiary Amines - Drugs For Stomach Cramps		
<i>dicyclomine oral capsule 10 mg</i>	Tier 1	
<i>dicyclomine oral solution 10 mg/5 ml</i>	Tier 1	
<i>dicyclomine oral tablet 20 mg</i>	Tier 1	
<i>dicyclomine oral tablet 40 mg</i>	Tier 3	QL (4 EA per 1 day)
Gi Antispasmodic And Benzodiazepine Combinations - Drugs For Stomach Cramps		
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	Tier 1	
LIBRAX (WITH CLIDINIUM) ORAL CAPSULE 5-2.5 MG (chlordiazepoxide/clidinium bromide)	Tier 3	
Gi Antispasmodic And Opioid Combinations - Drugs For Stomach Cramps		
<i>belladonna alkaloids-opium rectal suppository 16.2-30 mg, 16.2-60 mg</i>	Tier 1	
Gi Antispasmodic Combinations Other - Drugs For Stomach Cramps		
<i>belladonna alkaloids-opium rectal suppository 16.2-30 mg, 16.2-60 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>chlordiazepoxide-clidinium oral capsule 5-2.5 mg</i>	Tier 1	
DONNATAL ORAL ELIXIR 16.2 MG-0.1037 MG/5 ML (5 ML) (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Requires prior prescriptions for Dicyclomine and Hyoscyamine within the past 365 days; QL (1200 ML per 30 days)
DONNATAL ORAL TABLET 16.2-0.1037 -0.0194 MG (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Requires prior prescriptions for Dicyclomine and Hyoscyamine within the past 365 days; QL (8 EA per 1 day)
LIBRAX (WITH CLIDINIUM) ORAL CAPSULE 5-2.5 MG (chlordiazepoxide/clidinium bromide)	Tier 3	
<i>phenobarb-hyoscy-atropine-scop oral elixir 16.2-0.1037 - 0.0194 mg/5 ml</i>	Tier 3	ST: Requires prior prescriptions for Dicyclomine and Hyoscyamine within the past 365 days; QL (1200 ML per 30 days)
<i>phenobarb-hyoscy-atropine-scop oral tablet 16.2-0.1037 - 0.0194 mg</i>	Tier 3	ST: Requires prior prescriptions for Dicyclomine and Hyoscyamine within the past 365 days; QL (8 EA per 1 day)
PHENOHYTRO ORAL ELIXIR 16.2-0.1037 -0.0194 MG/5 ML (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Requires prior prescriptions for Dicyclomine and Hyoscyamine within the past 365 days; QL (1200 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHENOHYTRO ORAL TABLET 16.2-0.1037 -0.0194 MG (phenobarbital/hyoscyamine sulf/atropine sulf/scopolamine Hb)	Tier 3	ST: Requires prior prescriptions for Dicyclomine and Hyoscyamine within the past 365 days; QL (8 EA per 1 day)
H. Pylori Therapy - Bismuth And Antibiotics Combinations - Drugs For Ulcers And Stomach Acid		
<i>bismuth subcit k-metronidz-tcn oral capsule 140-125-125 mg</i>	Tier 1	
PYLERA ORAL CAPSULE 140-125-125 MG (colloidal bismuth subcitrate/metronidazole/tetracycline HCl)	Tier 3	
H. Pylori Therapy - Proton Pump Inhibitor And Antibiotics Combinations - Drugs For Ulcers And Stomach Acid		
<i>amoxicil-clarithromy-lansopraz oral combo pack 500-500-30 mg</i>	Tier 1	QL (112 EA per 10 days)
OMECLAMOX-PAK ORAL COMBO PACK 20 MG-500 MG-500 MG (40) (omeprazole/clarithromycin/amoxicillin trihydrate)	Tier 3	
TALICIA ORAL CAPSULE,IR - DELAY REL,BIPHASE 10-250-12.5 MG (omeprazole magnesium/amoxicillin trihydrate/rifabutin)	Tier 3	QL (168 EA per 14 days); Age (Min 18 Years)
H.Pylori Therapy-Potassium-Competitive Acid Blocker And Antibiotics - Drugs For The Stomach		
VOQUEZNA DUAL PAK ORAL COMBO PACK 20 MG (28)-500 MG (84) (vonoprazan fumarate/amoxicillin trihydrate)	Tier 3	PA; QL (112 EA per 14 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VOQUEZNA TRIPLE PAK ORAL COMBO PACK 20-500-500 MG (vonoprazan fumarate/amoxicillin trihydrate/clarithromycin)	Tier 3	PA; QL (112 EA per 14 days)
Ibs Agent - Gastrointestinal Chloride Channel Activator Agents - Drugs For Irritable Bowel Syndrome		
AMITIZA ORAL CAPSULE 24 MCG (lubiprostone)	Tier 3	QL (2 EA per 1 day)
AMITIZA ORAL CAPSULE 8 MCG (lubiprostone)	Tier 3	QL (4 EA per 1 day)
<i>lubiprostone oral capsule 24 mcg</i>	Tier 1	QL (2 EA per 1 day)
<i>lubiprostone oral capsule 8 mcg</i>	Tier 1	QL (4 EA per 1 day)
Ibs Agent - Guanylate Cyclase-C (Gc-C) Agonists - Drugs For Irritable Bowel Syndrome		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (linaclotide)	Tier 2	QL (1 EA per 1 day)
TRULANCE ORAL TABLET 3 MG (plecanatide)	Tier 2	QL (1 EA per 1 day)
Ibs Agent - Mixed Opioid Receptor Agonist And Antagonist - Drugs For Irritable Bowel Syndrome		
VIBERZI ORAL TABLET 100 MG, 75 MG (eluxadoline)	Tier 2	QL (2 EA per 1 day)
Ibs Agent - Selective 5-Ht3 Receptor Antagonists - Drugs For Irritable Bowel Syndrome		
<i>alosetron oral tablet 0.5 mg, 1 mg</i>	Tier 1	
LOTROXEX ORAL TABLET 0.5 MG, 1 MG (alosetron HCl)	Tier 3	
Ibs Agent - Sodium-Hydrogen Exchanger 3 (Nhe3) Inhibitor - Drugs For Irritable Bowel Syndrome		
IBSRELA ORAL TABLET 50 MG (tenapanor HCl)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Inflammatory Bowel Agent - Interleukin-12 And Il-23 Inhibitors, Mc Ab - Drugs For Inflammatory Bowel Disease		
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5 ML (ustekinumab)	Tier 3	PA; KP
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML (ustekinumab)	Tier 3	PA; KP
STEQEYMA SUBCUTANEOUS SYRINGE 90 MG/ML (ustekinumab-stba)	Tier 3	PA; KP
YESINTEK SUBCUTANEOUS SOLUTION 45 MG/0.5 ML (ustekinumab-kfce)	Tier 3	PA; KP
YESINTEK SUBCUTANEOUS SYRINGE 90 MG/ML (ustekinumab-kfce)	Tier 3	PA; KP
Inflammatory Bowel Agent - Interleukin-23 (Il-23) Inhibitor, Mc Ab - Drugs For Inflammatory Bowel Disease		
OMVOH PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 200 MG/2 ML (100 MG/ML X 2), 300MG/3ML(100MG /ML-200 MG/2ML) (mirikizumab-mrkz)	Tier 3	PA; KP
OMVOH SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML (100 MG/ML X 2), 300MG/3ML(100MG /ML-200 MG/2ML) (mirikizumab-mrkz)	Tier 3	PA; KP
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML) (risankizumab-rzaa)	Tier 3	PA; KP
TREMFYA ONE-PRESS SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML (guselkumab)	Tier 3	PA; KP
TREMFYA PEN INDUCTION PK-CROHN SUBCUTANEOUS PEN INJECTOR 200 MG/2 ML (guselkumab)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TREMFYA PEN SUBCUTANEOUS PEN INJECTOR 100 MG/ML, 200 MG/2 ML (guselkumab)	Tier 3	PA; KP
TREMFYA SUBCUTANEOUS SYRINGE 100 MG/ML, 200 MG/2 ML (guselkumab)	Tier 3	PA; KP
Inflammatory Bowel Agent - Aminosalicylates And Related Agents - Drugs For Inflammatory Bowel Disease		
APRISO ORAL CAPSULE,EXTENDED RELEASE 24HR 0.375 GRAM (mesalamine)	Tier 3	
AZULFIDINE EN-TABS ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG (sulfasalazine)	Tier 3	
AZULFIDINE ORAL TABLET 500 MG (sulfasalazine)	Tier 3	
<i>balsalazide oral capsule 750 mg</i>	Tier 1	
CANASA RECTAL SUPPOSITORY 1,000 MG (mesalamine)	Tier 3	
COLAZAL ORAL CAPSULE 750 MG (balsalazide disodium)	Tier 3	
DIPENTUM ORAL CAPSULE 250 MG (olsalazine sodium)	Tier 3	ST: Requires prior prescription for Lialda within the past 120 days
LIALDA ORAL TABLET,DELAYED RELEASE (DR/EC) 1.2 GRAM (mesalamine)	Tier 3	
<i>mesalamine oral capsule (with del rel tablets) 400 mg</i>	Tier 1	
<i>mesalamine oral capsule, extended release 500 mg</i>	Tier 1	
<i>mesalamine oral capsule,extended release 24hr 0.375 gram</i>	Tier 1	
<i>mesalamine oral tablet,delayed release (dr/ec) 1.2 gram, 800 mg</i>	Tier 1	
<i>mesalamine rectal enema 4 gram/60 ml</i>	Tier 1	
<i>mesalamine rectal suppository 1,000 mg</i>	Tier 1	
<i>mesalamine with cleansing wipe rectal enema kit 4 gram/60 ml</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG, 500 MG (mesalamine)	Tier 3	
ROWASA RECTAL ENEMA KIT 4 GRAM/60 ML (mesalamine with cleansing wipes)	Tier 3	
SFROWASA RECTAL ENEMA 4 GRAM/60 ML (mesalamine)	Tier 3	
<i>sulfasalazine oral tablet 500 mg</i>	Tier 1	
<i>sulfasalazine oral tablet, delayed release (drlec) 500 mg</i>	Tier 1	
Inflammatory Bowel Agent - Glucocorticoids - Drugs For Inflammatory Bowel Disease		
<i>budesonide oral capsule, delayed, extend. release 3 mg</i>	Tier 1	
<i>budesonide oral tablet, delayed and ext. release 9 mg</i>	Tier 1	ST: Requires prior prescription for Balsalazide within the past 120 days
<i>budesonide rectal foam 2 mg/actuation</i>	Tier 1	
CORTENEMA RECTAL ENEMA 100 MG/60 ML (hydrocortisone)	Tier 3	
CORTIFOAM RECTAL FOAM 10 % (80 MG) (hydrocortisone acetate)	Tier 3	
<i>hydrocortisone rectal enema 100 mg/60 ml</i>	Tier 1	
ORTIKOS ORAL CAPSULE, EXTENDED RELEASE 6 MG, 9 MG (budesonide)	Tier 3	PA
UCERIS ORAL TABLET, DELAYED AND EXT. RELEASE 9 MG (budesonide)	Tier 3	ST: Requires prior prescription for Balsalazide within the past 120 days
UCERIS RECTAL FOAM 2 MG/ACTION (budesonide)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Inflammatory Bowel Agent - Integrin Receptor Antagonist, Mc Antibody - Drugs For Inflammatory Bowel Disease		
ENTYVIO PEN SUBCUTANEOUS PEN INJECTOR 108 MG/0.68 ML (vedolizumab)	Tier 3	PA; KP
Inflammatory Bowel Agent - Janus Kinase (Jak) Inhibitors - Drugs For Inflammatory Bowel Disease		
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG (upadacitinib)	Tier 3	PA
XELJANZ ORAL TABLET 10 MG, 5 MG (tofacitinib citrate)	Tier 3	PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 11 MG, 22 MG (tofacitinib citrate)	Tier 3	PA
Inflammatory Bowel Agent - Sphingosine 1-Phosphate Receptor Modulator - Drugs For Irritable Bowel Syndrome		
VELSIPITY ORAL TABLET 2 MG (etrasimod arginine)	Tier 3	PA
ZEPOSIA ORAL CAPSULE 0.92 MG (ozanimod hydrochloride)	Tier 3	PA
ZEPOSIA STARTER KIT (28-DAY) ORAL CAPSULE,DOSE PACK 0.23 MG-0.46 MG -0.92 MG (21) (ozanimod hydrochloride)	Tier 3	PA
ZEPOSIA STARTER PACK (7-DAY) ORAL CAPSULE,DOSE PACK 0.23 MG (4)- 0.46 MG (3) (ozanimod hydrochloride)	Tier 3	PA
Inflammatory Bowel Agent - Tumor Necrosis Factor Alpha Blockers - Drugs For Inflammatory Bowel Disease		
<i>adalimumab-adaz subcutaneous pen injector 40 mg/0.4 ml, 80 mg/0.8 ml</i>	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>adalimumab-adaz subcutaneous syringe 20 mg/0.2 ml, 40 mg/0.4 ml</i>	Tier 3	PA; KP
CIMZIA POWDER FOR RECONST SUBCUTANEOUS KIT 400 MG (200 MG X 2 VIALS) (certolizumab pegol)	Tier 3	PA; KP
CIMZIA STARTER KIT SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 3	PA; KP
CIMZIA SUBCUTANEOUS SYRINGE KIT 400 MG/2 ML (200 MG/ML X 2) (certolizumab pegol)	Tier 3	PA; KP
HUMIRA PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN CROHNS-UC-HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN PSOR-UV-ADOL HS SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML-40 MG/0.4 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab)	Tier 3	PA; KP
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML (adalimumab)	Tier 3	PA; KP
SIMLANDI(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab-ryvk)	Tier 3	PA; KP
SIMLANDI(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML, 80 MG/0.8 ML (adalimumab-ryvk)	Tier 3	PA; KP
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML (golimumab)	Tier 2	PA; KP
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML (golimumab)	Tier 2	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYMFENTRA SUBCUTANEOUS PEN INJECTOR KIT 120 MG/ML (infliximab-dyyb)	Tier 3	PA; KP
ZYMFENTRA SUBCUTANEOUS SYRINGE KIT 120 MG/ML (infliximab-dyyb)	Tier 3	PA; KP
Intestinal Flora Modifiers - Drugs For Diarrhea		
ACIDOPHILUS PROBIOTIC BLEND ORAL CAPSULE 175 MG (Lactobacillus acidophilus,salivarius/B.bifidum/S.thermophil)	Tier 3	
<i>acidophilus-pectin, citrus oral capsule 7.5 mg (30 mill cell)-100 mg</i>	Tier 3	
<i>acidophilus-pectin, citrus oral tablet 25 million cell -100 mg</i>	Tier 3	
ADULT 50 PLUS PROBIOTIC ORAL CAPSULE 4 BILLION CELL (Lactobacillus combination no.9)	Tier 3	
ADVANCED PROBIOTIC ORAL CAPSULE 625 MG (10 BILLION CELL) (L.acidophilus/L.casei/L.lactis/L.rhamnosus/B.lactis/B.longum)	Tier 3	
ALIGN DUALBIOTIC ORAL TABLET,CHEWABLE 500 MILLION CELL-1.25 GRAM (Bacillus coagulans/inulin)	Tier 3	
AZO COMPLETE FEMININE BALANCE ORAL CAPSULE 5 BILLION CELL (Lactobacillus crispatus/L. gasseri/L. jensenii/L. rhamnosus)	Tier 3	
AZO DUAL PROTECTION ORAL CAPSULE 5 BILLION CELL- 15 MG (L.crispatus/L.gasseri/L.jensenii/L.rhamnosus/bacteriophages)	Tier 3	
AZO VAGINAL HEALTH PROBIOTIC ORAL CAPSULE 5 BILLION CELL (Lactobacillus crispatus/L. gasseri/L. jensenii/L. rhamnosus)	Tier 3	
BACICAP ORAL CAPSULE 20 BILLION CELL (Lactobacillus acidophilus,paracasei,plantarum/B.animalis)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BACID WITH LACTOSPORE ORAL CAPSULE 1 BILLION CELL (Bacillus coagulans)	Tier 3	
BENEFIBER ADVANCED ORAL POWDER IN PACKET 1 BILLION CELL- 4 GRAM (Bacillus coagulans/maltodextrin/guar gum)	Tier 3	
BENEFIBER DUAL ACTION ORAL TABLET,CHEWABLE 500 MILLION CELL-1.5 GRAM (Bacillus coagulans/inulin)	Tier 3	
BENEFIBER DUAL ACTION-THEANINE ORAL POWDER IN PACKET 1 BILLION CELL- 3 GRAM-200 MG (Bacillus coagulans/inulin/theanine)	Tier 3	
BILAC ORAL CAPSULE 33 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
BIOMEPRO ORAL CAPSULE,DELAYED RELEASE(DR/EC) 50 BILLION CELL (Lactobacillus acidophilus/Lactobacillus casei/L. rhamnosus)	Tier 3	
BIOMEPRO ORAL LIQUID 100 BILLION CELL/104 ML (Lactobacillus acidophilus/Lactobacillus casei/L. rhamnosus)	Tier 3	
BIOTINEX ORAL CAPSULE 700 MILLION CELL (Lactobacillus acidophilus)	Tier 3	
BIOZEN ORAL CAPSULE 15.5 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
CHILD PROBIOTIC DIGEST-IMMUNE ORAL TABLET,CHEWABLE 5 BILLION CELL (Lactobacillus acidophilus,salivarius/B.bifidum/S.thermophil)	Tier 3	
CHILDRENS CHEWABLE PROBIOTIC ORAL TABLET,CHEWABLE 1.5 BILLION CELL (L. acidophilus/L. rhamnosus/B. breve/S. thermophilus)	Tier 3	
CHILDREN'S DAILY PROBIOTIC ORAL POWDER IN PACKET 5 BILLION CELL (Lactobacillus rhamnosus GG)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHILDREN'S PROBIOTIC ORAL TABLET,CHEWABLE 5 BILLION CELL (L.acidophilus,casei,rhamnosus/B.breve,longum)	Tier 3	
CLAIRVEE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 5 BILLION CELL- 400 MCG DFE (L. acidophilus/L. rhamnosus/levomefolate sodium/lactoferrin)	Tier 3	
CRANBERRY-PROBIOTC(BLEND)-VITC ORAL TABLET 150 MM CELL- 250 MG-30 MG (L.acidophilus/L.salivar/B.bifidum/S.thermophilus/cranberry/C)	Tier 3	
CULTURELLE ABDOMINAL SUPP-CMFT ORAL POWDER IN PACKET 2 BILLION CELL- 4 GRAM (Bacillus coagulans/fucosyllactose)	Tier 3	
CULTURELLE ADVANCED REGULARITY ORAL CAPSULE 11 BILLION CELL (Lactobacillus paracasei/Lactobacillus rhamnosus)	Tier 3	
CULTURELLE BABY COLIC-SOOTHING ORAL DROPS 250 MM CELL-10 MCG/5 DROPS (Lactobacillus reuteri/Lactobacillus rhamnosus GG/vitamin D3)	Tier 3	
CULTURELLE BABY DIGESTIVE CALM ORAL DROPS 2 BILLION CELL/5 DROPS (Lactobacillus rhamnosus GG/Bifidobacterium animalis (lactis))	Tier 3	
CULTURELLE BABY HEALTH DEVELOP ORAL POWDER IN PACKET 2 BILLION CELL- 50 MG-300 MG (L. rhamnosus/B. animalis/dha/fucosyllactose/vitamin D3)	Tier 3	
CULTURELLE BLOATING GAS ORAL CAPSULE 5 BILLION CELL- 285 MG-50 MG (Lactobacillus rhamnosus GG/enzymes,digestive/ginger/minerals)	Tier 3	
CULTURELLE DIGESTIVE HEALTH ORAL CAPSULE 10 BILLION CELL -200 MG (Lactobacillus rhamnosus GG/inulin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CULTURELLE IMMUNE DEFENSE ORAL TABLET,CHEWABLE 10 BILLION CELL -90 MG-3 MG (L. rhamnosus GG/ascorbic acid/zinc oxide/elderberry fruit)	Tier 3	
CULTURELLE KIDS 4 IN 1 IMMUNE ORAL TABLET,CHEWABLE 5 BILLION CELL- 90 MG-20 MCG (L. rhamnosus/ascorbic acid/vitamin D3/zinc oxide/elderberry)	Tier 3	
CULTURELLE KIDS GROW-THRIVE ORAL POWDER IN PACKET 3.5 BILLION CELL-1 GRAM (Lactobacillus rhamnosus/Bifidobac animalis/fucosyllactose/D3)	Tier 3	
CULTURELLE KIDS GUMMY ORAL TABLET,CHEWABLE 1.5 BILLION CELL-1 GRAM (Bacillus subtilis/inulin)	Tier 3	
CULTURELLE KIDS IMMUNE DEFENSE ORAL TABLET,CHEWABLE 5 BILLION CELL- 90 MG-1.88 MG (L. rhamnosus GG/ascorbic acid/zinc oxide/elderberry fruit)	Tier 3	
CULTURELLE KIDS PROBIO-FIBER ORAL POWDER IN PACKET 2.5 BILLION CELL-3.5 GRAM (Lactobacillus rhamnosus GG/fiber)	Tier 3	
CULTURELLE KIDS PROBIOT-FIBER ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM-15 MG (Bacillus coagulans/Bacillus subtilis/inulin/ascorbic acid)	Tier 3	
CULTURELLE KIDS PROBIOTICS ORAL POWDER IN PACKET 5 BILLION CELL (Lactobacillus rhamnosus GG)	Tier 3	
CULTURELLE KIDS PROBIOTICS ORAL TABLET,CHEWABLE 5 BILLION CELL (Lactobacillus rhamnosus GG)	Tier 3	
CULTURELLE MEN'S DAILY HEALTH ORAL CAPSULE 10 BILLION CELL -90 MG (L. rhamnosus/vit C/vit D3/vit B6/vit B12/magnesium ox/selen)	Tier 3	
CULTURELLE METABOLISM-WT MGMT ORAL CAPSULE 12 BILLION CELL -1.7 MG-2.4 MCG (Lactobacillus rhamnosus/Bifido animalis/vit B6/vit B12)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CULTURELLE ORAL CAPSULE, SPRINKLE 15 BILLION CELL (Lactobacillus rhamnosus GG)	Tier 3	
CULTURELLE PROBIOTIC-PREBIOTIC ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM-15 MG (Bacillus coagulans/Bacillus subtilis/inulin/ascorbic acid)	Tier 3	
CULTURELLE SLIMBIOTICS ORAL CAPSULE 12 BILLION CELL -1.7 MG-2.4 MCG (Lactobacillus fermentum/Lactobacillus rhamnosus/vit B6/B12)	Tier 3	
CULTURELLE WOMEN'S 4-IN-1 ORAL CAPSULE 15 BILLION CELL -15 MG (L.crispatus/L.gasseri/L.jensenii/L.rhamnosus/bacteriophages)	Tier 3	
CULTURELLE WOMEN'S WELLNESS ORAL TABLET,CHEWABLE 12 BILLION CELL (Lactobacillus crispatus/L. gasseri/L. jensenii/L. rhamnosus)	Tier 3	
DAILY PROBIOTIC (4 STRAINS) ORAL CAPSULE 11 BILLION CELL -15 MG (Lactobacillus paracasei,rhamnosus/B.animalis/ascorbic acid)	Tier 3	
DAILY PROBIOTIC (B.INFANTIS) ORAL CAPSULE 1 BILLION CELL (Lactobacillus acidophilus,rhamnosus/Bifido infantis,longum)	Tier 3	
DAILY PROBIOTIC (S. BOULARDII) ORAL CAPSULE 250 MG (Saccharomyces boulardii)	Tier 3	
DERMACINRX LACTEROL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROBINATE ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROBISOL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROBITRAN ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DERMACINRX PROBITROL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DERMACINRX PROMEROL ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
DIGEST ADV PROBIO PLUS GAS ORAL CAPSULE 2 BILLION CELL (Bacillus coagulans/digestive enzymes combination no.10)	Tier 3	
DIGEST PROBIOTIC (S.BOULARDII) ORAL CAPSULE 250 MG (Saccharomyces boulardii)	Tier 3	
DIGESTIVE ADVANTAGE IMMUNE ORAL TABLET,CHEWABLE 250 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE INTENS BOW ORAL CAPSULE 1 BILLION CELL- 30,000 UNIT (Bacillus coagulans/protease/amylase/lipase)	Tier 3	
DIGESTIVE ADVANTAGE KID PROBIO ORAL TABLET,CHEWABLE 250 MILLION CELL (Bacillus coagulans)	Tier 3	
DIGESTIVE ADVANTAGE LACTOS SUP ORAL CAPSULE 500 MILLION CELL-3,000 UNIT (Bacillus coagulans/lactase)	Tier 3	
DIGESTIVE ADVANTAGE PROBIOTIC ORAL CAPSULE 2 BILLION CELL- 140 MG (Bacillus coagulans/calcium carbonate)	Tier 3	
DIGESTIVE PROBIOTIC ORAL CAPSULE, SPRINKLE 2 BILLION CELL (Lactobacillus acidophilus,rhamnosus/Bifido infantis,longum)	Tier 3	
ENVIVE ORAL CAPSULE 12 BILLION CELL (Lactobacillus acidophilus,paracasei,Bifidobacterium animalis)	Tier 3	
ESTROVEN SLIMBIOTICS ORAL CAPSULE 12 BILLION CELL -1.7 MG-2.4 MCG (Lactobacillus fermentum/Lactobacillus rhamnosus/vit B6/B12)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FEM DOPHILUS ORAL CAPSULE 1 BILLION CELL (Lactobacillus reuteri/Lactobacillus rhamnosus GG)	Tier 3	
FLORAJEN WOMEN ORAL CAPSULE 15 BILLION CELL (Lactobacillus acidophilus/Lactobacillus rhamnosus GG)	Tier 3	
FLORAMAX ORAL TABLET 1 MILLION CELL (Lactobacillus acidophilus/Lactobacillus bulgaricus)	Tier 3	
FLORASAVE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10 BILLION CELL -15 MG (Lactobacillus no.65/Bifidobac no.7/B.subtilis/bacteriophages)	Tier 3	
FLORASTART ORAL CAPSULE 250 MG (Saccharomyces boulardii)	Tier 3	
FLORASTOR ADVANCED ORAL CAPSULE 250-62.5-30 MG (S.boulardii/enzymes/ginger/peppermint leaf/fennel)	Tier 3	
FLORASTOR DIGEST-METABOLIC ORAL TABLET,CHEWABLE 500MILLION CELL -1 GRAM-125 MCG (Bacillus coagulans/inulin/cyanocobalamin)	Tier 3	
FLORASTOR WOMAN'S PROBIOTIC ORAL CAPSULE 11 BILLION CELL -200 MG (L.acidophilus/L.paracasei/L.rhamnosus/theanine)	Tier 3	
FLORASTORBABY ORAL POWDER IN PACKET 250 MG (Saccharomyces boulardii)	Tier 3	
FLORASTORKIDS ORAL POWDER IN PACKET 250 MG (Saccharomyces boulardii)	Tier 3	
FLORASTORSELECT GUT BOOST ORAL CAPSULE 250-300 MG (Saccharomyces boulardii/inulin)	Tier 3	
FLORASTORSELECT IMMUNITY BOOST ORAL CAPSULE 250 MG-60 MG- 10 MCG-10 MG (Saccharomyces boulardii/vitamin C/vitamin D3/zinc gluconate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLORATUMMYS QUICK DISSOLVE ORAL TABLET, EFFERVESCENT 2 BILLION CELL (Lactobacillus reuteri/Bifidobacterium infantis/FOS)	Tier 3	
FORTIFY OPT ADV (L. SALIVARUS) ORAL CAPSULE,DELAYED RELEASE(DR/EC) 100 BILLION CELL-75 MG (Lactobacillus no.83/Bifido animal,bifid,infant/inulin/acacia)	Tier 3	
FORTIFY OPTIMA PROBIOTIC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 35 BILLION CELL -75 MG (Lactobac no.108/B.animal,bifid,infant/S.therm/inulin/acacia)	Tier 3	
FORTIFY OPTIMA PROBIOTIC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 50 BILLION CELL (Lactobacillus acidophilus/B.animalis/B.bifidum/B.infantis)	Tier 3	
FORTIFY OPTIMA WOMEN ADVANCED ORAL CAPSULE,DELAYED RELEASE(DR/EC) 90 BILLION CELL -75 MG (Lactobacillus no.102/Bifid anim,bifid/L.lactis/inulin/acacia)	Tier 3	
FORTIFY OPTIMA WOMEN PROBIOTIC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 50 BILLION CELL (L.acidophilus,gasseri/Bifidobact animalis,bifidum,infantis)	Tier 3	
FORTIFY PROBIOTIC 50 PLUS ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 BILLION CELL-50 MG, 50 BILLION CELL-50 MG (Lactobacillus combo no.21/Bifidobacterium combo no.7/inulin)	Tier 3	
FORTIFY PROBIOTIC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 BILLION CELL-50 MG, 50 BILLION CELL-50 MG (Lactobacillus combo no.51/Bifido animalis, bifidum/inulin)	Tier 3	
FORTIFY WOMEN PROBIO(L.SALIV.) ORAL CAPSULE,DELAYED RELEASE(DR/EC) 50 BILLION CELL-50 MG (Lactobacillus combo no.32/Bifidobacterium animalis/inulin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORTIFY WOMEN PROBIOTIC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 BILLION CELL-50 MG (Lactobacillus combo no.51/Bifidobacterium animalis/inulin)	Tier 3	
IDEAL BOWEL SUPPORT ORAL CAPSULE 10 BILLION CELL (Lactobacillus plantarum)	Tier 3	
JARRO-DOPHILUS ALLERGEN FREE ORAL CAPSULE 10 BILLION CELL (L.acidoph,paracasei,plantarum,rhamn/B.animalis,breve)	Tier 3	
JARRO-DOPHILUS BABY ORAL POWDER 3 BILLION CELL- 600 MG/GRAM (Lactobacillus casei/L. rhamnosus/Bifido no.4/GOS)	Tier 3	
JARRO-DOPHILUS EPS ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25 BILLION CELL, 5 BILLION CELL (Lactobac no.19/Bifidobac breve,longum/Lactoc lactis/P. acidi)	Tier 3	
JARRO-DOPHILUS PLUS FOS ORAL CAPSULE 3.4 BILLION CELL-210 MG (Lactobacillus no.33/Bifido animalis,longum/FOS/inulin)	Tier 3	
JARRO-DOPHILUS WOMEN ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10 BILLION CELL, 5 BILLION CELL (Lactobacillus crispatus/L. gasseri/L. jensenii/L. rhamnosus)	Tier 3	
<i>L. acidophilus-b. coagulans oral tablet 35 million- 25 million cell</i>	Tier 3	
LACTEOL DIARRHEASE KIDS ORAL POWDER IN PACKET 10 BILLION CELL (Lactobacillus fermentum/Lactobacillus lactis)	Tier 3	
LACTEOL DIARRHEASE ORAL CAPSULE 10 BILLION CELL (Lactobacillus fermentum/Lactobacillus lactis)	Tier 3	
<i>lactobacillus acidophilus oral capsule 500 million cell</i>	Tier 3	
<i>lactobacillus acidophilus oral tablet 0.5 mg (100 million cell)</i>	Tier 3	
<i>lactobacillus acidophilus oral tablet 1 billion cell</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>Lactobacillus acidophilus</i> - <i>L.bulgar</i> oral tablet 1 million cell	Tier 3	
LACTOVIVE ORAL CAPSULE 31 BILLION CELL (<i>Lactobacillus acidophilus</i> / <i>Bifidobacterium animalis</i>)	Tier 3	
MAGE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 15 BILLION CELL -15 MG (<i>L. acidophilus</i> , <i>rhamnosus</i> / <i>Bifidobacterium animalis</i> / <i>B. subtilis</i> /bacteriophages)	Tier 3	
MVW COMPLETE FORM PROBIOTIC MINI ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 BILLION CELL -15 MG (<i>Lactobacillus</i> / <i>Bifidobacterium</i> / <i>S.boulardii</i> / <i>B.subtilis</i> / <i>S.thermophilus</i> /bacteriophage)	Tier 3	
MVW COMPLETE FORMULA PROBIOTIC ORAL CAPSULE,DELAYED RELEASE(DR/EC) 20 BILLION CELL -7.5 MG (<i>Lactobacillus</i> / <i>Bifidobacterium</i> / <i>S.boulardii</i> / <i>B.subtilis</i> / <i>S.thermophilus</i> /bacteriophage)	Tier 3	
NEWFLORA ORAL CAPSULE 10 BILLION CELL (<i>Lactobacillus acidophilus</i>)	Tier 3	
NUGUT BOWEL SUPPORT PROBIOTIC ORAL CAPSULE 5 BILLION CELL (<i>Lactobacillus plantarum</i>)	Tier 3	
OMNI-BIOTIC AB-10 ORAL POWDER IN PACKET 5 BILLION CELL (<i>L.acidophilus</i> , <i>paracasei</i> , <i>plantarum</i> , <i>rhamnosus</i> , <i>salivarius</i> - <i>B.animalis</i> , <i>bifidus</i> , <i>longum</i> - <i>E.faecium</i>)	Tier 3	
OMNI-BIOTIC BALANCE ORAL POWDER IN PACKET 2 BILLION CELL (<i>L.acidophilus</i> , <i>casei</i> , <i>salivarius</i> / <i>B.animalis</i> / <i>Lactococcus lactis</i> / <i>E.faecium</i>)	Tier 3	
OMNI-BIOTIC HETOX ORAL POWDER IN PACKET 15 BILLION CELL (<i>L.acidophilus</i> , <i>brevvis</i> , <i>casei</i> , <i>salivarius</i> / <i>B.animalis</i> , <i>bifidus</i> / <i>Lactococcus lactis</i>)	Tier 3	
OMNI-BIOTIC PANDA ORAL POWDER IN PACKET 3 BILLION CELL (<i>Bifidobacterium animalis</i> , <i>bifidum</i> / <i>Lactococcus lactis</i>)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNI-BIOTIC STRESS RELEASE ORAL POWDER IN PACKET 7.5 BILLION CELL (L.acido,casei,para,plant,sali/B.anim,bif/Lactococcus lactis)	Tier 3	
ONE-A-DAY TRUBIOTICS ORAL CAPSULE 2 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
PREBIOMAX ORAL TABLET,CHEWABLE 1.4 GRAM (xylooligosaccharides)	Tier 3	
PRIMADOPHILUS BIFIDUS ORAL CAPSULE,DELAYED RELEASE(DR/EC) 5 BILLION CELL (Lactobacillus acidophilus,rhamnosus/Bifidobact.breve,longum)	Tier 3	
PRIMADOPHILUS ORIGINAL ORAL CAPSULE,DELAYED RELEASE(DR/EC) 5 BILLION CELL (Lactobacillus acidophilus/Lactobacillus rhamnosus GG)	Tier 3	
PRIMIDAR ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
PROBACAP ORAL CAPSULE 10 BILLION CELL (Lactobacillus acidophilus)	Tier 3	
PROBICHEW ORAL TABLET,CHEWABLE 21 BILLION CELL - 1 GRAM (Bacillus coagulans/inulin)	Tier 3	
PROBIO DEFENSE ORAL CAPSULE 2 BILLION CELL- 2 MG-12.5 MCG (L. helveticus,rhamnosus/B. longum/zinc yeast/selenium yeast)	Tier 3	
PROBIOFLEXX ORAL CAPSULE 500 MG (Lacto99/B.bifidum/L.lactis/S.boul/S.therm/B.coag/enzyme/herb)	Tier 3	
PROBIOMAX 350 DF ORAL POWDER IN PACKET 350 BILLION CELL (Lacto no.89/Bifido no.9/L.lactis/S.thermophilus)	Tier 3	
PROBIOMAX COMPLETE DF ORAL CAPSULE,DELAYED RELEASE(DR/EC) 45 BILLION CELL (Lacto no.89/Bifido no.9/L.lactis/S.thermophilus)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROBIOMAX DAILY DF ORAL CAPSULE,DELAYED RELEASE(DR/EC) 30 BILLION CELL (Lactobacillus acidophilus,plantarum/Bifido animalis,longum)	Tier 3	
PROBIOMAX DF ORAL CAPSULE,DELAYED RELEASE(DR/EC) 100 BILLION CELL (Lactobacillus acidophilus,plantarum/Bifido animalis,longum)	Tier 3	
PROBIOMAX IG 26 DF ORAL CAPSULE 500 MILLION CELL-500 MG (Bacillus coagulans/hyperimmune egg)	Tier 3	
PROBIOMAX LEAN DF ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10 BILLION CELL (Bifidobacterium animalis)	Tier 3	
PROBIOMAX PLUS DF ORAL POWDER IN PACKET 40 BILLION CELL -1.5 GRAM (L.acidophilus,plantarum/B.animalis,longum/S.boulardii/larch)	Tier 3	
PROBIOMAX SB DF ORAL CAPSULE,DELAYED RELEASE(DR/EC) 35 BILLION CELL (L.acidophilus/L.plantarum/B.animalis/B.longum/S.boulardii)	Tier 3	
PROBIOMAX SERENITY ORAL CAPSULE,DELAYED RELEASE(DR/EC) 17.5 BILLION CELL (Lactobacillus paracasei)	Tier 3	
PROBIONEXX ORAL CAPSULE 500 MG (Lacto99/B.bifidum/L.lactis/S.boul/S.therm/B.coag/enzyme/herb)	Tier 3	
PROBIOTIC (B. COAGULANS) ORAL TABLET,CHEWABLE 1 BILLION CELL, 2.5 BILLION CELL (Bacillus coagulans)	Tier 3	
PROBIOTIC (S.BOULARDII) ORAL CAPSULE 250 MG (Saccharomyces boulardii)	Tier 3	
PROBIOTIC (WITH VITAMIN D3) ORAL TABLET,CHEWABLE 2 BILLION CELL- 5 MCG (Bacillus coagulans/cholecalciferol (vit D3))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROBIOTIC ACIDOPHILUS (4 STRN) ORAL TABLET 1 BILLION CELL- 250 MG (Lactobac acidophilus/L.bulgaricus/B.bifidium/S.thermophilus)	Tier 3	
PROBIOTIC ACIDOPHILUS(14-STRN) ORAL TABLET,CHEWABLE 3 BILLION CELL (Lactobacillus no.66/Bifidobacterium no.4/S.thermophilus)	Tier 3	
PROBIOTIC COLON SUPPORT ORAL CAPSULE 1.5 BILLION CELL (Lactobacillus gasseri/Bifidobacterium bifidum/Bifido longum)	Tier 3	
PROBIOTIC DIGEST SUPP (4-STRN) ORAL CAPSULE 11 BILLION CELL -15 MG (Lactobacillus paracasei,rhamnosus/B.animalis/ascorbic acid)	Tier 3	
PROBIOTIC DIGEST SUPP (6-STRN) ORAL CAPSULE 10 BILLION CELL -100 MG (L.acidoph,bulgar,paracasei,rhamnosu/B.animalis,longum/in ulin)	Tier 3	
PROBIOTIC DIGEST(L.RHAM,INULN) ORAL CAPSULE 20 BILLION CELL -200 MG (Lactobacillus rhamnosus GG/inulin)	Tier 3	
PROBIOTIC DIGEST(LACTO,BIFIDO) ORAL CAPSULE 1.5 BILLION CELL (L.acidophilus/L.gasseri/L.rhamnosus/B.bifidum/B.longum)	Tier 3	
PROBIOTIC FORMULA (INULIN) ORAL CAPSULE 1 BILLION-250 CELL-MG (Bacillus coagulans/inulin)	Tier 3	
PROBIOTIC ORAL CAPSULE 20 BILLION CELL (Lactobacillus combination no.10)	Tier 3	
PROBIOTIC ORAL CAPSULE 3 BILLION CELL (Lactobacillus combination no.4)	Tier 3	
PROBIOTIC PEARLS ACIDOPHILUS ORAL CAPSULE,DELAYED RELEASE(DR/EC) 1 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium longum)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROBIOTIC PEARLS COMPLETE ORAL CAPSULE,DELAYED RELEASE(DR/EC) 1 BILLION CELL (Lactobacillus combination no.13)	Tier 3	
PROBIOTIC PEARLS WOMEN'S ORAL CAPSULE,DELAYED RELEASE(DR/EC) 1 BILLION CELL (Lactobac acidophilus/Lactobac plantarum/Lactobac rhamnosus)	Tier 3	
PROBIOTIC-10 ORAL CAPSULE 20 BILLION CELL (L.acid,brev,bulg,casei,parac,plant,saliv/Bifidobac animalis)	Tier 3	
PROBIOTIC-IMMUNE ORAL TABLET,CHEWABLE 1 BILLION CELL- 45 MG-25 MCG (Bacillus coagulans,subtilis/vitamin C/vit D3/zinc gluconate)	Tier 3	
PROBIZEN ORAL CAPSULE 32 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
PROMELLA ORAL CAPSULE 32 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
REJUVAFLOR ORAL CAPSULE 10 BILLION CELL (Lactobacillus acidophilus)	Tier 3	
RELIBIOTIC ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
REPHRESH PRO-B ORAL CAPSULE 5 BILLION CELL (Lactobacillus reuteri/Lactobacillus rhamnosus GG)	Tier 3	
RESISTANCE FORMULA PROBIOTIC ORAL CAPSULE 10 BILLION CELL (Saccharomyces boulardii)	Tier 3	
REVITAFLO ORAL CAPSULE 10 BILLION CELL (Lactobacillus acidophilus)	Tier 3	
<i>saccharomyces boulardii oral capsule 250 mg</i>	Tier 3	
<i>saccharomyces boulardii-yeast oral capsule,delayed release(dr/ec) 5 billion cell- 200 mg</i>	Tier 3	
SENIOR PROBIOTIC ORAL CAPSULE 15 BILLION CELL (Lactobacillus combination no.4)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMILAC PROBIOTIC TRI-BLEND ORAL POWDER IN PACKET 1 BILLION CELL (Bifidobacterium animalis/Bifidobacterium infantis/S.thermoph)	Tier 3	
SUPERIOR PROBIOTIC ORAL CAPSULE 15 BILLION CELL (Lactobac.acidoph,plantar,rhamn/Bifidobac.animal,breve,lon gum)	Tier 3	
SUREBIOTIC ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
TRUBIOTICS BABY ORAL DROPS 3 BILLION CELL /0.27 ML (Bifidobacterium animalis)	Tier 3	
TRUBIOTICS GUMMY ORAL TABLET,CHEWABLE 1.5BILLION CELL -7.5 MCG-1.8 G (Bacillus subtilis/cholecalciferol (vit D3)/inulin)	Tier 3	
TRUBIOTICS KIDS CHEWABLE ORAL TABLET,CHEWABLE 6 BILLION CELL (Lactobacillus rhamnosus GG/Bifidobacterium animalis (lactis))	Tier 3	
TRUBIOTICS KIDS GUMMY ORAL TABLET,CHEWABLE 1.5 BILLION CELL-1.8 GRAM (Bacillus subtilis/inulin/ascorbic acid)	Tier 3	
TRUBIOTICS ORAL CAPSULE 2 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
UP4 PROBIOTICS KIDS CUBES ORAL TABLET,CHEWABLE 1 BILLION CELL- 20 MCG (Lactobacillus acidophilus/Bifidobacterium animalis/vit D2)	Tier 3	
UP4 PROBIOTICS MEN'S ORAL CAPSULE 50 BILLION CELL -90 MG-30 MCG (Lactobac no.21/Bifidobac no.7/vit C/vit D3/vit B6/vit B12)	Tier 3	
UP4 PROBIOTICS PLUS PREBIOTIC ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM-15 MG (Bacillus coagulans/Bacillus subtilis/inulin/ascorbic acid)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UP4 PROBIOTICS ULTRA ORAL CAPSULE 50 BILLION CELL (Lactobacillus combination no.51/Bifidobacterium combo no.4)	Tier 3	
UP4 PROBIOTICS WOMEN'S ORAL CAPSULE 5 BILLION CELL- 250 MG (L.acidophilus/L.gasseri/L.plant/L.rham/B.animalis/cranberry)	Tier 3	
UP4 PROBIOTICS-PREBIOTICS KIDS ORAL TABLET,CHEWABLE 1 BILLION CELL- 1 GRAM-15 MG (Bacillus coagulans/Bacillus subtilis/inulin/ascorbic acid)	Tier 3	
WELLPRO-31 ORAL CAPSULE 31 BILLION CELL (Lactobacillus acidophilus/Bifidobacterium animalis)	Tier 3	
XYBIOTIC ORAL CAPSULE 15 BILLION CELL -1,000 MCG-25MG (L. acidophilus/Bacillus coagulans/folic acid/inulin)	Tier 3	
YUM-YUM DOPHILUS ORAL TABLET,CHEWABLE 2.5 BILLION CELL-50 MG, 500 MILLION CELL-50 MG (L.acidophilus,plantarum/B.animalis,breve/FOS/inulin)	Tier 3	
Irritable Bowel Syndrome (Ibs) Agents - Drugs For Irritable Bowel Syndrome		
<i>alosetron oral tablet 0.5 mg, 1 mg</i>	Tier 1	
AMITIZA ORAL CAPSULE 24 MCG (lubiprostone)	Tier 3	QL (2 EA per 1 day)
AMITIZA ORAL CAPSULE 8 MCG (lubiprostone)	Tier 3	QL (4 EA per 1 day)
LOTRONEX ORAL TABLET 0.5 MG, 1 MG (alosetron HCl)	Tier 3	
<i>lubiprostone oral capsule 24 mcg</i>	Tier 1	QL (2 EA per 1 day)
<i>lubiprostone oral capsule 8 mcg</i>	Tier 1	QL (4 EA per 1 day)
VIBERZI ORAL TABLET 100 MG, 75 MG (eluxadoline)	Tier 2	QL (2 EA per 1 day)
Laxative - Bulk Forming - Drugs To Prevent Constipation		
BENEFIBER (INULIN-CORN FIBER) ORAL TABLET,CHEWABLE 2 GRAM (soluble corn fiber/inulin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BENEFIBER (WHEAT DEXTRIN) ORAL TABLET 1 GRAM (wheat dextrin)	Tier 3	
BENEFIBER CLEAR SF (DEXTRIN) ORAL POWDER IN PACKET 3 GRAM/3.5 GRAM (wheat dextrin)	Tier 3	
BENEFIBER SUGAR FREE (DEXTRIN) ORAL POWDER 3 GRAM/4 GRAM (wheat dextrin)	Tier 3	
BENEFIBER SUGAR FREE (DEXTRIN) ORAL POWDER IN PACKET 3 GRAM/4 GRAM (wheat dextrin)	Tier 3	
BENEFIBER SUGAR FREE (DEXTRIN) ORAL TABLET,CHEWABLE 1 GRAM (wheat dextrin)	Tier 3	
BENEFIBER SUGAR FREE (INULIN) ORAL POWDER IN PACKET 3 GRAM (inulin)	Tier 3	
BEST FIBER ORAL POWDER 3 GRAM/3.5 GRAM, 3 GRAM/4 GRAM (wheat dextrin)	Tier 3	
CHILDRENS FIBER GUMMY BEAR ORAL TABLET,CHEWABLE 1.5 GRAM (polydextrose)	Tier 3	
CLEAR FIBER ORAL POWDER 3 GRAM/4 GRAM (dextrin)	Tier 3	
DAILY FIBER (PSYLLIUM-ASPART) ORAL POWDER IN PACKET 3 GRAM, 3.4 GRAM (psyllium husk)	Tier 3	
DAILY FIBER (PSYLLIUM-SUCROSE) ORAL POWDER 3 GRAM/7 GRAM (psyllium husk (with sugar))	Tier 3	
DAILY FIBER ORAL CAPSULE 0.4 GRAM (psyllium husk)	Tier 3	
EASY FIBER (WHEAT DEXTRIN) ORAL TABLET,CHEWABLE 1 GRAM-100 MG CALCIUM (wheat dextrin/calcium carbonate)	Tier 3	
EASY FIBER ORAL POWDER 3 GRAM/3.8 GRAM (dextrin)	Tier 3	
FIBER (DEXTRIN) ORAL POWDER IN PACKET 3 GRAM/4 GRAM (dextrin)	Tier 3	
FIBER (PSYLLIUM HUSK-SUGAR) ORAL POWDER 3 GRAM/11 GRAM (psyllium husk (with sugar))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIBER (WITH ASPARTAME) ORAL POWDER 3 GRAM/5.8 GRAM (psyllium husk)	Tier 3	
FIBER GUMMIES (WITH B-COMPLEX) ORAL TABLET,CHEWABLE 2.5 GRAM (polydextrose/vitamin B complex)	Tier 3	
FIBER GUMMIES ORAL TABLET,CHEWABLE 1.7 GRAM (inulin)	Tier 3	
FIBER SUPPLEMENT(WHEATDEXTRIN) ORAL POWDER 3 GRAM/3.8 GRAM (wheat dextrin)	Tier 3	
FIBER THERAPY (PSYLLIUM-SUCRO) ORAL POWDER 3 GRAM/12 GRAM, 3 GRAM/7 GRAM (psyllium husk (with sugar))	Tier 3	
FIBERWELL ORAL TABLET,CHEWABLE 2.5 GRAM (polydextrose)	Tier 3	
GERI-MUCIL (ASPARTAME) ORAL POWDER 3 GRAM/5.8 GRAM (psyllium husk)	Tier 3	
GERI-MUCIL (SUGAR) ORAL POWDER 3 GRAM/12 GRAM (psyllium husk (with sugar))	Tier 3	
KONSYL SUGAR-FREE ORAL POWDER IN PACKET 6 GRAM (psyllium husk)	Tier 3	
METAMUCIL (INULIN-CORN FIBER) ORAL TABLET,CHEWABLE 1.7 GRAM (soluble corn fiber/inulin)	Tier 3	
NUTRISOURCE FIBER ORAL PACKET (guar gum)	Tier 3	
NUTRISOURCE FIBER ORAL POWDER (guar gum)	Tier 3	
PREBIOTIC FIBER (FOS) ORAL TABLET,CHEWABLE 2.5 GRAM (fructooligosaccharides)	Tier 3	
PREBIOTIC FIBER DIGESTIVE ORAL TABLET,CHEWABLE 1.7 GRAM (inulin)	Tier 3	
PREBIOTIC FIBER ORAL TABLET,CHEWABLE 2 GRAM (inulin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREBIOTIC INULIN-FOS ORAL POWDER 3 GRAM/3.8GRAM (SCOOP) (fructooligosaccharides/inulin)	Tier 3	
<i>psyllium husk (with sugar) oral powder 3 gram/7 gram</i>	Tier 3	
<i>psyllium husk oral capsule 0.4 gram</i>	Tier 3	
REGULOID (ASPARTAME) ORAL POWDER 3 GRAM/5.8 GRAM (psyllium husk)	Tier 3	
REGULOID (PSYLLIUM HUSK) ORAL CAPSULE 0.4 GRAM (psyllium husk)	Tier 3	
REGULOID (PSYLLIUM HUSK) ORAL POWDER 3 GRAM/5.4 GRAM, 3 GRAM/5.8 GRAM (psyllium husk)	Tier 3	
REGULOID (PSYLLIUM HUSK-SUCRO) ORAL POWDER 3 GRAM/12 GRAM, 3 GRAM/7 GRAM (psyllium husk (with sugar))	Tier 3	
SMOOTH TEXTURE FIBER ORAL POWDER 3 GRAM/5.8 GRAM (psyllium husk)	Tier 3	
Laxative - Saline And Osmotic - Drugs To Prevent Constipation		
lactulose (Constulose Oral Solution 10 Gram/15 MI)	Tier 1	
lactulose (Kristalose Oral Packet 20 Gram)	Tier 3	ST: Requires prior prescription for generic Lactulose solution within the past 120 days; QL (2 EA per 1 day)
<i>lactulose oral packet 10 gram</i>	Tier 3	ST: Requires prior prescription for generic Lactulose solution within the past 120 days; QL (3 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lactulose oral packet 20 gram</i>	Tier 3	ST: Requires prior prescription for generic Lactulose solution within the past 120 days; QL (2 EA per 1 day)
<i>lactulose oral solution 10 gram/15 ml</i>	Tier 1	
<i>sorbitol solution 70 %</i>	Tier 3	
Laxative - Saline/Osmotic Mixtures - Drugs To Prevent Constipation		
GAVILYTE-C ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM (peg 3350/sod sulf/sod bicarb/sod chloride/potassium chloride)	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 4000, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (4000 ML per 1 FILL)
peg 3350/sod sulf/sod bicarb/sod chloride/potassium chloride (Gavilyte-G Oral Recon Soln 236-22.74-6.74 -5.86 Gram)	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 4000, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (4000 ML per 1 FILL)
sodium chloride/sodium bicarbonate/potassium chloride/peg (Gavilyte-N Oral Recon Soln 420 Gram)	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 4000, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (4000 ML per 1 FILL)
GOLYTELY ORAL RECON SOLN 236-22.74-6.74 -5.86 GRAM (peg 3350/sod sulf/sod bicarb/sod chloride/potassium chloride)	Tier 3	QL (4000 ML per 1 FILL)
MOVIPREP ORAL POWDER IN PACKET 100-7.5-2.691 GRAM (peg 3350/sodium sulfate/sod chloride/KCl/ascorbate sod/vit C)	Tier 3	QL (1 EA per 1 FILL)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 4000, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (4000 ML per 1 FILL)
<i>peg3350-sod sul-nacl-kcl-asb-c oral powder in packet 100-7.5-2.691 gram</i>	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 1, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (1 EA per 1 FILL)
<i>peg-electrolyte soln oral recon soln 420 gram</i>	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 4000, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (4000 ML per 1 FILL)
PLENVU ORAL POWDER IN PACKET, SEQUENTIAL 140-9-5.2 GRAM (peg 3350/sodium sulfate/sod chloride/KCl/ascorbate sod/vit C)	Tier 3	ST: Requires prior prescription for Clenpiq, generic bowel prep, or Sutab within the past 120 days; \$0 COPAY IF QUANTITY LIMITED TO 3, FILL OF 2 IN 365 DAYS, TRIAL OF CLENPIQ, SUTAB, OR A GENERIC BOWEL PREP PRODUCT, AND 45-75 YEARS OF AGE; QL (3 EA per 1 FILL)
<i>sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram</i>	Tier 1	\$0 COPAY IF QUANTITY LIMITED TO 354, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (354 ML per 1 FILL)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUFLAVE ORAL RECON SOLN 178.7-7.3-0.5 GRAM (peg 3350/sodium sulfate,chloride/potassium chlor/magnesium)	Tier 2	ST: Requires prior prescription for Clenpiq, generic bowel prep, or Sutab within the past 120 days; \$0 COPAY IF QUANTITY LIMITED TO 2, FILL OF 2 IN 365 DAYS, TRIAL OF CLENPIQ, SUTAB, OR A GENERIC BOWEL PREP PRODUCT, AND 45-75 YEARS OF AGE; QL (2 EA per 1 FILL)
SUPREP BOWEL PREP KIT ORAL RECON SOLN 17.5-3.13-1.6 GRAM (sodium sulfate/potassium sulfate/magnesium sulfate)	Tier 3	QL (354 ML per 1 FILL)
SUTAB ORAL TABLET 1.479-0.188- 0.225 GRAM (sodium sulfate/potassium chloride/magnesium sulfate)	Tier 2	\$0 COPAY IF QUANTITY LIMITED TO 24, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (24 EA per 1 FILL)
Laxative - Stimulant - Drugs To Prevent Constipation		
<i>cascara sagrada oral tablet 450 mg</i>	Tier 3	
<i>senna leaf oral capsule 450 mg</i>	Tier 3	
SENOKOT KIDS ORAL TABLET,CHEWABLE 8.7 MG (senna leaf extract)	Tier 3	
SENOKOT ORAL TABLET,CHEWABLE 8.7 MG (senna leaf extract)	Tier 3	
SENOKOT-CHAMOMILE ORAL TEA 1,400 MG- 1,100 MG (senna leaf/herbal complex no.324)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Laxative - Stimulant And Saline/Osmotic Combinations - Drugs To Prevent Constipation		
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM- 12 GRAM/175 ML (sodium picosulfate/magnesium oxide/citric acid)	Tier 2	\$0 COPAY IF QUANTITY LIMITED TO 350, FILL OF 2 IN 365 DAYS, AND 45-75 YEARS OF AGE; QL (350 ML per 1 FILL)
Peptic Ulcer - Gastric Lumen Adherent Cytoprotectives - Drugs For Ulcers And Stomach Acid		
CARAFATE ORAL SUSPENSION 100 MG/ML (sucralfate)	Tier 3	
CARAFATE ORAL TABLET 1 GRAM (sucralfate)	Tier 3	
<i>sucralfate oral suspension 100 mg/ml</i>	Tier 1	
<i>sucralfate oral tablet 1 gram</i>	Tier 1	
Short Bowel Syndrome (Sbs) - Glucagon-Like Peptide-2 (Glp-2) Analog - Drugs For The Stomach		
GATTEX 30-VIAL SUBCUTANEOUS KIT 5 MG (teduglutide)	Tier 3	PA; KP
GATTEX ONE-VIAL SUBCUTANEOUS KIT 5 MG (teduglutide)	Tier 3	PA; KP
Short Bowel Syndrome (Sbs) Agents - Drugs For The Stomach		
<i>glutamine oral powder 100 %</i>	Tier 3	
<i>octreotide acetate injection solution 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	Tier 3	KP
<i>octreotide acetate injection syringe 100 mcg/ml (1 ml), 50 mcg/ml (1 ml), 500 mcg/ml (1 ml)</i>	Tier 3	KP
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML (octreotide acetate)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Genitourinary Therapy - Drugs For The Urinary System		
Bph Agent- 5-Alpha Reductase Inhib And Alpha-1 Adrenoceptor Antag Comb - Drugs For The Prostate		
<i>dutasteride-tamsulosin oral capsule, er multiphase 24 hr 0.5-0.4 mg</i>	Tier 1	ST: Requires prior prescription for Alfuzosin, Doxazosin, Finasteride 5mg, Prazosin, Silodosin, Tamsulosin, or Terazosin within the past 120 days
JALYN ORAL CAPSULE, ER MULTIPHASE 24 HR 0.5-0.4 MG (dutasteride/tamsulosin HCl)	Tier 3	ST: Requires prior prescription for Alfuzosin, Doxazosin, Finasteride 5mg, Prazosin, Silodosin, Tamsulosin, or Terazosin within the past 120 days
Bph Agent- 5-Alpha-Reductase And Phosphodiesterase-5 (Pde5) Inhibitors - Drugs For The Prostate		
ENTADFI ORAL CAPSULE 5-5 MG (finasteride/tadalafil)	Tier 3	
Cystinosis Therapy (Cystine Depleting Agents) - Drugs For The Urinary System		
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (cysteamine bitartrate)	Tier 3	
PROCYSBI ORAL CAPSULE, DELAYED REL SPRINKLE 25 MG, 75 MG (cysteamine bitartrate)	Tier 3	PA
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET 300 MG, 75 MG (cysteamine bitartrate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
G.U. Irrigants - Anti-Infective - Drugs For The Urinary System		
<i>neomycin-polymyxin b gu irrigation solution 40 mg-200,000 unit/ml</i>	Tier 1	
G.U. Irrigants - Drugs For The Urinary System		
<i>acetic acid irrigation solution 0.25 %</i>	Tier 1	
GLYCINE UROLOGIC IRRIGATION SOLUTION 1.5 % (glycine urologic solution)	Tier 3	
<i>glycine urologic solution irrigation solution 1.5 %</i>	Tier 1	
RENACIDIN IRRIGATION SOLUTION 1980.6 MG-59.4 MG-980.4MG/30ML (citric acid/gluconolactone/magnesium carbonate)	Tier 3	
<i>sorbitol irrigation solution 3 %</i>	Tier 1	
<i>sorbitol-mannitol transurethral solution 2.7-0.54 gram/100 ml</i>	Tier 1	
Interstitial Cystitis Agents - Drugs For The Urinary System		
ELMIRON ORAL CAPSULE 100 MG (pentosan polysulfate sodium)	Tier 2	
Kidney Stone Agents - Drugs For The Urinary System		
THIOLA EC ORAL TABLET,DELAYED RELEASE (DR/EC) 100 MG, 300 MG (tiopronin)	Tier 3	
THIOLA ORAL TABLET 100 MG (tiopronin)	Tier 3	
<i>tiopronin oral tablet 100 mg</i>	Tier 3	
<i>tiopronin oral tablet, delayed release (dr/ec) 100 mg, 300 mg</i>	Tier 3	
tiopronin (Venxxiva Oral Tablet, Delayed Release (Dr/Ec) 100 Mg, 300 Mg)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist - Drugs For The Bladder		
GEMTESA ORAL TABLET 75 MG (vibegron)	Tier 3	ST: Requires prior prescriptions for Myrbetriq and Oxybutynin IR/XR within the past 365 days; QL (1 EA per 1 day)
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON 8 MG/ML (mirabegron)	Tier 2	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR 25 MG, 50 MG (mirabegron)	Tier 1	QL (1 EA per 1 day)
Oxalosis Agent - Oxalate Inhibitor, Small Interfering Rna Directed - Drugs For The Urinary System		
RIVFLOZA SUBCUTANEOUS SOLUTION 80 MG/0.5 ML (160 MG/ML) (nedosiran sodium)	Tier 3	KP
RIVFLOZA SUBCUTANEOUS SYRINGE 128 MG/0.8 ML, 160 MG/ML (nedosiran sodium)	Tier 3	KP
Phosphate Binders - Calcium-Based - Drugs For The Urinary System		
calcium acetate(phosphat bind) oral capsule 667 mg	Tier 1	
calcium acetate(phosphat bind) oral tablet 667 mg	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Phosphate Binders - Drugs For The Urinary System		
AURYXIA ORAL TABLET 210 MG IRON (ferric citrate)	Tier 3	ST: Requires prior prescriptions for Velphoro and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (12 EA per 1 day)
<i>calcium acetate(phosphat bind) oral capsule 667 mg</i>	Tier 1	
<i>calcium acetate(phosphat bind) oral tablet 667 mg</i>	Tier 1	
<i>ferric citrate oral tablet 210 mg iron</i>	Tier 1	ST: Requires prior prescriptions for Velphoro and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (12 EA per 1 day)
FOSRENOL ORAL POWDER IN PACKET 1,000 MG, 750 MG (lanthanum carbonate)	Tier 3	ST: Requires prior prescriptions for Velphoro and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (3 EA per 1 day)
FOSRENOL ORAL TABLET,CHEWABLE 1,000 MG, 500 MG, 750 MG (lanthanum carbonate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lanthanum oral tablet, chewable 1,000 mg, 500 mg, 750 mg</i>	Tier 1	
RENVELA ORAL POWDER IN PACKET 0.8 GRAM, 2.4 GRAM (sevelamer carbonate)	Tier 3	
RENVELA ORAL TABLET 800 MG (sevelamer carbonate)	Tier 3	
<i>sevelamer carbonate oral powder in packet 0.8 gram, 2.4 gram</i>	Tier 1	
<i>sevelamer carbonate oral tablet 800 mg</i>	Tier 1	
<i>sevelamer hcl oral tablet 400 mg, 800 mg</i>	Tier 1	
VELPHORO ORAL TABLET, CHEWABLE 500 MG (sucroferric oxyhydroxide)	Tier 2	QL (6 EA per 1 day)
Phosphate Binders - Iron-Based - Drugs For The Urinary System		
AURYXIA ORAL TABLET 210 MG IRON (ferric citrate)	Tier 3	ST: Requires prior prescriptions for Velporo and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (12 EA per 1 day)
<i>ferric citrate oral tablet 210 mg iron</i>	Tier 1	ST: Requires prior prescriptions for Velporo and one of the following: generic Sevelamer HCL, Sevelamer Carbonate, Calcium Acetate, or Lanthanum Carbonate within the past 365 days; QL (12 EA per 1 day)
VELPHORO ORAL TABLET, CHEWABLE 500 MG (sucroferric oxyhydroxide)	Tier 2	QL (6 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Polycystic Kidney Disease - Vasopressin V2 Receptor Antagonists - Drugs For The Urinary System		
JYNARQUE ORAL TABLET 15 MG, 30 MG (tolvaptan)	Tier 3	PA
JYNARQUE ORAL TABLETS, SEQUENTIAL 15 MG (AM)/ 15 MG (PM), 30 MG (AM)/ 15 MG (PM), 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM) (tolvaptan)	Tier 3	PA
<i>tolvaptan (polycys kidney dis) oral tablet 15 mg</i>	Tier 3	QL (30 EA per 365 days)
<i>tolvaptan (polycys kidney dis) oral tablet 30 mg</i>	Tier 3	QL (60 EA per 365 days)
<i>tolvaptan (polycys kidney dis) oral tablets, sequential 15 mg (am)/ 15 mg (pm), 30 mg (am)/ 15 mg (pm), 45 mg (am)/ 15 mg (pm), 60 mg (am)/ 30 mg (pm), 90 mg (am)/ 30 mg (pm)</i>	Tier 3	PA
Prostatic Hypertrophy Agent - Alpha-1-Adrenoceptor Antagonists - Drugs For The Prostate		
<i>alfuzosin oral tablet extended release 24 hr 10 mg</i>	Tier 1	
FLOMAX ORAL CAPSULE 0.4 MG (tamsulosin HCl)	Tier 3	
RAPAFLO ORAL CAPSULE 4 MG, 8 MG (silodosin)	Tier 3	
<i>silodosin oral capsule 4 mg, 8 mg</i>	Tier 1	
<i>tamsulosin oral capsule 0.4 mg</i>	Tier 1	
UROXATRAL ORAL TABLET EXTENDED RELEASE 24 HR 10 MG (alfuzosin HCl)	Tier 3	
Prostatic Hypertrophy Agent - Type II 5-Alpha Reductase Inhibitors - Drugs For The Prostate		
<i>finasteride oral tablet 5 mg</i>	Tier 1	
PROSCAR ORAL TABLET 5 MG (finasteride)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Prostatic Hypertrophy Agent-Sel.Cgmp Phosphodiesterase Type5 Inhibitor - Drugs For The Prostate		
CIALIS ORAL TABLET 5 MG (tadalafil)	Tier 3	PA; QL (1 EA per 1 day)
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	Tier 1	PA; QL (1 EA per 1 day)
Prostatic Hypertrophy Agent-Type I And li 5- Alpha Reductase Inhibitors - Drugs For The Prostate		
AVODART ORAL CAPSULE 0.5 MG (dutasteride)	Tier 3	
<i>dutasteride oral capsule 0.5 mg</i>	Tier 1	
Urinary Acidifier - Bacterial Urease Inhibitor - Drugs For Infections		
LITHOSTAT ORAL TABLET 250 MG (acetohydroxamic acid)	Tier 3	
Urinary Acidifier - Phosphates - Drugs For Infections		
K-PHOS NO 2 ORAL TABLET 305-700 MG (sodium phosphate,monobasic/potassium phosphate,monobasic)	Tier 3	
K-PHOS ORIGINAL ORAL TABLET,SOLUBLE 500 MG (potassium phosphate,monobasic)	Tier 3	
WES-PHOS 250 NEUTRAL ORAL TABLET 250 MG (sodium phosphate,dibasic/pot phos,monob/sod phosphate mono)	Tier 3	
Urinary Alkalinizer - Citrates - Drugs For Infections		
CITRATABS ORAL TABLET EXTENDED RELEASE 7.5 MEQ (magnesium citrate/potassium citrate)	Tier 3	
LITHOLYTE ORAL POWDER IN PACKET 15 MEQ (magnesium citrate/potassium citrate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORACIT ORAL SOLUTION 490-640 MG/5 ML (citric acid/sodium citrate)	Tier 3	
<i>potassium citrate oral tablet extended release 10 meq (1,080 mg), 15 meq, 5 meq (540 mg)</i>	Tier 1	
<i>potassium citrate-citric acid oral solution 1,100-334 mg/5 ml</i>	Tier 3	
<i>sodium citrate-citric acid oral solution 490-640 mg/5 ml</i>	Tier 1	
<i>sodium citrate-citric acid oral solution 500-334 mg/5 ml</i>	Tier 3	
TRICITRATES ORAL SOLUTION 550-500-334 MG/5 ML (sodium/potassium/potassium citrate/sodium citrate/cit ac)	Tier 3	
UROCIT-K 10 ORAL TABLET EXTENDED RELEASE 10 MEQ (1,080 MG) (potassium citrate)	Tier 3	
UROCIT-K 15 ORAL TABLET EXTENDED RELEASE 15 MEQ (potassium citrate)	Tier 3	
Urinary Analgesics - Drugs For Infections		
<i>phenazopyridine oral tablet 100 mg, 200 mg</i>	Tier 1	
PYRIDIUM ORAL TABLET 100 MG, 200 MG (phenazopyridine HCl)	Tier 3	
Urinary Antibacterial - Methenamine And Salts - Drugs For Infections		
<i>methenamine hippurate oral tablet 1 gram</i>	Tier 1	
<i>methenamine mandelate oral tablet 0.5 gram, 1 gram</i>	Tier 1	
UROQID-ACID NO.2 ORAL TABLET 500-500 MG (methenamine mandelate/sodium phosphate,monobasic)	Tier 3	
Urinary Antibacterial - Nitrofurantoin Derivatives - Drugs For Infections		
FURADANTIN ORAL SUSPENSION 25 MG/5 ML (nitrofurantoin)	Tier 3	PA
MACROBID ORAL CAPSULE 100 MG (nitrofurantoin monohydrate/macrocystals)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>nitrofurantoin macrocrystal oral capsule 25 mg</i>	Tier 1	QL (4 EA per 1 day)
<i>nitrofurantoin monohyd/m-cryst oral capsule 100 mg</i>	Tier 1	
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	Tier 1	PA
<i>nitrofurantoin oral suspension 50 mg/5 ml</i>	Tier 3	
Urinary Antibacterials Other - Drugs For Infections		
<i>fosfomycin tromethamine oral packet 3 gram</i>	Tier 1	
MONUROL ORAL PACKET 3 GRAM (fosfomycin tromethamine)	Tier 3	
Urinary Anti-Infective Methenamine-Antispas-Analg Combinations - Drugs For Infections		
URELLE ORAL TABLET 81-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URETRON D-S ORAL TABLET 81.6-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 2	
URIBEL TABS ORAL TABLET 81.6-0.12-10.8 MG (methenamine/methylene blue/benzoic acid/salicylat/hyoscyamin)	Tier 3	
URIMAR-T ORAL CAPSULE 120-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URIMAR-T ORAL TABLET 120-10.8-0.12 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
URNEVA ORAL CAPSULE 120-10.8-40.8 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
URO-MP ORAL CAPSULE 118-10-40.8-36 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 1	
URO-SP ORAL CAPSULE 118-10-40.8-36 MG (methenamine/methylene blue/sod phos/p.salicylate/hyoscyamine)	Tier 3	
Urinary Anti-Infective Methenamine-Antispasmodic Combinations - Drugs For Infections		
<i>methen-sod phos-meth blue-hyos oral tablet 81.6-40.8-0.12 mg</i>	Tier 1	
UROGESIC-BLUE ORAL TABLET 81.6-40.8-0.12 MG (methenamine/sod phosph,monobasic/methylene blue/hyoscyamine)	Tier 1	
URYL ORAL TABLET 81.6-40.8-0.12 MG (methenamine/sod phosph,monobasic/methylene blue/hyoscyamine)	Tier 3	
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder) - Drugs For The Bladder		
<i>darifenacin oral tablet extended release 24 hr 15 mg, 7.5 mg</i>	Tier 1	
<i>solifenacin oral tablet 10 mg, 5 mg</i>	Tier 1	
VESICARE LS ORAL SUSPENSION 1 MG/ML (solifenacin succinate)	Tier 3	
VESICARE ORAL TABLET 10 MG, 5 MG (solifenacin succinate)	Tier 3	
Urinary Antispasmodic - Anticholinergics, Non-Selective - Drugs For The Bladder		
ANASPAZ ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ED-SPAZ ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 1	
<i>hyoscyamine sulfate oral drops 0.125 mg/ml</i>	Tier 1	
<i>hyoscyamine sulfate oral elixir 0.125 mg/5 ml</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet 0.125 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet extended release 12 hr 0.375 mg</i>	Tier 1	
<i>hyoscyamine sulfate oral tablet,disintegrating 0.125 mg</i>	Tier 1	
<i>hyoscyamine sulfate sublingual tablet 0.125 mg</i>	Tier 1	
HYOSYNE ORAL DROPS 0.125 MG/ML (hyoscyamine sulfate)	Tier 1	
HYOSYNE ORAL ELIXIR 0.125 MG/5 ML (hyoscyamine sulfate)	Tier 1	
LEVBID ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG (hyoscyamine sulfate)	Tier 3	
LEVSIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 3	
LEVSIN/SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 3	
NULEV ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 3	
OSCIMIN ORAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
OSCIMIN SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 1	
SYMAX DUOTAB ORAL TABLET,EXT RELEASE MULTIPHASE 0.125 MG-0.25 MG (0.375 MG) (hyoscyamine sulfate)	Tier 3	
SYMAX FASTABS ORAL TABLET,DISINTEGRATING 0.125 MG (hyoscyamine sulfate)	Tier 3	
SYMAX-SL SUBLINGUAL TABLET 0.125 MG (hyoscyamine sulfate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYMAX-SR ORAL TABLET EXTENDED RELEASE 12 HR 0.375 MG (hyoscyamine sulfate)	Tier 3	
Urinary Antispasmodic - Smooth Muscle Relaxants - Drugs For The Bladder		
<i>fesoterodine oral tablet extended release 24 hr 4 mg, 8 mg</i>	Tier 1	QL (1 EA per 1 day)
<i>flavoxate oral tablet 100 mg</i>	Tier 1	
<i>oxybutynin chloride oral syrup 5 mg/5 ml</i>	Tier 1	
<i>oxybutynin chloride oral tablet 2.5 mg</i>	Tier 1	
<i>oxybutynin chloride oral tablet 5 mg</i>	Tier 1	
<i>oxybutynin chloride oral tablet extended release 24hr 10 mg, 15 mg, 5 mg</i>	Tier 1	
OXYTROL TRANSDERMAL PATCH SEMIWEEKLY 3.9 MG/24 HR (oxybutynin)	Tier 3	ST: Requires prior prescriptions for Myrbetriq and Oxybutynin IR/XR within the past 365 days
<i>tolterodine oral capsule, extended release 24hr 2 mg, 4 mg</i>	Tier 1	
<i>tolterodine oral tablet 1 mg, 2 mg</i>	Tier 1	
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG (fesoterodine fumarate)	Tier 3	QL (1 EA per 1 day)
<i>trospium oral capsule, extended release 24hr 60 mg</i>	Tier 1	
<i>trospium oral tablet 20 mg</i>	Tier 1	
Urinary Retention Therapy - Parasympathomimetic Agents - Drugs For The Bladder		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	Tier 1	
Gout And Hyperuricemia Therapy - Drugs For Pain And Fever		
Gout Acute Therapy - Antimitotics - Gout Drugs		
<i>colchicine oral capsule 0.6 mg</i>	Tier 1	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>colchicine oral tablet 0.6 mg</i>	Tier 1	QL (4 EA per 1 day)
COLCRYS ORAL TABLET 0.6 MG (colchicine)	Tier 3	QL (4 EA per 1 day)
GLOPERBA ORAL SOLUTION 0.6 MG/5 ML (colchicine)	Tier 3	ST: Requires prior prescription for Colchicine capsules or tablets within the past 120 days; QL (10 ML per 1 day)
MITIGARE ORAL CAPSULE 0.6 MG (colchicine)	Tier 3	QL (2 EA per 1 day)
Gout And Hyperuricemia - Antimitotic-Uricosuric Combinations - Gout Drugs		
<i>probenecid-colchicine oral tablet 500-0.5 mg</i>	Tier 3	
Hyperuricemia Therapy - Uricosurics - Gout Drugs		
<i>probenecid oral tablet 500 mg</i>	Tier 1	
Hyperuricemia Therapy - Xanthine Oxidase Inhibitors - Gout Drugs		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	Tier 1	
<i>allopurinol oral tablet 200 mg</i>	Tier 3	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	Tier 1	ST: Requires prior prescription for Allopurinol within the past 120 days; QL (30 EA per 30 days)
ULORIC ORAL TABLET 40 MG, 80 MG (febuxostat)	Tier 3	ST: Requires prior prescription for Allopurinol within the past 120 days; QL (30 EA per 30 days)
ZYLOPRIM ORAL TABLET 100 MG (allopurinol)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hematological Agents		
Hematopoietic Agents - Hypoxia Inducible Factor Prolyl Hydroxylase Inh		
VAFSEO ORAL TABLET 150 MG, 300 MG (vadadustat)	Tier 3	PA
Hemophilia Treatment Agents - Small Interfering Rna (Sirna)		
QFITLIA PEN SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML (fitusiran sodium)	Tier 3	PA; KP
QFITLIA SUBCUTANEOUS SOLUTION 20 MG/0.2 ML (fitusiran sodium)	Tier 3	PA; KP
Pnh - Complement Factor B Inhibitors		
FABHALTA ORAL CAPSULE 200 MG (iptacopan HCl)	Tier 3	PA
Pnh - Complement Factor D Inhibitors		
VOYDEYA ORAL TABLET 100 MG, 150 MG (50 MG X 1-100 MG X 1) (danicopan)	Tier 3	PA
Hematological Agents - Drugs For The Blood		
Agents To Treat Attp- Anti Von Willebrand Factor (Vwf) A1 Domain - Drugs For The Blood		
CABLIVI INJECTION KIT 11 MG (caplacizumab-yhdp)	Tier 3	PA; KP
Agents To Treat Paroxysmal Nocturnal Hemoglobinuria (Pnh) - Drugs For The Blood		
EMPAVELI SUBCUTANEOUS SOLUTION 1,080 MG/20 ML (pegcetacoplan)	Tier 3	PA; KP
FABHALTA ORAL CAPSULE 200 MG (iptacopan HCl)	Tier 3	PA
VOYDEYA ORAL TABLET 100 MG, 150 MG (50 MG X 1-100 MG X 1) (danicopan)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Anticoagulants - Citrate-Based - Drugs To Prevent Blood Clots		
ACD SOLUTION A SOLUTION 2.45-2.2 GRAM- 800 MG/100 ML (dextrose-water/sodium citrate/citric acid)	Tier 3	
ACD-A SOLUTION (citrate dextrose solution)	Tier 3	
ACD-A SOLUTION 2.45-2.2 GRAM- 730 MG/100 ML (dextrose-water/sodium citrate/citric acid)	Tier 3	
<i>anticoag citrate phos dextrose solution 2.63-222 gram-mg/100ml</i>	Tier 1	
<i>sodium citrate in 0.9 % nacl solution 0.5 %</i>	Tier 1	
<i>sodium citrate intra-catheter solution 4 %</i>	Tier 1	
<i>sodium citrate intra-catheter syringe 4 % (3 ml), 4 % (5 ml)</i>	Tier 1	
<i>sodium citrate solution 4 gram /100 ml (4 %)</i>	Tier 1	
Anticoagulants - Coumarin - Drugs To Prevent Blood Clots		
warfarin sodium (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	Tier 1	
<i>warfarin oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	Tier 1	
Anti-Inhibitor Coagulation Complex - Drugs To Prevent Bleeding		
FEIBA NF INTRAVENOUS RECON SOLN 1,750-3,250 UNIT, 350-650 UNIT, 700-1,300 UNIT (anti-inhibitor coagulant complex)	Tier 3	KP
Blood Cell And Platelet Disorder Treatment- Tyrosine Kinase Inhibitors - Drugs For The Blood		
TAVALISSE ORAL TABLET 100 MG, 150 MG (fostamatinib disodium)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WAYRILZ ORAL TABLET 400 MG (rilzabrutinib)	Tier 3	PA
C1 Esterase Inhibitor Agents - Drugs For The Blood		
BERINERT INTRAVENOUS KIT 500 UNIT (10 ML) (C1 esterase inhibitor)	Tier 3	PA; KP
CINRYZE INTRAVENOUS RECON SOLN 500 UNIT (5 ML) (C1 esterase inhibitor)	Tier 3	PA; KP
HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT (C1 esterase inhibitor)	Tier 3	PA; KP
RUCONEST INTRAVENOUS RECON SOLN 2,100 UNIT (C1 esterase inhibitor, recombinant)	Tier 3	PA; KP
Cxcr4 Chemokine Receptor Antagonists - Drugs For The Blood		
XOLREMDI ORAL CAPSULE 100 MG (mavorixafor)	Tier 3	PA
Direct Factor Xa Inhibitors - Drugs To Prevent Blood Clots		
ELIQUIS DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 5 MG (74 TABS) (apixaban)	Tier 2	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG (apixaban)	Tier 2	QL (2 EA per 1 day)
ELIQUIS ORAL TABLET 5 MG (apixaban)	Tier 2	QL (74 EA per 30 days)
<i>rivaroxaban oral suspension for reconstitution 1 mg/ml</i>	Tier 1	QL (20 ML per 1 day)
<i>rivaroxaban oral tablet 2.5 mg</i>	Tier 1	QL (2 EA per 1 day)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (edoxaban tosylate)	Tier 3	ST: Requires prior prescriptions for Eliquis and Xarelto within the past 365 days; QL (30 EA per 30 days)
XARELTO DVT-PE TREAT 30D START ORAL TABLETS,DOSE PACK 15 MG (42)- 20 MG (9) (rivaroxaban)	Tier 2	QL (51 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XARELTO ORAL SUSPENSION FOR RECONSTITUTION 1 MG/ML (rivaroxaban)	Tier 2	QL (20 ML per 1 day)
XARELTO ORAL TABLET 10 MG, 20 MG (rivaroxaban)	Tier 2	QL (1 EA per 1 day)
XARELTO ORAL TABLET 15 MG, 2.5 MG (rivaroxaban)	Tier 2	QL (2 EA per 1 day)
Erythropoietins - Drugs For The Blood		
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (darbepoetin alfa in polysorbate 80)	Tier 3	PA; KP
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 25 MCG/0.42 ML, 300 MCG/0.6 ML, 40 MCG/0.4 ML, 500 MCG/ML, 60 MCG/0.3 ML (darbepoetin alfa in polysorbate 80)	Tier 3	PA; KP
EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML (epoetin alfa)	Tier 3	PA; KP
MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 120 MCG/0.3 ML, 150 MCG/0.3 ML, 200 MCG/0.3 ML, 30 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML (methoxy polyethylene glycol-epoetin beta)	Tier 3	PA; KP
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML (epoetin alfa)	Tier 3	PA; KP
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML (epoetin alfa-epbx)	Tier 3	PA; KP
Factor Ix Preparations - Drugs To Prevent Bleeding		
ALPHANINE SD INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 500 (+/-) UNIT (factor IX)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALPROLIX INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 500 UNIT (factor IX recombinant, Fc fusion protein)	Tier 3	KP
BENEFIX INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT (factor IX human recombinant)	Tier 3	KP
IDELVION INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,500 (+/-) UNIT, 500 (+/-) UNIT (factor IX recombinant, albumin fusion protein)	Tier 3	KP
IXINITY INTRAVENOUS RECON SOLN 1,000 UNIT, 1,500 UNIT, 3,000 UNIT, 500 UNIT (factor IX human recombinant, threonine 148)	Tier 3	KP
PROFILNINE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 500 (+/-) UNIT (factor IX complex, prothrombin complex conc no.4, 3-factor)	Tier 3	KP
REBINYN INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (factor IX (human) recombinant, pegylated)	Tier 3	KP
RIXUBIS INTRAVENOUS RECON SOLN 1,000 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 500 UNIT (factor IX human recombinant)	Tier 3	KP
Factor Vii Preparations - Drugs To Prevent Bleeding		
NOVOSEVEN RT INTRAVENOUS RECON SOLN 1 MG (1,000 MCG), 2 MG (2,000 MCG), 5 MG (5,000 MCG), 8 MG (8,000 MCG) (coagulation factor VIIa (recombinant))	Tier 3	KP
SEVENFACT INTRAVENOUS RECON SOLN 1 MG (1,000 MCG), 2 MG (2,000 MCG), 5 MG (5,000 MCG) (coagulation factor VIIa recombinant-jncw)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Factor VIII Preparations (Ahf) - Drugs To Prevent Bleeding		
ADVATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 4,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) recombinant,full length)	Tier 3	KP
ADYNOVATE INTRAVENOUS SOLUTION 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT, 750 (+/-) UNIT (antihemophilic factor (FVIII) recombinant, full length, peg)	Tier 3	KP
AFSTYLA INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT RANGE, 1,500 (+/-) UNIT RANGE, 2,000 (+/-) UNIT RANGE, 2,500 (+/-) UNIT RANGE, 250 (+/-) UNIT RANGE, 3,000 (+/-) UNIT RANGE, 500 (+/-) UNIT RANGE (antihemophilic factor VIII recomb,single-chn,B-dom truncated)	Tier 3	KP
ALPHANATE INTRAVENOUS RECON SOLN 1,000 (400 VWF) UNIT/10 ML, 1,500 (600 VWF) UNIT/10 ML, 2,000 (800 VWF) UNIT/10 ML, 250 (100 VWF) UNIT/5 ML, 500 (200 VWF) UNIT/5 ML (antihemophilic factor, human/von Willebrand factor,human)	Tier 3	KP
ALTUVIIIIO INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 4000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor rFVIII Fc-VWF-XTEN,BDD-eh1)	Tier 3	KP
ELOCTATE INTRAVENOUS RECON SOLN 1,000 UNIT, 1,500 UNIT, 2,000 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 5,000 UNIT, 500 UNIT, 6,000 UNIT, 750 UNIT (antihemophilic factor (FVIII) recombinant, Fc fusion protein)	Tier 3	KP
ESPEROCT INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 4,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) rec, B-dom truncated peg-exei)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMOFIL M HIGH INTRAVENOUS RECON SOLN 801-1,500 UNIT (antihemophilic factor, human)	Tier 3	KP
HEMOFIL M LOW INTRAVENOUS RECON SOLN 220-400 UNIT (antihemophilic factor, human)	Tier 3	KP
HEMOFIL M MID INTRAVENOUS RECON SOLN 401-800 UNIT (antihemophilic factor, human)	Tier 3	KP
HEMOFIL M SUPER HIGH INTRAVENOUS RECON SOLN 1,501-2,000 UNIT (antihemophilic factor, human)	Tier 3	KP
HUMATE-P INTRAVENOUS RECON SOLN 1,000-2,400 UNIT, 250-600 UNIT, 500-1,200 UNIT (antihemophilic factor, human/von Willebrand factor,human)	Tier 3	KP
JIVI INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 3,000 (+/-) UNIT, 4,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) rec, B-domain deleted peg-aucl)	Tier 3	KP
KOATE INTRAVENOUS RECON SOLN 250 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor, human)	Tier 3	KP
KOGENATE FS INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) recombinant,full length)	Tier 3	KP
KOVALTRY INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (FVIII) recombinant,full length)	Tier 3	KP
NOVOEIGHT INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor VIII recombinant, B-domain truncated)	Tier 3	KP
NUWIQ INTRAVENOUS RECON SOLN 1000 UNIT, 2,000 UNIT, 2,500 UNIT, 250 UNIT, 3,000 UNIT, 4,000 UNIT, 500 UNIT (antihemophilic factor VIII rec HEK cell, B-domain deleted)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OBIZUR INTRAVENOUS RECON SOLN 500 (+/-) UNIT RANGE (antihemophilic factor VIII, recombinant porcine sequence)	Tier 3	KP
RECOMBIMATE INTRAVENOUS RECON SOLN 1,000 (+/-) UNIT, 1,500 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor VIII, human recombinant)	Tier 3	KP
WILATE INTRAVENOUS RECON SOLN 1,000-1,000 UNIT, 500-500 UNIT (antihemophilic factor, human/von Willebrand factor,human)	Tier 3	KP
XYNTHA INTRAVENOUS SOLUTION 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (factor VIII) recomb,B-domain deleted)	Tier 3	KP
XYNTHA SOLOFUSE INTRAVENOUS SYRINGE 1,000 (+/-) UNIT, 2,000 (+/-) UNIT, 250 (+/-) UNIT, 3,000 (+/-) UNIT, 500 (+/-) UNIT (antihemophilic factor (factor VIII) recomb,B-domain deleted)	Tier 3	KP
Factor X Preparations - Drugs To Prevent Bleeding		
COAGADEX INTRAVENOUS RECON SOLN 250 (+/-) UNIT RANGE, 500 (+/-) UNIT RANGE (coagulation factor X)	Tier 3	KP
Factor Xiii Preparations - Drugs To Prevent Bleeding		
CORIFACT INTRAVENOUS RECON SOLN 1,000-1,600 UNIT (factor XIII)	Tier 3	KP
TRETTEN INTRAVENOUS RECON SOLN 2,500 UNIT (factor XIII A-subunit, recombinant)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Granulocyte Colony-Stimulating Factor (G-Csf) - Drugs For The Blood		
FULPHILA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-jmdb)	Tier 3	PA; KP
FYLNETRA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-pbbk)	Tier 3	PA; KP
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6 ML (tbo-filgrastim)	Tier 3	PA; KP
GRANIX SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (tbo-filgrastim)	Tier 3	PA; KP
NEULASTA ONPRO SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML (pegfilgrastim)	Tier 3	PA; KP
NEULASTA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim)	Tier 3	PA; KP
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML (filgrastim)	Tier 3	PA; KP
NEUPOGEN INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim)	Tier 3	PA; KP
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML (filgrastim-aafi)	Tier 3	PA; KP
NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim-aafi)	Tier 3	PA; KP
NYPOZI INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim-txid)	Tier 3	PA; KP
NYVEPRIA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-apgf)	Tier 3	PA; KP
RELEUKO SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim-ayow)	Tier 3	PA; KP
ROLVEDON SUBCUTANEOUS SYRINGE 13.2 MG/0.6 ML (eflapeggrastim-xnst)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
STIMUFEND SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-fpgk)	Tier 3	PA; KP
UDENYCA AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 6 MG/0.6 ML (pegfilgrastim-cbqv)	Tier 3	PA; KP
UDENYCA ONBODY SUBCUTANEOUS SYRINGE, W/ WEARABLE INJECTOR 6 MG/0.6 ML (pegfilgrastim-cbqv)	Tier 3	PA; KP
UDENYCA SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-cbqv)	Tier 3	PA; KP
ZARXIO INJECTION SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML (filgrastim-sndz)	Tier 3	PA; KP
ZIEXTENZO SUBCUTANEOUS SYRINGE 6 MG/0.6 ML (pegfilgrastim-bmez)	Tier 3	PA; KP
Granulocyte-Macrophage Colony-Stimulating Factor (Gm-Csf) - Drugs For The Blood		
LEUKINE INJECTION RECON SOLN 250 MCG (sargramostim)	Tier 3	PA; KP
Hematorheologic Agents - Drugs For The Blood		
<i>pentoxifylline oral tablet extended release 400 mg</i>	Tier 1	
Hemophilia Treatment Agents - Monoclonal Antibody - Drugs For The Blood		
ALHEMO PEN SUBCUTANEOUS PEN INJECTOR 150 MG/1.5 ML (100 MG/ML), 300 MG/3 ML (100 MG/ML), 60 MG/1.5 ML (40 MG/ML) (concizumab-mtci)	Tier 3	PA; KP
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7 ML, 12 MG/0.4 ML, 150 MG/ML, 30 MG/ML, 300 MG/2 ML (150 MG/ML), 60 MG/0.4 ML (emicizumab-kxwh)	Tier 3	PA; KP
HYMPAVZI PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML (marstacimab-hncq)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Hemostatic Systemic - Antifibrinolytic Agents - Drugs To Prevent Bleeding		
AMICAR ORAL SOLUTION 250 MG/ML (25 %) (aminocaproic acid)	Tier 3	
AMICAR ORAL TABLET 1,000 MG, 500 MG (aminocaproic acid)	Tier 3	
<i>aminocaproic acid oral solution 250 mg/ml (25 %)</i>	Tier 1	
<i>aminocaproic acid oral tablet 1,000 mg, 500 mg</i>	Tier 1	
<i>tranexamic acid oral tablet 650 mg</i>	Tier 1	
Hemostatic Systemic- Von Willebrand Factor (Vwf) Preparations - Drugs To Prevent Bleeding		
VONVENDI INTRAVENOUS RECON SOLN 1,300 (+/-) UNIT RANGE, 650 (+/-) UNIT RANGE (von Willebrand factor (recombinant))	Tier 3	KP
Hemostatic Topical Agents - Drugs To Prevent Bleeding		
ASTRINGYN TOPICAL SOLUTION 259 MG/G (ferric subsulfate)	Tier 3	
AVITENE FLOUR TOPICAL POWDER (microfibrillar collagen)	Tier 3	
AVITENE TOPICAL POWDER IN PACKET (microfibrillar collagen)	Tier 3	
AVITENE TOPICAL SHEET 35 X 35 MM, 70 X 35 MM, 70 X 70 MM (microfibrillar collagen)	Tier 3	
ENDO AVITENE TOPICAL SHEET 10 MM, 5 MM (microfibrillar collagen)	Tier 3	
GELFILM IMPLANT FILM (gelatin)	Tier 3	
GEL-FLOW NT TOPICAL SYRINGE (gelatin sponge,absorbable)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GEL-FLOW TOPICAL SYRINGE KIT 5,000 UNIT (thrombin (bovine))/gelatin sponge,absorbable)	Tier 3	
GELFOAM COMPRESSED SIZE 100 TOPICAL SPONGE 100 CM (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM JMI POWDER TOPICAL KIT 5,000 UNIT (thrombin (bovine))/gelatin sponge,absorbable)	Tier 3	
GELFOAM JMI SPONGE TOPICAL COMBO PACK 5,000 UNIT (thrombin (bovine))/gelatin sponge,absorbable)	Tier 3	
GELFOAM MUCOUS MEMBRANE POWDER (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM SPONGE SIZE 100 TOPICAL SPONGE 100 (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM SPONGE SIZE 12-7MM TOPICAL SPONGE 12-7 MM (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM SPONGE SIZE 200 TOPICAL SPONGE 200 (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM SPONGE SIZE 50 TOPICAL SPONGE 50 (gelatin sponge,absorbable/porcine skin)	Tier 3	
GELFOAM TOPICAL SPONGE 4 (gelatin sponge,absorbable/porcine skin)	Tier 3	
MONSEL'S TOPICAL SOLUTION 0.2 TO 0.22 GRAM/ML IRON (ferric subsulfate)	Tier 3	
MONSEL'S TOPICAL SOLUTION WITH APPLICATOR 0.2 TO 0.22 GRAM/ML (ferric subsulfate)	Tier 1	
RECOTHROM SPRAY KIT TOPICAL RECON SOLN 20,000 UNIT (thrombin (recombinant))	Tier 3	
RECOTHROM TOPICAL RECON SOLN 20,000 UNIT, 5,000 UNIT (thrombin (recombinant))	Tier 3	
SURGIFOAM TOPICAL SPONGE 100 , 100 CM, 12-7 MM, 50 (gelatin sponge,absorbable/porcine skin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGE AVITENE TOPICAL POWDER (microfibrillar collagen)	Tier 3	
THROMBI-GEL TOPICAL PADS, MEDICATED 10 CM2, 100 CM2, 40 CM2 (thrombin(bov)/calcium chlor/cmc/gel,pork/dressing,hemostatic)	Tier 3	
THROMBIN-JMI NASAL NASAL SPRAY SYRINGE 5,000 UNIT (thrombin (bovine))	Tier 1	
THROMBIN-JMI TOPICAL RECON SOLN 20,000 UNIT, 5,000 UNIT (thrombin (bovine))	Tier 1	
THROMBIN-JMI TOPICAL SPRAY SYRINGE 20,000 UNIT, 5,000 UNIT (thrombin (bovine))	Tier 1	
THROMBIN-JMI TOPICAL SPRAY,NON-AEROSOL 20,000 UNIT (thrombin (bovine))	Tier 1	
THROMBI-PAD TOPICAL PADS, MEDICATED 3 X 3 " (thrombin(bov)/calcium chlor/cme-cell sod/dressing,hemostatic)	Tier 3	
ULTRAFOAM TOPICAL SPONGE 2 X 6.25 X 7 CM-CM-MM, 8 X 12.5 X 1 CM, 8 X 12.5 X 3 CM-CM-MM, 8 X 6.25 X 1 CM (microfibrillar collagen)	Tier 3	
Hemostatic Topical Combinations - Drugs To Prevent Bleeding		
EVICEL TOPICAL SOLUTION 800-1,200 UNIT /ML (1 ML X 2), 800-1,200 UNIT /ML(2ML X 2), 800-1,200 UNIT /ML(5 ML X 2) (thrombin(human plasma derived)/fibrinogen/calcium chloride)	Tier 3	
VISTASEAL-FIBRIN SEALANT TOPICAL SYRINGE 500 UNIT-80 MG /ML (10 ML), 500 UNIT-80 MG /ML (2 ML), 500 UNIT-80 MG /ML (4 ML) (thrombin(human plasma derived)/fibrinogen/calcium chloride)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Heparin Flush Formulations - Drugs To Prevent Blood Clots		
HEP FLUSH-10 (PF) INTRAVENOUS SOLUTION 10 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	KP
<i>heparin (porcine) in 0.9% nacl intravenous parenteral solution 2,500 unit/500 ml (5 unit/ml), 5,000 unit/500 ml (10 unit/ml)</i>	Tier 1	KP
<i>heparin lock flush (porcine) intravenous solution 10 unit/ml</i>	Tier 1	KP
HEPARIN LOCKFLUSH(PORCINE)(PF) INTRAVENOUS SYRINGE 10 UNIT/ML, 100 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	KP
<i>heparin, porcine (pf) intravenous syringe 1 unit/ml</i>	Tier 1	KP
<i>heparin, porcine (pf) intravenous syringe 10 unit/ml, 100 unit/ml</i>	Tier 1	KP
Heparins - Drugs To Prevent Blood Clots		
HEP FLUSH-10 (PF) INTRAVENOUS SOLUTION 10 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	KP
<i>heparin (porcine) in 0.9% nacl intravenous parenteral solution 2,500 unit/500 ml (5 unit/ml), 5,000 unit/500 ml (10 unit/ml)</i>	Tier 1	KP
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	Tier 1	KP
<i>heparin (porcine) injection cartridge 5,000 unit/ml (1 ml)</i>	Tier 1	KP
<i>heparin (porcine) injection solution 1,000 unit/ml, 10,000 unit/ml, 20,000 unit/ml, 5,000 unit/ml</i>	Tier 1	KP
<i>heparin (porcine) injection syringe 5,000 unit/ml</i>	Tier 1	KP
<i>heparin lock flush (porcine) intravenous solution 10 unit/ml</i>	Tier 1	KP
HEPARIN LOCKFLUSH(PORCINE)(PF) INTRAVENOUS SYRINGE 10 UNIT/ML, 100 UNIT/ML (heparin sodium,porcine/PF)	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>heparin, porcine (pf) injection solution 1,000 unit/ml</i>	Tier 1	KP
<i>heparin, porcine (pf) injection syringe 5,000 unit/0.5 ml, 5,000 unit/ml</i>	Tier 1	KP
<i>heparin, porcine (pf) intravenous syringe 1 unit/ml</i>	Tier 1	KP
<i>heparin, porcine (pf) intravenous syringe 10 unit/ml, 100 unit/ml</i>	Tier 1	KP
Indirect Factor Xa Inhibitors - Drugs To Prevent Blood Clots		
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML (fondaparinux sodium)	Tier 3	KP; QL (24 ML per 30 days)
ARIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML (fondaparinux sodium)	Tier 3	KP; QL (15 ML per 30 days)
ARIXTRA SUBCUTANEOUS SYRINGE 5 MG/0.4 ML (fondaparinux sodium)	Tier 3	KP; QL (12 ML per 30 days)
ARIXTRA SUBCUTANEOUS SYRINGE 7.5 MG/0.6 ML (fondaparinux sodium)	Tier 3	KP; QL (18 ML per 30 days)
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml</i>	Tier 1	KP; QL (24 ML per 30 days)
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	Tier 1	KP; QL (15 ML per 30 days)
<i>fondaparinux subcutaneous syringe 5 mg/0.4 ml</i>	Tier 1	KP; QL (12 ML per 30 days)
<i>fondaparinux subcutaneous syringe 7.5 mg/0.6 ml</i>	Tier 1	KP; QL (18 ML per 30 days)
Low Molecular Weight Heparins - Drugs To Prevent Blood Clots		
<i>enoxaparin subcutaneous solution 300 mg/3 ml</i>	Tier 1	KP; QL (30 ML per 30 days)
<i>enoxaparin subcutaneous syringe 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 30 mg/0.3 ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENOXILUV SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML (enoxaparin sodium)	Tier 3	KP
FRAGMIN SUBCUTANEOUS SOLUTION 2,500 ANTI-XA UNIT/ML (dalteparin sodium,porcine)	Tier 3	KP; QL (8 ML per 1 day)
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML (dalteparin sodium,porcine)	Tier 3	KP; QL (7.6 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML (dalteparin sodium,porcine)	Tier 3	KP; QL (60 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 12,500 ANTI-XA UNIT/0.5 ML (dalteparin sodium,porcine)	Tier 3	KP; QL (30 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 15,000 ANTI-XA UNIT/0.6 ML (dalteparin sodium,porcine)	Tier 3	KP; QL (36 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 18,000 ANTI-XA UNIT/0.72 ML (dalteparin sodium,porcine)	Tier 3	KP; QL (43.2 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML (dalteparin sodium,porcine)	Tier 3	KP; QL (12 ML per 30 days)
FRAGMIN SUBCUTANEOUS SYRINGE 7,500 ANTI-XA UNIT/0.3 ML (dalteparin sodium,porcine)	Tier 3	KP; QL (18 ML per 30 days)
LOVENOX SUBCUTANEOUS SOLUTION 300 MG/3 ML (enoxaparin sodium)	Tier 3	KP; QL (30 ML per 30 days)
LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML, 120 MG/0.8 ML, 150 MG/ML, 30 MG/0.3 ML, 40 MG/0.4 ML, 60 MG/0.6 ML, 80 MG/0.8 ML (enoxaparin sodium)	Tier 3	KP
Plasma Proteins Which Facilitate Anticoagulation - Drugs For The Blood		
RYPLAZIM INTRAVENOUS RECON SOLN 68.8 MG (plasminogen, human-tvmh)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Platelet Aggregation Inhib - Cyclopentyl-Triazolo-Pyrimidines (Cptps) - Drugs For The Blood		
BRILINTA ORAL TABLET 60 MG, 90 MG (ticagrelor)	Tier 3	QL (2 EA per 1 day)
<i>ticagrelor oral tablet 60 mg, 90 mg</i>	Tier 1	QL (2 EA per 1 day)
Platelet Aggregation Inhibitor Combinations - Drugs For The Blood		
<i>aspirin-dipyridamole oral capsule, er multiphase 12 hr 25-200 mg</i>	Tier 1	
Platelet Aggregation Inhibitors - Phosphodiesterase Iii Inhibitors - Drugs For The Blood		
<i>cilostazol oral tablet 100 mg, 50 mg</i>	Tier 1	
Platelet Aggregation Inhibitors - Quinazoline Agents - Drugs For The Blood		
AGRYLIN ORAL CAPSULE 0.5 MG (anagrelide HCl)	Tier 3	
<i>anagrelide oral capsule 0.5 mg, 1 mg</i>	Tier 1	
Platelet Aggregation Inhibitors - Salicylates - Drugs For The Blood		
ADULT ASPIRIN REGIMEN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
ADULT LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
ASPIRIN CHILDRENS ORAL TABLET,CHEWABLE 81 MG (aspirin)	PV	
<i>aspirin oral tablet 325 mg</i>	PV	
<i>aspirin oral tablet,chewable 81 mg</i>	PV	
<i>aspirin oral tablet,delayed release (dr/ec) 325 mg, 81 mg</i>	PV	
BAYER ASPIRIN ORAL TABLET 325 MG (aspirin)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BAYER ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	PV	
BAYER LOW DOSE ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
CHILDREN'S ASPIRIN ORAL TABLET,CHEWABLE 81 MG (aspirin)	PV	
DURLAZA ORAL CAPSULE,EXTENDED RELEASE 24HR 162.5 MG (aspirin)	Tier 3	PA
ECOTRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 325 MG (aspirin)	PV	
ST JOSEPH ASPIRIN ORAL TABLET,CHEWABLE 81 MG (aspirin)	PV	
ST. JOSEPH ASPIRIN ORAL TABLET,DELAYED RELEASE (DR/EC) 81 MG (aspirin)	PV	
Platelet Aggregation Inhibitors - Thienopyridine Agents - Drugs For The Blood		
<i>clopidogrel oral tablet 300 mg</i>	Tier 1	QL (4 EA per 30 days)
<i>clopidogrel oral tablet 75 mg</i>	Tier 1	
EFFIENT ORAL TABLET 10 MG, 5 MG (prasugrel HCl)	Tier 3	QL (1 EA per 1 day)
PLAVIX ORAL TABLET 75 MG (clopidogrel bisulfate)	Tier 3	
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	Tier 1	QL (1 EA per 1 day)
Platelet Aggregation Inhibitors-Salicylates And Proton Pump Inhib Comb - Drugs For The Blood		
YOSPRALA ORAL TABLET,IR,DELAYED REL,BIPHASIC 325-40 MG, 81-40 MG (aspirin/omeprazole)	Tier 3	PA
Platelet Aggregation Inhib-Pdesterase And Adenosine Deaminase Inhibitr - Drugs For The Blood		
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Platelet Aggregation Inhib-Protease-Activ.Receptor-1(Par-1) Antagonist - Drugs For The Blood		
ZONTIVITY ORAL TABLET 2.08 MG (vorapaxar sulfate)	Tier 3	QL (1 EA per 1 day)
Pnh - Complement (C3) Inhibitors - Drugs For The Blood		
EMPAVELI SUBCUTANEOUS SOLUTION 1,080 MG/20 ML (pegcetacoplan)	Tier 3	PA; KP
Pyruvate Kinase (Pk) Activators - Drugs For The Blood		
PYRUKYND ORAL TABLET 20 MG, 5 MG, 50 MG (mitapivat sulfate)	Tier 3	PA
PYRUKYND ORAL TABLETS,DOSE PACK 20 MG (7)- 5 MG (7), 50 MG (7)- 20 MG (7) (mitapivat sulfate)	Tier 3	PA
Sickle Cell Anemia Agents, Others - Drugs For The Blood		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (hydroxyurea)	Tier 3	
ENDARI ORAL POWDER IN PACKET 5 GRAM (glutamine)	Tier 3	PA
<i>glutamine (sickle cell) oral powder in packet 5 gram</i>	Tier 3	PA
SIKLOS ORAL TABLET 1,000 MG (hydroxyurea)	Tier 3	ST: Requires prior prescriptions for generic Hydroxyurea and Droxia within the past 365 days
SIKLOS ORAL TABLET 100 MG (hydroxyurea)	Tier 3	QL (2 EA per 1 day)
XROMI ORAL SOLUTION 100 MG/ML (hydroxyurea)	Tier 3	PA
Thrombin Inhibitor - Selective Direct And Reversible - Drugs To Prevent Blood Clots		
<i>dabigatran etexilate oral capsule 110 mg, 150 mg, 75 mg</i>	Tier 1	QL (2 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG (dabigatran etexilate mesylate)	Tier 3	ST: Requires prior prescriptions for Eliquis and Xarelto within the past 365 days; QL (2 EA per 1 day)
PRADAXA ORAL PELLETS IN PACKET 110 MG, 150 MG, 20 MG, 30 MG, 40 MG, 50 MG (dabigatran etexilate mesylate)	Tier 3	PA
Thrombopoietin Receptor Agonists - Drugs For The Blood		
ALVAIZ ORAL TABLET 18 MG, 36 MG, 54 MG, 9 MG (eltrombopag choline)	Tier 3	PA
DOPTelet (10 TAB PACK) ORAL TABLET 20 MG (avatrombopag maleate)	Tier 3	PA
DOPTelet (15 TAB PACK) ORAL TABLET 20 MG (avatrombopag maleate)	Tier 3	PA
DOPTelet (30 TAB PACK) ORAL TABLET 20 MG (avatrombopag maleate)	Tier 3	PA
<i>eltrombopag olamine oral powder in packet 12.5 mg, 25 mg</i>	Tier 3	PA
<i>eltrombopag olamine oral tablet 12.5 mg, 25 mg, 50 mg, 75 mg</i>	Tier 3	PA
MULPLETA ORAL TABLET 3 MG (lusutrombopag)	Tier 3	PA
PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG (eltrombopag olamine)	Tier 3	PA
PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG (eltrombopag olamine)	Tier 3	PA
Hepatobiliary System Treatment Agents		
Agents To Treat Cerebrotendinous Xanthomatosis (Ctx)		
CHENODAL ORAL TABLET 250 MG (chenodiol)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CTEXTLI ORAL TABLET 250 MG (chenodiol)	Tier 3	PA
Non-Alcoholic Steatohepatitis (Nash) Agents - Thr-Beta Agonist		
REZDIFFRA ORAL TABLET 100 MG, 60 MG, 80 MG (resmetirom)	Tier 3	PA
Peroxisome Proliferator-Activated Receptor (Ppar) Agonist		
IQIRVO ORAL TABLET 80 MG (elafibranor)	Tier 3	PA
LIVDELZI ORAL CAPSULE 10 MG (seladelpar lysine)	Tier 3	PA
Hepatobiliary System Treatment Agents - Drugs For The Liver		
Farnesoid X Receptor (Fxr) Agonist, Bile Acid Analog - Drugs For The Liver		
OICALIVA ORAL TABLET 10 MG, 5 MG (obeticholic acid)	Tier 3	PA
Ileal Bile Acid Transporter (Ibat) Inhibitor - Drugs For The Liver		
BYLVAY ORAL CAPSULE 1,200 MCG, 400 MCG (odevixibat)	Tier 3	PA
BYLVAY ORAL PELLETT 200 MCG, 600 MCG (odevixibat)	Tier 3	PA
LIVMARLI ORAL SOLUTION 19 MG/ML, 9.5 MG/ML (maralixibat chloride)	Tier 3	PA
LIVMARLI ORAL TABLET 10 MG, 15 MG, 20 MG, 30 MG (maralixibat chloride)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Immunosuppressive Agents - Drugs For Organ Transplants		
Immunosuppressive - Calcineurin Inhibitors - Drugs For Organ Transplants		
ASTAGRAF XL ORAL CAPSULE,EXTENDED RELEASE 24HR 0.5 MG, 1 MG, 5 MG (tacrolimus)	Tier 3	ST: Requires prior prescription for generic Tacrolimus within the past 120 days
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	Tier 1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	Tier 1	
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HR 0.75 MG, 1 MG, 4 MG (tacrolimus)	Tier 3	ST: Requires prior prescription for generic Tacrolimus within the past 120 days
cyclosporine, modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	Tier 1	
cyclosporine, modified (Gengraf Oral Solution 100 Mg/ML)	Tier 1	
LUPKYNIS ORAL CAPSULE 7.9 MG (voclosporin)	Tier 3	PA
NEORAL ORAL CAPSULE 100 MG, 25 MG (cyclosporine, modified)	Tier 3	
NEORAL ORAL SOLUTION 100 MG/ML (cyclosporine, modified)	Tier 3	
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG, 5 MG (tacrolimus)	Tier 3	
PROGRAF ORAL GRANULES IN PACKET 0.2 MG, 1 MG (tacrolimus)	Tier 2	
SANDIMMUNE ORAL CAPSULE 100 MG, 25 MG (cyclosporine)	Tier 3	
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Immunosuppressive - Inosine Monophosphate Dehydrogenase Inhibitors - Drugs For Organ Transplants		
CELLCEPT ORAL CAPSULE 250 MG (mycophenolate mofetil)	Tier 3	
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION 200 MG/ML (mycophenolate mofetil)	Tier 3	
CELLCEPT ORAL TABLET 500 MG (mycophenolate mofetil)	Tier 3	
<i>mycophenolate mofetil oral capsule 250 mg</i>	Tier 1	
<i>mycophenolate mofetil oral suspension for reconstitution 200 mg/ml</i>	Tier 1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	Tier 1	
<i>mycophenolate sodium oral tablet, delayed release (dr/ec) 180 mg, 360 mg</i>	Tier 1	
MYFORTIC ORAL TABLET, DELAYED RELEASE (DR/EC) 180 MG, 360 MG (mycophenolate sodium)	Tier 3	
MYHIBBIN ORAL SUSPENSION 200 MG/ML (mycophenolate mofetil)	Tier 3	PA
Immunosuppressive - Interleukin-6 (IL-6) Receptor Inhibitors - Drugs For Organ Transplants		
ENSPRYNG SUBCUTANEOUS SYRINGE 120 MG/ML (satralizumab-mwge)	Tier 3	PA; KP
Immunosuppressive - Mammalian Target Of Rapamycin (Mtor) Inhibitors - Drugs For Organ Transplants		
<i>everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	Tier 1	
<i>sirolimus oral solution 1 mg/ml</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG (everolimus)	Tier 2	
ZORTRESS ORAL TABLET 1 MG (everolimus)	Tier 3	
Immunosuppressive - Purine Analogs - Drugs For Organ Transplants		
azathioprine (Azasan Oral Tablet 100 Mg, 75 Mg)	Tier 3	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	
IMURAN ORAL TABLET 50 MG (azathioprine)	Tier 3	
Locomotor System		
Als Agents - Antisense Oligonucleotide (Aso)		
QALSODY INTRATHECAL SOLUTION 100 MG/15 ML (6.7 MG/ML) (tofersen)	Tier 3	KP
Duchenne Muscular Dystrophy - Histone Deacetylase (Hdac) Inhibitor		
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (givinostat hydrochloride)	Tier 3	PA
Fibrodysplasia Ossificans Progressiva-Retinoic Acid Receptor Agonists		
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG, 10 MG, 2.5 MG, 5 MG (palovarotene)	Tier 3	PA
Friedreich Ataxia-Nuclear Factor Erythroid-Rel.Factor2(Nrf2) Activator		
SKYCLARYS ORAL CAPSULE 50 MG (omaveloxolone)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Locomotor System - Drugs For Muscles, Ligaments, Tendons, And Bones		
Agents To Treat Periodic Paralysis - Carbonic Anhydrase Inhibitors - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>dichlorphenamide oral tablet 50 mg</i>	Tier 3	PA
KEVEYIS ORAL TABLET 50 MG (dichlorphenamide)	Tier 3	PA
dichlorphenamide (Ormalvi Oral Tablet 50 Mg)	Tier 3	PA
Als Agents - Antioxidants/Anti-Inflammatories - Drugs For Nerves And Muscles		
RADICAVA ORS ORAL SUSPENSION 105 MG/5 ML (edaravone)	Tier 3	
RADICAVA ORS STARTER KIT SUSP ORAL SUSPENSION 105 MG/5 ML (edaravone)	Tier 3	
Amyotrophic Lateral Sclerosis (Als) Agents - Benzothiazoles - Drugs For Nerves And Muscles		
RILUTEK ORAL TABLET 50 MG (riluzole)	Tier 3	
<i>riluzole oral tablet 50 mg</i>	Tier 1	
TEGLUTIK ORAL SUSPENSION 50 MG/10 ML (riluzole)	Tier 3	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10 ML (riluzole)	Tier 3	PA
Antimyasthenic Agent - Neonatal Fc Receptor (FcRn) Inhibitor - Drugs For Nerves And Muscles		
VYVGART HYTRULO SUBCUTANEOUS SYRINGE 1,000 MG-10,000 UNIT/5 ML (efgartigimod alfa-hyaluronidase-qvfc)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Antimyasthenic Agent - Reversible Cholinesterase Inhibitors - Drugs For Nerves And Muscles		
MESTINON ORAL SYRUP 60 MG/5 ML (pyridostigmine bromide)	Tier 3	
MESTINON ORAL TABLET 60 MG (pyridostigmine bromide)	Tier 3	
MESTINON TIMESPAN ORAL TABLET EXTENDED RELEASE 180 MG (pyridostigmine bromide)	Tier 3	
<i>pyridostigmine bromide oral syrup 60 mg/5 ml</i>	Tier 1	
<i>pyridostigmine bromide oral tablet 30 mg</i>	Tier 1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	Tier 1	
<i>pyridostigmine bromide oral tablet extended release 180 mg</i>	Tier 1	
Antimyasthenic Agents Other - Drugs For Nerves And Muscles		
FIRDAPSE ORAL TABLET 10 MG (amifampridine phosphate)	Tier 3	PA
ZILBRYSQ SUBCUTANEOUS SYRINGE 16.6 MG/0.416 ML, 23 MG/0.574 ML, 32.4 MG/0.81 ML (zilucoplan sodium)	Tier 3	PA; KP
Musculoskeletal Therapy Agent - Viscosupplements - Drugs For Muscles, Ligaments, Tendons, And Bones		
DUROLANE INTRA-ARTICULAR SYRINGE 60 MG/3 ML (hyaluronate sodium, stabilized)	Tier 3	PA; KP; QL (3 ML per 180 days)
EUFLEXXA INTRA-ARTICULAR SYRINGE 10 MG/ML(MW 2.4 -3.6 MILLION) (hyaluronate sodium)	Tier 2	PA; KP; QL (6 ML per 180 days)
GEL-ONE INTRA-ARTICULAR SYRINGE 30 MG/3 ML (hyaluronate sod, cross-linked)	Tier 3	PA; KP; QL (3 ML per 180 days)
GELSYN-3 INTRA-ARTICULAR SYRINGE 16.8 MG/2 ML (hyaluronate sodium)	Tier 3	PA; KP; QL (6 ML per 180 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENVISC 850 INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (12.5 ML per 180 days)
HYALGAN INTRA-ARTICULAR SOLUTION 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (10 ML per 180 days)
HYALGAN INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (10 ML per 180 days)
HYMOVIS INTRA-ARTICULAR SYRINGE 24 MG/3 ML (hyaluronate sodium, modified, non-crosslinked)	Tier 3	PA; KP; QL (6 ML per 180 days)
MONOVISC INTRA-ARTICULAR SYRINGE 88 MG/4 ML (hyaluronate sodium, stabilized)	Tier 3	PA; KP; QL (4 ML per 180 days)
ORTHOVISC INTRA-ARTICULAR SYRINGE 30 MG/2 ML (hyaluronate sodium)	Tier 3	PA; KP; QL (8 ML per 180 days)
SUPARTZ FX INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (12.5 ML per 180 days)
SYNOJOYNT INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (6 ML per 180 days)
SYNVISC INTRA-ARTICULAR SYRINGE 16 MG/2 ML (hylan G-F 20)	Tier 2	PA; KP; QL (6 ML per 180 days)
SYNVISC-ONE INTRA-ARTICULAR SYRINGE 48 MG/6 ML (hylan G-F 20)	Tier 2	PA; KP; QL (6 ML per 180 days)
TRILURON INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (6 ML per 180 days)
TRIVISC INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (7.5 ML per 180 days)
VISCO-3 INTRA-ARTICULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	PA; KP; QL (7.5 ML per 180 days)
Skeletal Muscle Relaxant - Analgesic Salicylate Combinations - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin oral tablet 200-325 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
orphenadrine citrate/aspirin/caffeine (Norgesic Forte Oral Tablet 50-770-60 Mg)	Tier 3	QL (4 EA per 1 day)
<i>orphenadrine-asa-caffeine oral tablet 25-385-30 mg</i>	Tier 3	QL (8 EA per 1 day)
orphenadrine citrate/aspirin/caffeine (Orphengesic Forte Oral Tablet 50-770-60 Mg)	Tier 3	QL (4 EA per 1 day)
Skeletal Muscle Relaxant - Central Muscle Relaxants - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>baclofen intrathecal kit 40,000 mcg/20ml (2,000 mcg/ml)</i>	Tier 1	KP
<i>baclofen intrathecal solution 10,000 mcg/20ml (500 mcg/ml), 20,000 mcg/20ml (1,000 mcg/ml), 40,000 mcg/20ml (2,000 mcg/ml)</i>	Tier 1	KP
<i>baclofen intrathecal syringe 50 mcg/ml (1 ml)</i>	Tier 1	KP
<i>baclofen oral solution 10 mg/5 ml (2 mg/ml), 5 mg/5 ml</i>	Tier 1	PA
<i>baclofen oral suspension 25 mg/5 ml (5 mg/ml)</i>	Tier 1	PA
<i>baclofen oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>baclofen oral tablet 15 mg</i>	Tier 3	
<i>baclofen oral tablet 5 mg</i>	Tier 1	
<i>carisoprodol oral tablet 250 mg, 350 mg</i>	Tier 1	
<i>chlorzoxazone oral tablet 250 mg, 375 mg, 750 mg</i>	Tier 3	ST: Requires prior prescription for Chlorzoxazone 500mg within the past 120 days; QL (4 EA per 1 day)
<i>chlorzoxazone oral tablet 500 mg</i>	Tier 1	
<i>cyclobenzaprine oral capsule,extended release 24hr 15 mg, 30 mg</i>	Tier 3	QL (1 EA per 1 day)
<i>cyclobenzaprine oral tablet 10 mg, 5 mg, 7.5 mg</i>	Tier 1	
CYCLOTENS REFILL COMBO PACK 10 MG (cyclobenzaprine HCl/TENS unit electrodes)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYCLOTENS STARTER COMBO PACK 10 MG (cyclobenzaprine HCl/TENS unit/TENS unit electrodes)	Tier 3	
cyclobenzaprine HCl (Fexmid Oral Tablet 7.5 Mg)	Tier 3	
FLEQSUVY ORAL SUSPENSION 25 MG/5 ML (5 MG/ML) (baclofen)	Tier 3	PA
GABLOFEN INTRATHECAL SOLUTION 10,000 MCG/20ML (500 MCG/ML), 20,000 MCG/20ML (1,000 MCG/ML), 40,000 MCG/20ML (2,000 MCG/ML) (baclofen)	Tier 3	KP
GABLOFEN INTRATHECAL SYRINGE 10,000 MCG/20ML (500 MCG/ML), 20,000 MCG/20ML (1,000 MCG/ML), 40,000 MCG/20ML (2,000 MCG/ML), 50 MCG/ML (1 ML) (baclofen)	Tier 3	KP
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 50 MCG/ML, 500 MCG/ML (baclofen)	Tier 3	KP
LYVISPAH ORAL GRANULES IN PACKET 10 MG, 20 MG, 5 MG (baclofen)	Tier 3	PA
<i>metaxalone oral tablet 400 mg, 800 mg</i>	Tier 1	
<i>metaxalone oral tablet 640 mg</i>	Tier 3	
<i>methocarbamol oral tablet 1,000 mg</i>	Tier 3	
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	Tier 1	
<i>orphenadrine citrate oral tablet extended release 100 mg</i>	Tier 1	
OZOBAX ORAL SOLUTION 5 MG/5 ML (baclofen)	Tier 3	PA
SOMA ORAL TABLET 250 MG, 350 MG (carisoprodol)	Tier 3	
methocarbamol (Tanlor Oral Tablet 1,000 Mg)	Tier 3	
<i>tizanidine oral capsule 2 mg, 4 mg, 6 mg</i>	Tier 1	
<i>tizanidine oral tablet 2 mg, 4 mg</i>	Tier 1	
carisoprodol (Vanadom Oral Tablet 350 Mg)	Tier 3	
ZANAFLEX ORAL CAPSULE 2 MG, 4 MG, 6 MG (tizanidine HCl)	Tier 3	
ZANAFLEX ORAL TABLET 4 MG (tizanidine HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Skeletal Muscle Relaxant - Direct Muscle Relaxants - Drugs For Muscles, Ligaments, Tendons, And Bones		
DANTRIUM ORAL CAPSULE 25 MG (dantrolene sodium)	Tier 3	
<i>dantrolene oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
Skeletal Muscle Relaxant - Opioid Analgesic Combinations - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	Tier 1	QL (8 EA per 1 day); Age (Min 12 Years)
Skeletal Muscle Relaxant And Topical Irritant Counter-Irritant Comb. - Drugs For Muscles, Ligaments, Tendons, And Bones		
CYCLOPAK KIT 5 MG-2.5 %- 2.5 % (cyclobenzaprine/lidocaine/prilocaine/glycerin)	Tier 3	
Skeletal Muscle Relaxant, Salicylate, And Opioid Analgesic Comb. - Drugs For Muscles, Ligaments, Tendons, And Bones		
<i>carisoprodol-aspirin-codeine oral tablet 200-325-16 mg</i>	Tier 1	QL (8 EA per 1 day); Age (Min 12 Years)
Spinal Muscular Atrophy - Exon Inclusion Antisense Oligonucleotide - Drugs For Nerves And Muscles		
SPINRAZA (PF) INTRATHECAL SOLUTION 12 MG/5 ML (nusinersen sodium/PF)	Tier 3	KP
Spinal Muscular Atrophy - Motor Neuron 2 (Smn2) Splicing Modifier - Drugs For Nerves And Muscles		
EVRYSDI ORAL RECON SOLN 0.75 MG/ML (risdiplam)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVRYSDI ORAL TABLET 5 MG (risdiplam)	Tier 3	
Medical Supplies And Durable Medical Equipment (Dme)		
Medical Supplies And Dme - Epidural Administration Sets		
IVENIX LVP EPIDURAL SET NRFIT EPIDURAL INFUSION SET (epidural administration set)	Tier 3	KP
Medical Supplies And Durable Medical Equipment (Dme) - Medical Supplies And Durable Medical Equipment		
Medical Supplies And Dme - Blood Coagulation Testing Supplies - Medical Supplies And Durable Medical Equipment		
COAGUCHEK XS (prothrombin time/INR test meter)	Tier 3	
Medical Supplies And Dme - Blood Collection Needles - Medical Supplies And Durable Medical Equipment		
MONOJECT BLOOD COLLECTION NEEDLE 20 GAUGE X 1", 20 X 1 1/2 ", 21 GAUGE X 1", 22 GAUGE X 1" (needles, blood collection)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Blood Glucose Tests - Medical Supplies And Durable Medical Equipment		
ACCU-CHEK AVIVA PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ACCU-CHEK GUIDE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ACCU-CHEK SMARTVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCUTREND GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ADVANCED GLUC METER TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ADVOCATE REDI-CODE PLUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGAMATRIX AMP TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
AGAMATRIX JAZZ TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
AGAMATRIX PRESTO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
 PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
 PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASSURE 4 STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ASSURE PLATINUM TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ASSURE PRISM MULTI STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIONIME RIGHTEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
BLOOD GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
BLULINK GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARESENS N TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CARETOUCH TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CHOICEDM CLARUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE MICRO TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE PRO STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE TALK TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE VOICE PLUS TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CONTOUR NEXT TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CONTOUR PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	
CONTOUR TEST STRIPS STRIP (blood sugar diagnostic)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIATRUE PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY PLUS II TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY STEP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TALK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TALK PLUS II TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TOUCH BLULINK TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TRAK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TRAK II TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASYGLUCO TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASYMAX 15 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASYMAX STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELEMENT COMPACT TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ELEMENT TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE BLOOD GLUCOSE SYSTEM STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
 PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
 PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE EVO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE PRO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE TALK TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE WAVE GLUCOSE TEST STRP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVENCARE G2 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVENCARE G3 TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVENCARE MINI GLUCOSE TEST STR STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVENCARE PROVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVENCARE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVOLUTION TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EZ SMART PLUS TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EZ SMART TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA 6 CONNECT GLUCOSE STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA 6CONN-GTEL-TN'G ADV STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA D40-G31 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA G20 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA GD50 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA GTEL GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA TN'G ADVAN PRO TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA TN'G VOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA V10 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA V10-V12-D10-D20 STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORACARE GD20 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORACARE GD40 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE INSULINX STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE INSULINX TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE LITE STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE PRECISION NEO STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GE100 BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GE333 BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCO NAVII TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD 01 SENSOR PLUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD EXPRESSION STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD SHINE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD VITAL SENSOR STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD VITAL TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCOM GLUCOSE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GM100 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GOJJI BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
HARMONY GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
HEALTHPRO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IHEALTH GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
INFINITY TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
MICRO BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICRODOT BLOOD GLUCOSE SYSTEM STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
MICRODOT XTRA BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
MYGLUCOHEALTH STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
 PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
 PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUTEK 2TEK TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
NOVA MAX GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ON CALL EXPRESS TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH ULTRA TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ONETOUCH VERIO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
OPTIUM EZ STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTIUM TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PHARMACIST CHOICE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PIP BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PLATINUM TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION PCX PLUS TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION PCX TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRECISION POINT OF CARE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION Q-I-D TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION XTRA TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMIER TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PREMIUM V10 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRO VOICE V8-V9 TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY NO CODING STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
QUINTET AC STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
QUINTET GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REFUAH PLUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RELION CONFIRM-MICRO STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RELION PRIME TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELION ULTIMA STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
REVEAL TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RIGHTEST GS550 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIGHTTEST GT333 TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SMART SENSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SMARTTEST TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLUS V2 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SURE-TEST EASYPLUS MINI STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
TELCARE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEST N'GO TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
TRUE METRIX GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
TRUETEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
 PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
 PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUETRACK TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ULTIMA TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ULTRATRAK STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRATRAK ULTIMATE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
UNISTRIP1 TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
VIVAGUARD INO TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
Medical Supplies And Dme - Blood Glucose-Ketone Comb. Test Supplies - Medical Supplies And Durable Medical Equipment		
FORA GTEL MULTI-FUNCTN MONITOR DEVICE (blood ketone and glucose monitor)	DME	
FORA TN'G ADV MOBILE MULTI MTR DEVICE (blood ketone and glucose monitor)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA TN'G ADVANCE PRO MONITOR DEVICE (blood ketone and glucose monitor)	DME	
GOJJI MULTI-FUNCTIONAL METER DEVICE (blood ketone and glucose monitor)	DME	
GOJJI MULTI-FUNCTIONAL METER KIT (blood ketone and glucose monitor)	DME	
NOVA MAX PLUS GLUC-KETON METER DEVICE (blood ketone and glucose monitor)	DME	
NOVA MAX PLUS GLUC-KETON METER KIT (blood ketone and glucose monitor)	DME	
PRECISION XTRA KETONE-GLUCOSE KIT (blood ketone and glucose monitor)	DME	
Medical Supplies And Dme - Blood Pressure Device Combinations - Medical Supplies And Durable Medical Equipment		
2TEK GLUCOSE/BLOOD PRESSURE KIT (blood-glucose meter and wrist blood pressure monitor)	DME	
FORA D40D GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D40G GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
Medical Supplies And Dme - Cervical Caps - Medical Supplies And Durable Medical Equipment		
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (cervical cap)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Compression Stockings - Medical Supplies And Durable Medical Equipment		
T.E.D. ANTI-EMBOLISM STOCKING (compression stocking, knee high, regular length, small)	Tier 3	
T.E.D. KNEE LENGTH-M-LONG (compression stocking, knee high, long length, small circumference)	Tier 3	
T.E.D. KNEE LENGTH-S-REGULAR (compression stocking, knee high, regular length, small)	Tier 3	
Medical Supplies And Dme - Conception Assistance Supplies - Medical Supplies And Durable Medical Equipment		
CONCEPTION KIT (conception assistance supplies combination no.1)	Tier 3	
Medical Supplies And Dme - Covid-19 Miscellaneous Testing Supplies - Medical Supplies And Durable Medical Equipment		
ADVIN COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days)
BD VERITOR SARS-COV-2, FLU A-B KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
BD VERITOR SYSTEM SARS-COV-2 KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID AG CARD HOME TST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
BINAXNOW COVID-19 AG CARD KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID-19 AG SELF TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARESTART COVID-19 AG HOME TST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
CLINITEST COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
CORDX COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
CORDX TYFAST FLU-COVID-19 TEST KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
COVID-19 AT-HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
<i>covid19 test adm.by pharmacist</i>	Tier 3	
ELLUME COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
FASTEP COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
FLOWFLEX COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
FLOWFLEX PLUS COVID-19 AND FLU KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
GENABIO COVID-19 RAPID AT-HOME KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
GOTOKNOW COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days)
ID NOW COVID-19 TEST KIT KIT (COVID-19 molecular nucleic acid test assay)	Tier 3	
IHEALTH COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
INDICAID COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
INTELISWAB COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LUCIRA CHECK-IT COVID HOME TST KIT (COVID-19 molecular nucleic acid test assay)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
ON-GO COVID-19 AG AT HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
PILOT COVID-19 AT-HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
PIXEL COVID19 HOME COLLECT KIT (COVID-19 test specimen collection)	Tier 3	
QUICKVUE AT-HOME COVID-19 TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
QUICKVUE SARS ANTIGEN KIT (COVID-19 antigen immunoassay test)	Tier 3	
RAPID SARS-COV-2 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
RAPIDGO FLU AND COVID-19 TEST KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
SOFIA SARS ANTIGEN FIA KIT (COVID-19 antigen immunoassay test)	Tier 3	
SOFIA2 FLU-SARS ANTIGEN FIA KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
SPEEDYSWAB COVID-19 AND FLU KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
SPEEDYSWAB COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
Medical Supplies And Dme - Dental Supplies Other - Medical Supplies And Durable Medical Equipment		
Q-CARE RX Q2 KIT 0.12 % (dental suction device/chlorhexidine/dental swab 1/mouthwash)	Tier 3	
Q-CARE RX Q4 KIT 0.12 % (dental suction device/chlorhexidine gl/dental swab comb no.1)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Diaphragms - Medical Supplies And Durable Medical Equipment		
CAYA CONTOURED VAGINAL DIAPHRAGM 65-80 MM (diaphragms, contoured)	PV	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM (diaphragms, wide seal)	PV	
Medical Supplies And Dme - Drug Application Supplies - Medical Supplies And Durable Medical Equipment		
PCCA ACCUPEN-15 DEVICE (topical cream metered-dose device)	Tier 3	
STERILE DROPTAINERS (eye drop dispenser)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Feeding Tubes And Supplies - Medical Supplies And Durable Medical Equipment		
ENFIT IRRIGAT SYRINGE-CONTAINR KIT (feeder irrigation kit)	Tier 3	
<i>enteral connector, enfit</i>	Tier 3	
ENTERAL GRAVITY BAG SET-ENFIT (feeder container with gravity set, ENFit)	Tier 3	
KANGAROO 924 SAFETY SCREW (pump set)	Tier 3	
KANGAROO EPUMP SET (feeder container with pump set)	Tier 3	
KANGAROO GRAVITY SET (feeder container with gravity set)	Tier 3	
RELIZORB CARTRIDGE (enteral pump accessory for fat hydrolysis)	Tier 3	
Medical Supplies And Dme - Female Condoms - Medical Supplies And Durable Medical Equipment		
FC2 FEMALE CONDOM (condoms, female)	PV	
Medical Supplies And Dme - Gauze Bandages - Medical Supplies And Durable Medical Equipment		
CURITY AMD TOPICAL BANDAGE 1 X 5 "-YARD, 1/4 X 36 " (gauze bandage)	Tier 3	
Medical Supplies And Dme - Gauze Pads And Dressings - Medical Supplies And Durable Medical Equipment		
CURITY IODOFORM PACKING STRIP TOPICAL BANDAGE 1 X 5 "-YARD, 1/2 X 5 "-YARD, 1/4 X 5 "-YARD, 2 X 5 "-YARD (iodoform)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PETROLEUM GAUZE TOPICAL BANDAGE (petrolatum,white)	Tier 3	
RESTORE TOPICAL BANDAGE 2 X 2 " (silver/calcium alginate)	Tier 3	
XEROFORM PETROLATUM DRESSING TOPICAL BANDAGE 1 X 8 ", 2 X 2 ", 4 X 3 "-YARD, 4 X 4 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM PETROLATUM OVERWRAP TOPICAL BANDAGE 1 X 8 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM TOPICAL BANDAGE 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
Medical Supplies And Dme - Glucose Monitoring Test Supplies - Medical Supplies And Durable Medical Equipment		
2-IN-1 LANCET DEVICE 30 GAUGE (lancets)	DME	
2TEK CONTROL (HIGH-NORMAL) SOLUTION (blood glucose calibration control solution, high and normal)	DME	
2TEK GLUCOSE/BLOOD PRESSURE KIT (blood-glucose meter and wrist blood pressure monitor)	DME	
ACCU-CHEK AVIVA CONTROL SOLN SOLUTION (blood glucose calibration control high and low)	DME	
ACCU-CHEK FASTCLIX LANCET DRUM (lancets)	DME	
ACCU-CHEK FASTCLIX LANCING DEV KIT (lancing device/lancets)	DME	
ACCU-CHEK GUIDE GLUCOSE METER (blood-glucose meter)	DME	
ACCU-CHEK GUIDE L1-L2 CTRL SOL SOLUTION (blood glucose calibration control high and low)	DME	
ACCU-CHEK GUIDE ME GLUCOSE MTR (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK SAFE-T-PRO 23 GAUGE (lancets)	DME	
ACCU-CHEK SAFE-T-PRO PLUS 23 GAUGE (lancets)	DME	
ACCU-CHEK SMARTVIEW CONTRL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
ACCU-CHEK SOFT DEV LANCETS KIT (lancing device/lancets)	DME	
ACCU-CHEK SOFTCLIX LANCETS (lancets)	DME	
ACCUTREND GLUCOSE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ACTI-LANCE LANCETS 17 GAUGE, 23 GAUGE, 28 GAUGE (lancets)	DME	
ADJUSTABLE LANCING DEVICE (lancing device)	DME	
ADVANCED ALL-IN-ONE METER KIT (blood-glucose meter)	DME	
ADVANCED GLUCOSE METER (blood-glucose meter)	DME	
ADVANCED LANCING DEVICE KIT (lancing device/lancets)	DME	
ADVANCED TRAVEL LANCETS 28 GAUGE (lancets)	DME	
ADVOCATE LANCET 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
ADVOCATE LANCING DEVICE (lancing device)	DME	
ADVOCATE REDI-CODE PLUS (blood-glucose meter)	DME	
ADVOCATE REDI-CODE PLUS CTRL L SOLUTION (blood glucose calibration control solution, low)	DME	
ADVOCATE REDI-CODE+ CTRL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
AGAMATRIX CONTROL SOLN-HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
AGAMATRIX CONTROL SOLN-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGAMATRIX CONTROL SOLN-NORM-HI SOLUTION (blood glucose calibration control solution, high and normal)	DME	
AGAMATRIX JAZZ WIRELESS 2 MNTR KIT (blood-glucose meter)	DME	
AGAMATRIX PRESTO SYSTEM (blood-glucose meter)	DME	
AGAMATRIX ULTRA-THIN LANCET 33 GAUGE (lancets)	DME	
ALKALINE BATTERIES (diabetic supplies, miscell)	DME	
ALTERNATE SITE LANCET 26 GAUGE (lancets)	DME	
ALTERNATE SITE LANCING DEVICE (lancing device)	DME	
AQUA LANCE LANCING DEVICE (lancing device)	DME	
ASSURE 4 CONTROL SOLUTION COMBO PACK (blood-glucose calib. control)	DME	
ASSURE DOSE NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ASSURE DOSE NORM-HI CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ASSURE LANCE 25 GAUGE, 28 GAUGE (lancets)	DME	
ASSURE LANCE PLUS 21 GAUGE, 25 GAUGE, 30 GAUGE (lancets)	DME	
ASSURE PLATINUM GLUCOSE METER (blood-glucose meter)	DME	
ASSURE PRISM CONTROL 1-2 SOLN SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ASSURE PRISM MULTI METER (blood-glucose meter)	DME	
AUTO-LANCET MINI (lancing device)	DME	
AUTOLET IMPRESSION LANC DEV KIT (lancing device/lancets)	DME	
AUTOLET LANCING DEVICE (lancing device)	DME	
AUTOLET LITE (lancing device)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD MICROTAINER LANCET 1.5 X 2 MM (blade lancet, safety)	DME	
BD MICROTAINER LANCET 21 GAUGE, 30 GAUGE (lancets)	DME	
BIGFOOT UNITY KIT (flash glucose sensor/blood glucose test strips/pen needles)	Tier 3	
BIONIME RIGHTEST GM300 SYSTEM KIT (blood-glucose meter)	DME	
BIOTEL CARE BGM-4 METER (blood-glucose meter)	DME	
<i>blood glucose contrl hi,normal solution</i>	DME	
<i>blood glucose control, normal solution</i>	DME	
BLOOD GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
<i>blood-glucose meter</i>	DME	
<i>blood-glucose meter kit</i>	DME	
BLULINK BG SYSTEM REFILL KIT 32 GAUGE (lancets with blood glucose test strips)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
BLULINK DIABETIC TEST BUNDLE KIT (blood-glucose meter)	DME	
BLULINK GLUCOSE MONITOR SYSTEM (blood-glucose meter)	DME	
BREEZE 2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREEZE 2 CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
BREEZE 2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
BULLSEYE MINI SAFETY LANCETS 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
BUTTERFLY TOUCH LANCET 30 GAUGE (lancets)	DME	
CAREONE LANCING DEVICE (lancing device)	DME	
CAREONE ULTRA THIN LANCET (lancets)	DME	
CARESENS CONTROL A AND B SOLUTION (blood glucose calibration control solution, high and normal)	DME	
CARESENS LANCETS 30 GAUGE (lancets)	DME	
CARESENS N (blood-glucose meter)	DME	
CARESENS N FELIZ BT GLUC METER (blood-glucose meter)	DME	
CARESENS N FELIZ GLUCOSE METER (blood-glucose meter)	DME	
CARESENS N PLUS BT KIT (blood-glucose meter)	DME	
CARESENS N VOICE (blood-glucose meter)	DME	
CARETOUCH CONTROL SOLN L2-L3 SOLUTION (blood glucose calibration control solution, high and normal)	DME	
CARETOUCH GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
CARETOUCH LANCING DEVICE (lancing device)	DME	
CARETOUCH SAFETY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
CARETOUCH TWIST LANCET 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
CEQUR SIMPLICITY INSERTER (diabetic supplies,miscell)	DME	
CHEMSTRIP BG LOG BOOK (diabetic supplies,miscell)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOICE DM CLARUS NORM CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CHOICEDM CLARUS (blood-glucose meter)	DME	
CHOSEN LANCET 30 GAUGE (lancets)	DME	
CHOSEN LANCING DEVICE (lancing device)	DME	
CHOSEN SAFETY LANCET 28 GAUGE (lancets)	DME	
CLEVER CHEK BLOOD GLUCOSE (blood-glucose meter)	DME	
CLEVER CHEK BLOOD GLUCOSE SYST KIT (blood-glucose meter)	DME	
CLEVER CHEK LANCETS 30 GAUGE (lancets)	DME	
CLEVER CHOICE BLOOD GLUC SYS (blood-glucose meter)	DME	
CLEVER CHOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
CLEVER CHOICE LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
CLEVER CHOICE LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CLEVER CHOICE LEVEL 3 CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
CLEVER CHOICE MICRO (blood-glucose meter)	DME	
CLEVER CHOICE PRO (blood-glucose meter)	DME	
CLEVER CHOICE TALK GLUCOSE SYS (blood-glucose meter)	DME	
COAGUCHEK LANCETS (lancets)	DME	
COLOR LANCETS 21 GAUGE (lancets)	DME	
COMFORT EZ LANCETS 23 GAUGE, 28 GAUGE (lancets)	DME	
COMFORT TOUCH PLUS SAFETY LANC 30 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT TOUCH ULT THIN LANCETS 31 GAUGE (lancets)	DME	
CONTOUR CONTROL SOLUTION, HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
CONTOUR CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR METER (blood-glucose meter)	DME	
CONTOUR NEXT EZ METER (blood-glucose meter)	DME	
CONTOUR NEXT GEN METER (blood-glucose meter)	DME	
CONTOUR NEXT GEN METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT GLUCOSE METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT LEV 1 CONTROL SOL SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR NEXT LEV 2 CONTROL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR NEXT LINK 2.4 KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT LINK KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT METER (blood-glucose meter)	DME	
CONTOUR NEXT ONE METER (blood-glucose meter)	DME	
CONTOUR PLUS BLUE METER (blood-glucose meter)	DME	
DEXCOM G6 RECEIVER (blood-glucose meter, receiver, continuous)	DME	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G6 SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEXCOM G6 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G7 RECEIVER (blood-glucose meter, receiver, continuous)	DME	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G7 SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DIATRUE CONTROL SOLN NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
DIATRUE CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
DIATRUE CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
DIATRUE PLUS BLOOD GLUCOSE MET (blood-glucose meter)	DME	
DROPLET GENTEEL LANCING DEVICE (lancing device)	DME	
DROPLET LANCETS 30 GAUGE (lancets)	DME	
DROPLET LANCING DEVICE (lancing device)	DME	
DROPSAFE ACTI-LANCE 23 GAUGE (lancets)	DME	
EASY COMFORT LANCETS 30 GAUGE (lancets)	DME	
EASY MINI EJECT LANCING DEVICE (lancing device)	DME	
EASY PLUS II BLOOD GLUCOSE MET (blood-glucose meter)	DME	
EASY PLUS II HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY PLUS II LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY STEP BLOOD GLUCOSE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY STEP HIGH CONTROL SOLN SOLUTION (blood glucose calibration control solution, high)	DME	
EASY STEP LOW CONTROL SOLUTION SOLUTION (blood glucose calibration control solution, low)	DME	
EASY STEP NORMAL CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY TALK BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY TALK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TALK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TALK PLUS II HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TALK PLUS II LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TOUCH BLU CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH BLULINK GLUC SYST (blood-glucose meter)	DME	
EASY TOUCH GLUCOSE MONITOR (blood-glucose meter)	DME	
EASY TOUCH HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH LANCING DEVICE (lancing device)	DME	
EASY TOUCH SAFETY LANCETS 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH TWIST LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
EASY TRAK BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY TRAK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TRAK II BLOOD GLUCOSE MTR (blood-glucose meter)	DME	
EASY TRAK II CTRL SOLN-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY TRAK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TWIST AND CAP LANCETS 28 GAUGE (lancets)	DME	
EASYGLUCO METER KIT (blood-glucose meter)	DME	
EASYGLUCO MONITORING SYSTEM KIT (blood-glucose meter)	DME	
EASYMAX 15 LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX NG (blood-glucose meter)	DME	
EASYMAX NG KIT (blood-glucose meter)	DME	
EASYMAX NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX T1 KIT (blood-glucose meter)	DME	
EASYMAX V SPEAKING GLUCOSE SYS (blood-glucose meter)	DME	
EASY-TOUCH BLOOD GLUCOSE METER (blood-glucose meter)	DME	
ELEMENT COMPACT GLUCOSE METER (blood-glucose meter)	DME	
ELEMENT COMPACT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELEMENT COMPACT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT COMPACT V GLUCOSE MTR (blood-glucose meter)	DME	
ELEMENT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ELEMENT LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
ELEMENT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT PLUS BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
EMBRACE BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
EMBRACE EVO BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
EMBRACE EVO GLUCOSE MONITOR (blood-glucose meter)	DME	
EMBRACE EVO LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE GLUCOSE CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE GLUCOSE CONTROL LOW SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE LANCETS 30 GAUGE (lancets)	DME	
EMBRACE LANCING DEVICE (lancing device)	DME	
EMBRACE PRO GLUCOSE METER (blood-glucose meter)	DME	
EMBRACE PRO SOLUTION (blood glucose calibration control solution, high and normal)	DME	
EMBRACE SAFETY LANCET 21 GAUGE, 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE TALK BLOOD GLUCOSE SYS KIT (blood-glucose meter)	DME	
EMBRACE TALK CONTROL-HIGH (L2) SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE TALK CONTROL-LOW (L1) SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE TALK GLUCOSE MONITOR (blood-glucose meter)	DME	
EMBRACE WAVE PLUS GLUCOSE MTR (blood-glucose meter)	DME	
EVENCARE G2 (blood-glucose meter)	DME	
EVENCARE G2 SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE G3 CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE G3 GLUCOSE METER KIT (blood-glucose meter)	DME	
EVENCARE KIT (blood-glucose meter)	DME	
EVENCARE MINI MONITOR SYSTEM (blood-glucose meter)	DME	
EVENCARE SOLUTION (blood glucose calibration control high and low)	DME	
EVERSENSE 365 SENSOR SUBCUTANEOUS DEVICE (glucose sensor,implantable,continuous/dexamethasone acetate)	Tier 3	PA; KP
EVERSENSE 365 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
EVOLUTION BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
EVOLUTION NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
E-Z JECT LANCETS , 26 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
E-Z JECT THIN LANCETS 28 GAUGE (lancets)	DME	
EZ SMART CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EZ SMART LANCETS 28 GAUGE (lancets)	DME	
EZ SMART PLUS SYSTEM KIT (blood-glucose meter)	DME	
EZ SMART SYSTEM KIT (blood-glucose meter)	DME	
FINGERSTIX LANCETS (lancets)	DME	
FORA D40D GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D40G GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA G20 KIT (blood-glucose meter)	DME	
FORA G30A (blood-glucose meter)	DME	
FORA GD50 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORA HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORA LANCING DEVICE (lancing device)	DME	
FORA LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORA NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORA PREMIUM V10 GLUCOSE METER (blood-glucose meter)	DME	
FORA TEST N'GO VOICE METER (blood-glucose meter)	DME	
FORA TN'G VOICE METER (blood-glucose meter)	DME	
FORA V12 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORACARE GD20 GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GD40B GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GDH HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORACARE GDH LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORACARE GDH NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORACARE LANCETS 30 GAUGE (lancets)	DME	
FREESTYLE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
FREESTYLE FLASH SYSTEM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM LITE KIT (blood-glucose meter)	DME	
FREESTYLE INSULINX (blood-glucose meter)	DME	
FREESTYLE LANCETS 28 GAUGE (lancets)	DME	
FREESTYLE LIBRE 14 DAY READER (flash glucose scanning reader)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 14 DAY SENSOR KIT (flash glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 2 PLUS SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 2 READER (flash glucose scanning reader)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 SENSOR KIT (flash glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 3 PLUS SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 3 READER (blood-glucose meter, receiver, continuous)	DME	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 3 SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LITE METER KIT (blood-glucose meter)	DME	
FREESTYLE PRECISION NEO METER (blood-glucose meter)	DME	
FREESTYLE SIDEKICK II KIT (blood-glucose meter)	DME	
FREESTYLE SYSTEM KIT KIT (blood-glucose meter)	DME	
FREESTYLE UNISTIK 2 (lancets)	DME	
GDRIVE KIT (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
GE100 CONTROL SOLUTION NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GE333 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GLUCO NAVII GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
GLUCOCARD 01 HI-NORMAL CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
GLUCOCARD 01 METER KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD 01 NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD EXPRESSION (blood-glucose meter)	DME	
GLUCOCARD EXPRESSION KIT (blood-glucose meter)	DME	
GLUCOCARD EXPRESSION SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD SHINE CONNEX METER (blood-glucose meter)	DME	
GLUCOCARD SHINE EXPRESS METER (blood-glucose meter)	DME	
GLUCOCARD SHINE METER (blood-glucose meter)	DME	
GLUCOCARD SHINE METER KIT KIT (blood-glucose meter)	DME	
GLUCOCARD SHINE SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD SHINE XL METER (blood-glucose meter)	DME	
GLUCOCARD VITAL KIT (blood-glucose meter)	DME	
GLUCOCOM AUTOLINK (diabetic supplies, miscell)	DME	
GLUCOCOM BLOOD GLUCOSE KIT (blood-glucose meter)	DME	
GLUCOCOM CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
GLUCOCOM CONTROL NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCOM LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOSE KETONE CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GM100 KIT (blood-glucose meter)	DME	
GOJJI GLUCOSE CNTRL SOL-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GOJJI LANCETS 30 GAUGE (lancets)	DME	
GOJJI LANCING DEVICE (lancing device)	DME	
GUARDIAN 4 GLUCOSE SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
GUARDIAN 4 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN CONNECT TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN LINK 3 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN SENSOR 3 DEVICE (blood-glucose sensor)	Tier 3	PA
HEALTHPRO GLUCOSE MONITOR (blood-glucose meter)	DME	
HEALTHPRO HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
HYPOLANCE AST LANCING KIT (lancing device/lancets)	DME	
IHEALTH CONTROL SOLN LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
IHEALTH GLUCO PLUS METER KIT (blood-glucose meter)	DME	
INCONTROL LANCING DEVICE (lancing device)	DME	
INCONTROL SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
INCONTROL ULTRA THIN LANCETS 28 GAUGE (lancets)	DME	
INFINITY CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
INFINITY CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
INFINITY CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFINITY METER KIT KIT (blood-glucose meter)	DME	
INFINITY STARTER KIT KIT (blood-glucose meter)	DME	
INJECT EASE LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
INSUL-CAP (diabetic supplies,miscell)	DME	
INSUL-EZE (diabetic supplies,miscell)	DME	
INVACARE LANCETS 30 GAUGE (lancets)	DME	
<i>lancets , 21 gauge, 26 gauge, 28 gauge, 30 gauge, 33 gauge</i>	DME	
LANCETS, SUPER THIN (lancets)	DME	
LANCETS,THIN , 28 GAUGE (lancets)	DME	
LANCETS,ULTRA THIN (lancets)	DME	
<i>lancing device</i>	DME	
LANCING DEVICE WITH LANCETS (lancing device)	DME	
<i>lancing device with lancets kit</i>	DME	
LANCING SYSTEM (lancing device)	DME	
LANZO LANCING DEVICE KIT (lancing device/lancets)	DME	
MEDISENSE COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE CONTROLS 1-HI 1-LO COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE GLUCOSE KETONE COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MEDISENSE THIN LANCETS 28 GAUGE (lancets)	DME	
MEDLANCE PLUS LANCETS 21 GAUGE, 25 GAUGE, 30 GAUGE (lancets)	DME	
MEDLANCE PLUS SPECIAL BLADE 0.8 X 2 MM (blade lancet, safety)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
METER-CHECK SOLUTION (blood glucose calibration control solution, normal)	DME	
MICRO THIN LANCETS 33 GAUGE (lancets)	DME	
MICRODOT BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
MICRODOT HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
MICRODOT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MICROLET 2 LANCING DEVICE KIT (lancing device/lancets)	DME	
MICROLET LANCET (lancets)	DME	
MICROLET NEXT LANCING DEVICE KIT (lancing device/lancets)	DME	
MINI LANCING DEVICE (lancing device)	DME	
MINIMED QUICK-SERTER (MMT-395) (diabetic supplies, miscell)	DME	
MOBILE LANCETS 30 GAUGE (lancets)	DME	
MONOLET LANCETS 21 GAUGE (lancets)	DME	
MONOLET THIN LANCETS 28 GAUGE (lancets)	DME	
MULTI-LANCET DEVICE 2 KIT (lancing device/lancets)	DME	
MYGLUCOHEALTH CONTROL SOLUTION SOLUTION (blood glucose calibration control solutions high, normal, low)	DME	
MYGLUCOHEALTH KIT (blood-glucose meter)	DME	
MYGLUCOHEALTH LANCETS 30 GAUGE (lancets)	DME	
NOVA SAFETY LANCETS 23 GAUGE, 28 GAUGE (lancets)	DME	
NOVA SUREFLEX LANCETS (lancets)	DME	
NOVAMAX PLUS GLU-KET SOLUTION (blood glucose and ketone control, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ON CALL EXPRESS CONTROL SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
ON CALL EXPRESS METER (blood-glucose meter)	DME	
ON CALL EXPRESS METER KIT (blood-glucose meter)	DME	
ON CALL LANCET 30 GAUGE (lancets)	DME	
ON CALL LANCING DEVICE (lancing device)	DME	
ONETOUCH DELICA PLUS LANC DEV KIT (lancing device/lancets)	DME	
ONETOUCH DELICA PLUS LANCET 30 GAUGE, 33 GAUGE (lancets)	DME	
ONETOUCH DELICA SAFETY LANCET 30 GAUGE (lancets)	DME	
ONETOUCH ULTRA CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH ULTRA2 METER (blood-glucose meter)	DME	
ONETOUCH ULTRASOFT 2 LANCET 30 GAUGE (lancets)	DME	
ONETOUCH VERIO FLEX METER (blood-glucose meter)	DME	
ONETOUCH VERIO HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ONETOUCH VERIO MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH VERIO REFLECT METER (blood-glucose meter)	DME	
ON-THE-GO LANCETS 30 GAUGE (lancets)	DME	
OVAL TAPE (diabetic supplies,miscell)	DME	
PERFECT POINT SAFETY LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
PHARMACIST CHOICE GLUCOSE SYS (blood-glucose meter)	DME	
PIP BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PIP GLUCOSE CONTROL SOLN L1-L2 SOLUTION (blood glucose calibration control high and low)	DME	
PIP LANCET 28 GAUGE, 30 GAUGE (lancets)	DME	
PRECISION (blood-glucose meter)	DME	
PRECISION GLUCOSE CONTROL SOLN COMBO PACK (blood-glucose calib. control)	DME	
PRECISION GLUCOSE/KETONE CONTR COMBO PACK (blood-glucose calib. control)	DME	
PRECISION XTRA MONITOR (blood-glucose meter)	DME	
PREMIER BLU GLUCOSE METER (blood-glucose meter)	DME	
PREMIER CLASSIC GLUCOSE METER (blood-glucose meter)	DME	
PREMIER COMPACT GLUCOSE METER KIT (blood-glucose meter)	DME	
PREMIER VOICE GLUCOSE METER (blood-glucose meter)	DME	
PREMIUM BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	
PREMIUM V10 (blood-glucose meter)	DME	
PRESSURE ACTIVATED LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
PRO COMFORT LANCET 30 GAUGE, 31 GAUGE (lancets)	DME	
PRO COMFORT SAFETY LANCET 30 GAUGE (lancets)	DME	
PRO VOICE V9 GLUCOSE MONITOR (blood-glucose meter)	DME	
PRODIGY AUTOCODE METER KIT (blood-glucose meter)	DME	
PRODIGY AUTOCODE MONITOR SYST (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
PRODIGY CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
PRODIGY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
PRODIGY LANCING DEVICE (lancing device)	DME	
PRODIGY POCKET METER KIT (blood-glucose meter)	DME	
PRODIGY TWIST TOP LANCET 28 GAUGE (lancets)	DME	
PRODIGY VOICE GLUCOSE METER KIT (blood-glucose meter)	DME	
PURE COMFORT LANCETS 30 GAUGE (lancets)	DME	
PURE COMFORT SAFETY LANCETS 30 GAUGE (lancets)	DME	
PUSH BUTTON SAFETY LANCETS 28 GAUGE (lancets)	DME	
QUINTET AC (blood-glucose meter)	DME	
QUINTET BLOOD GLUCOSE METER (blood-glucose meter)	DME	
REFUAH PLUS GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
REFUAH PLUS GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
RELIAMED LANCET 28 GAUGE, 30 GAUGE (lancets)	DME	
RELIAMED MINI LANCING DEVICE (lancing device)	DME	
RELIAMED SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
RELION ALL-IN-ONE METER KIT (blood-glucose meter)	DME	
RELION CONFIRM KIT (blood-glucose meter)	DME	
RELION MICRO GLUCOSE MONITOR (blood-glucose meter)	DME	
RELION MICRO GLUCOSE MONITOR KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELION PRIME METER (blood-glucose meter)	DME	
REVEAL BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
RIGHTEST CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
RIGHTEST CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GD500 LANCING DEVICE (lancing device)	DME	
RIGHTEST GL300 LANCETS 30 GAUGE (lancets)	DME	
RIGHTEST GM550 SYSTEM KIT (blood-glucose meter)	DME	
RIGHTEST GT333 GLUCOSE METER (blood-glucose meter)	DME	
SAFETY LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SAFETY-LET LANCETS 30 GAUGE (lancets)	DME	
SIMPLERA SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
SIMPLERA SYNC SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
SINGLE-LET (lancets)	DME	
SMART SENSE LANCETS 21 GAUGE, 26 GAUGE, 33 GAUGE (lancets)	DME	
SMART SENSE MONITORING SYSTEM (blood-glucose meter)	DME	
SMARTDIABETES VANTAGE (lancing device)	DME	
SMARTEST CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
SMARTEST EJECT KIT (blood-glucose meter)	DME	
SMARTEST LANCET (lancets)	DME	
SMARTEST PERSONA GLUCOSE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMARTEST PERSONA STARTER KIT (blood-glucose meter)	DME	
SMARTEST PRONTO GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PRONTO STARTER KIT (blood-glucose meter)	DME	
SMARTEST PROTEGE KIT (blood-glucose meter)	DME	
SMARTEST SMART CODE METER KIT (blood-glucose meter)	DME	
SMARTEST TALKING METER KIT (blood-glucose meter)	DME	
SOLUS V2 AUDIBLE METER (blood-glucose meter)	DME	
SOLUS V2 AUDIBLE METER KIT (blood-glucose meter)	DME	
SOLUS V2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
SOLUS V2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
SOLUS V2 LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SOLUS V2 LANCING DEVICE KIT (lancing device/lancets)	DME	
STERILANCE TL 30 GAUGE, 32 GAUGE (lancets)	DME	
SUPER THIN LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SURE COMFORT LANCETS 18 GAUGE, 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
SURE COMFORT LANCING PEN (lancing device)	DME	
SUREFLEX DEVICE WITH LANCETS KIT (lancing device/lancets)	DME	
SUREFLEX LANCING DEVICE (lancing device)	DME	
SURE-LANCE , 26 GAUGE, 28 GAUGE (lancets)	DME	
SURE-LANCE ULTRA THIN 30 GAUGE (lancets)	DME	
SURE-PEN LANCING DEVICE (lancing device)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURE-TEST EASYPLUS MINI METER (blood-glucose meter)	DME	
SURE-TEST EASYPLUS MINI SOLUTION (blood glucose calibration control solution, normal)	DME	
SURE-TOUCH LANCET (lancets)	DME	
TD GOLD LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
TD GOLD LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
TECHLITE LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
TELCARE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
TELCARE LANCETS 30 GAUGE (lancets)	DME	
TEMPO REFILL KIT WITH GAUZE KIT (lancets/blood glucose test strips/pen needles/gauze)	DME	
TEMPO WELCOME KIT KIT (blood glucose meter/insulin data transf accessory, bluetooth)	Tier 3	
TEST N'GO BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
THIN LANCETS 26 GAUGE (lancets)	DME	
TOPCARE UNIVERSAL1 LANCET , 33 GAUGE (lancets)	DME	
TRUE COMFORT LANCET 30 GAUGE (lancets)	DME	
TRUE METRIX AIR GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX AIR GLUCOSE METER KIT (blood-glucose meter)	DME	
TRUE METRIX GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX GO GLUCOSE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE METRIX LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
TRUE METRIX LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
TRUE METRIX LEVEL 3 SOLUTION (blood glucose calibration control solution, high)	DME	
TRUE2GO BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUEDRAW LANCING DEVICE (lancing device)	DME	
TRUEPLUS LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
TRUERESULT BLOOD GLUCOSE SYSTM KIT (blood-glucose meter)	DME	
TRUETRACK BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUETRACK SMART SYSTEM KIT (blood-glucose meter)	DME	
TWIST LANCETS 30 GAUGE, 32 GAUGE (lancets)	DME	
ULTI-LANCE (lancing device)	DME	
ULTI-LANCE KIT (lancing device/lancets)	DME	
ULTILET BASIC LANCETS 30 GAUGE (lancets)	DME	
ULTILET CLASSIC LANCETS , 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET SAFETY LANCETS 23 GAUGE (lancets)	DME	
ULTIMA MONITOR (blood-glucose meter)	DME	
ULTRA THIN II LANCETS 30 GAUGE (lancets)	DME	
ULTRA THIN LANCETS , 28 GAUGE, 30 GAUGE, 31 GAUGE (lancets)	DME	
ULTRA THIN PLUS LANCETS 33 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA TLC LANCETS (lancets)	DME	
ULTRA-CARE LANCETS 30 GAUGE (lancets)	DME	
ULTRALANCE LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
ULTRA-THIN II LANCETS 28 GAUGE (lancets)	DME	
ULTRATRAK GLUCOSE METER (blood-glucose meter)	DME	
ULTRATRAK GLUCOSE METER KIT (blood-glucose meter)	DME	
ULTRATRAK HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ULTRATRAK NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ULTRATRAK ULTIMATE (blood-glucose meter)	DME	
ULTRATRAK ULTIMATE SOLUTION (blood glucose calibration control high and low)	DME	
UNILET COMFORTOUCH LANCET , 26 GAUGE (lancets)	DME	
UNILET GP LANCET (lancets)	DME	
UNILET LANCET 28 GAUGE, 33 GAUGE (lancets)	DME	
UNILET LANCETS 30 GAUGE (lancets)	DME	
UNILET SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
UNISTIK 2 DEVICE KIT (lancing device/lancets)	DME	
UNISTIK 2 EXTRA LANCET 21 GAUGE (lancets)	DME	
UNISTIK 2 NORMAL LANCET 21 GAUGE (lancets)	DME	
UNISTIK 3 COMFORT LANCET 28 GAUGE (lancets)	DME	
UNISTIK 3 EXTRA LANCET 21 GAUGE (lancets)	DME	
UNISTIK 3 GENTLE 30 GAUGE (lancets)	DME	
UNISTIK 3 NORMAL LANCET 23 GAUGE (lancets)	DME	
UNISTIK COMFORT LANCETS 28 GAUGE (lancets)	DME	
UNISTIK CZT LANCET 23 GAUGE, 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNISTIK EXTRA LANCETS 21 GAUGE (lancets)	DME	
UNISTIK NORMAL LANCETS 23 GAUGE (lancets)	DME	
UNISTIK PRO LANCET 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK SAFETY 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTIK TOUCH LANCETS 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTRIP LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
UNIVERSAL 1 LANCETS 21 GAUGE, 26 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
VERIFINE SAFETY LANCET MINI 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
VERIFINE UNIVERSAL LANCET 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
VIVAGUARD INO CTRL SOLN-L1,2,3 SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
VIVAGUARD INO CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
VIVAGUARD INO CTRL SOLN-L2 SOLUTION (blood glucose calibration control solution, normal)	DME	
VIVAGUARD INO GLUCOSE METER (blood-glucose meter)	DME	
VIVAGUARD INO SMART GLUC METER (blood-glucose meter)	DME	
VIVAGUARD LANCET 30 GAUGE (lancets)	DME	
VIVAGUARD LANCING DEVICE (lancing device)	DME	
VIVAGUARD SAFETY LANCET 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Incontinence Supplies - Medical Supplies And Durable Medical Equipment		
CURITY DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
FLEXI-SEAL SIGNAL FMS RECTAL (fecal collector with charcoal filter/catheter/syringe)	Tier 3	
MONO-FLO DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
NIGHTTIME UNDERPANTS L-XL (diaper,brief,youth,disposable)	Tier 3	
TENSCARE ITOUCH SURE VAGINAL DEVICE (incont device,muscle toner,elt)	Tier 3	
YONI FIT BLADDER SUPPORT VAGINAL 34-38 MM, 34-38-42 MM, 42-45 MM, 45-48-52 MM, 48-52 MM (pessary)	Tier 3	
Medical Supplies And Dme - Infant Diapers - Medical Supplies And Durable Medical Equipment		
BOYS TRAINING PANTS 4T-5T (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 1 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 2 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 3 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 4 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 5 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 6 (diaper/brief,infant-toddler, disposable)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GIRLS TRAINING PANTS 4T-5T (diaper/brief,infant-toddler, disposable)	Tier 3	
Medical Supplies And Dme - Insulin Needles- Syringes And Admin Supplies - Medical Supplies And Durable Medical Equipment		
1ST TIER UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
1ST TIER UNIFINE PENTIPS PLUS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ADVOCATE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ADVOCATE SYRINGES SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
AQINJECT PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ASSURE ID DUO PRO SFTY PEN NDL NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
ASSURE ID PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
ASSURE ID PRO PEN NEEDLE NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTOJECT 2 INJECTION DEVICE SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOPEN 1 TO 21 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOPEN 2 TO 42 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOSHIELD DUO PEN NEEDLE NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 30 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 1 ML 27 GAUGE X 5/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
CAREFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARETOUCH INSULIN SYRINGE SYRINGE 1 ML 28 X 5/16", 1 ML 29 GAUGE X 5/16, 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
CARETOUCH PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CLICKFINE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
COMFORT EZ PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
COMFORT EZ PRO SAFETY PEN NDL NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT TOUCH PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 31 GAUGE X 5/32", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 1/4", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16", 0.5ML 30 GAUGE X 15/64" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
DROPLET MICRON PEN NEEDLE NEEDLE 34 GAUGE X 9/64" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DROPLET PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
DROPSAFE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
DROPSAFE INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
DROPSAFE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16", 0.3 ML 31 X 1/2" (syringe with needle, insulin, 0.3 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 29 X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle, insulin, 0.5 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16", 1 ML 32 GAUGE X 5/16" (syringe with needle, disposable, insulin 1 mL)	Tier 1	
EASY COMFORT PEN NEEDLES NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/32", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.3 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY GLIDE PEN NEEDLE NEEDLE 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY TOUCH LUER LOCK INSULIN SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
EASY TOUCH NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY TOUCH PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
EASY TOUCH SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16", 30 GAUGE X 1/4", 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH UNI-SLIP SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
EMBRACE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 3/16", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EXEL INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.3 mL)	Tier 1	
EXEL INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
EXEL INSULIN SYRINGE 1 ML 30 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXTENDED RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
FREESTYLE PRECISION SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
FREESTYLE PRECISION SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
HEALTHWISE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INCONTROL PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INPEN (FOR HUMALOG) BLUE SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin lispro)	DME	KP
INPEN (FOR HUMALOG) GREY SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin lispro)	DME	KP
INPEN (FOR HUMALOG) PINK SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin lispro)	DME	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INPEN (NOVOLOG OR FIASP) BLUE SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin aspart)	DME	KP
INPEN (NOVOLOG OR FIASP) GREY SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin aspart)	DME	KP
INPEN (NOVOLOG OR FIASP) PINK SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin aspart)	DME	KP
<i>insulin syringe u100 half mark syringe 0.3 ml 31 gauge x 1/4"</i>	Tier 1	
INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 0.3 ml 29 gauge x 1/2", 0.3 ml 30, 0.3 ml 30 gauge x 1/2", 0.3 ml 30 gauge x 5/16", 0.3 ml 31 gauge x 1/4", 0.3 ml 31 gauge x 15/64", 0.3 ml 31 gauge x 5/16", 0.5 ml 29 gauge x 1/2", 0.5 ml 30 gauge x 1/2", 0.5 ml 30 gauge x 5/16", 0.5 ml 31 gauge x 5/16", 1 ml 27 gauge x 1/2", 1 ml 27 gauge x 5/8", 1 ml 28 gauge, 1 ml 28 gauge x 1/2", 1 ml 29 gauge x 1/2", 1 ml 29 gauge x 7/16", 1 ml 30 gauge x 1/2", 1 ml 30 gauge x 3/8", 1 ml 30 gauge x 5/16, 1 ml 30 gauge x 7/16", 1 ml 31 gauge x 1/4", 1 ml 31 gauge x 15/64", 1 ml 31 gauge x 5/16, 1/2 ml 27 gauge x 1/2", 1/2 ml 28 gauge, 1/2 ml 28 gauge x 1/2", 1/2 ml 29, 1/2 ml 30 gauge, 1/2 ml 31 gauge x 1/4", 1/2 ml 31 gauge x 15/64"</i>	Tier 1	
<i>insulin u-500 syringe-needle syringe 1/2 ml 31 gauge x 15/64"</i>	Tier 1	
INSUPEN PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.3 ML 30 X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAXICOMFORT II PEN NEEDLE NEEDLE 31 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1/2 ML 27 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
MINI ULTRA-THIN II NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 1 ML , 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
NANO 2ND GEN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
NANO PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
NOVOFINE 32 NEEDLE 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVOFINE PLUS NEEDLE 32 GAUGE X 1/6" (pen needle, diabetic)	Tier 1	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
OMNIPOD DASH PDM KIT (GEN 4) (insulin pump controller)	Tier 2	
PARADIGM RESERVOIR 1.8 ML (insulin pump syringe, 1.8 mL)	Tier 1	
PARADIGM RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
<i>pen needle, diabetic needle 29 gauge x 1/2", 30 gauge x 3/16", 30 gauge x 5/16", 31 gauge x 1/4", 31 gauge x 3/16", 31 gauge x 5/16", 31 gauge x 5/32", 32 gauge x 1/4", 32 gauge x 3/16", 32 gauge x 5/16", 32 gauge x 5/32", 33 gauge x 1/4", 33 gauge x 3/16", 33 gauge x 5/32"</i>	Tier 1	
<i>pen needle, diabetic needle 29 gauge x 15/32", 31 gauge x 1/3", 31 gauge x 1/6", 31 gauge x 13/64", 31 gauge x 15/64"</i>	Tier 1	
<i>pen needle, diabetic, safety needle 31 gauge x 3/16", 31 gauge x 5/32"</i>	Tier 1	
PENTIPS PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PIP PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PREVENT DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRO COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
PRO COMFORT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PRO COMFORT PEN NEEDLE NEEDLE 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PURE COMFORT PEN NEEDLE NEEDLE 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16" (syringe w-needle 0.3 mL,insulin,safety w-self-cont.dis.unit)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (insulin syringe-needle,safety,disposal unit,0.5 mL)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle 1 mL,insulin,safety w-self-con.disp.unit)	Tier 1	
SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SECURESAFE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
SECURESAFE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
SECURESAFE PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
SIMPLI PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SKY SAFETY PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
SURE COMFORT INS. SYR. U-100 SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, 0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 1/4", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, 0.3 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 31 GAUGE X 1/4" (syringe with needle, insulin, 0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 5/16" (syringe with needle, disposable, insulin 1 mL)	Tier 1	
SURE COMFORT PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURE-FINE PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
TECHLITE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TECHLITE PLUS PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.3 ML 30 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TERUMO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 X 3/8", 0.3 ML 31 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 X 3/8", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 3/8", 1 ML 31 X 3/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TOPCARE CLICKFINE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16", 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE COMFORT SAFE INSULIN SYRG SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
TRUE COMFORT SAFE INSULIN SYRG SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16", 1 ML 32 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
TRUE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
TRUEPLUS INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUEPLUS INSULIN SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUEPLUS PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 1/4" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTICARE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTICARE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTICARE SAFETY PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
ULTICARE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTICARE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTICARE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTIGUARD SAFEPACK-INSULIN SYR SYRINGE 0.3 ML 30 X 1/2", 0.3 ML 31 X 5/16" (syringe with needle,insulin disposable,0.3 mL/empty containr)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1 ML 30 X 1/2", 1 ML 31 X 5/16" (syringe with needle, insulin, 1 mL and sharps container)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1/2 ML 30 X 1/2", 1/2 ML 31 X 5/16" (syringe-needle, insulin, 0.5 mL/container, empty)	Tier 1	
ULTIGUARD SAFEPAK-PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, remover and disposal unit)	Tier 1	
ULILET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE, 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, 0.3 mL)	Tier 1	
ULILET INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 29 (syringe with needle, insulin, 0.5 mL)	Tier 1	
ULILET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, disposable, insulin 1 mL)	Tier 1	
ULILET PEN NEEDLE NEEDLE 29 GAUGE, 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA CMFT INS SYR (HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30, 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, 0.3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE, 1/2 ML 28 GAUGE X 1/2", 1/2 ML 29 , 1/2 ML 30 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 30 GAUGE X 7/16", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA FLO INSUL SYR(HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA FLO PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA THIN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRACARE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA-FINE INS SYR (HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA-FINE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA-FINE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-FINE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-FINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-THIN II (SHORT) PEN NDL NEEDLE 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INS PEN NEEDLES NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA-THIN II INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
UNIFINE OTC PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS MAXFLOW NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS PLUS MAXFLOW NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS PLUS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PROTECT NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
UNIFINE SAFECONTROL PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
UNIFINE ULTRA PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VANISHPOINT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 3/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANISHPOINT SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
VERIFINE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
VERIFINE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
VERIFINE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
VERIFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VERIFINE PLUS PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VERIFINE PLUS PEN NEEDLE-SHARP NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic, remover and disposal unit)	Tier 1	
Medical Supplies And Dme - Iv Sets-Tubing - Medical Supplies And Durable Medical Equipment		
BD INSYTE AUTOGUARD INFUSION SET 22 GAUGE X 1", 24 GAUGE X 3/4" (intravenous catheter)	Tier 3	
BD SAF-T-INTIMA INFUSION SET 22 GAUGE X 3/4" (intravenous catheter kit)	Tier 3	
INSYTE IV CATHETER INFUSION SET 14 X 1.75 ", 20 X 1.16 " (intravenous catheter)	Tier 3	
IVENIX ADMIN SET 2INLET 2YSITE INFUSION SET (intravenous administration set)	Tier 3	
IVENIX ADMIN SET 2INLET Y-SITE INFUSION SET (intravenous administration set)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEXIVA INFUSION SET 18 X 1 1/4 ", 18 X 1 3/4 ", 20 GAUGE X 1", 20 X 1 1/4 ", 20 X 1 3/4 ", 22 GAUGE X 1", 24 GAUGE X 3/4", 24 X 0.56 " (intravenous catheter)	Tier 3	
PHASEAL SECONDARY SET INFUSION SET (intravenous piggyback administration set)	Tier 3	
PHASEAL Y-SITE (y-site line connector, closed system)	Tier 3	
Medical Supplies And Dme - Male Condoms - Medical Supplies And Durable Medical Equipment		
AIMSCO LATEX CONDOM DEVICE (condoms, latex, lubricated)	PV	
DUREX AVANTI BARE REAL FEEL (condoms, non-latex, lubricated)	PV	
DUREX EXTRA SENSITIVE CONDOM DEVICE (condoms, latex, lubricated)	PV	
DUREX TROPICAL CONDOM DEVICE (condoms, latex, lubricated)	PV	
FANTASY CONDOM DEVICE (condoms, latex, lubricated)	PV	
KIMONO LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
KIMONO MICROTHIN AQUA LUBE CON DEVICE (condoms, latex, lubricated)	PV	
KIMONO MICROTHIN CONDOMS DEVICE (condoms, latex, non-lubricated)	PV	
KIMONO MICROTHIN LARGE CONDOMS DEVICE (condoms, latex, lubricated)	PV	
KIMONO TEXTURED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
KIMONO THIN LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TROJAN ULTRA RIBBED CONDOM DEVICE (condoms, latex, lubricated)	PV	
TRUE COVER CONDOM DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX LATEX CONDOM DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX NON-LUB CONDOMS DEVICE (condoms, latex, non-lubricated)	PV	
TRUSTEX-RIA LUB/SPERMICIDE DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX-RIA LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX-RIA NON-LUB CONDOMS DEVICE (condoms, latex, non-lubricated)	PV	
Medical Supplies And Dme - Male Erectile Dysfunction Aids - Medical Supplies And Durable Medical Equipment		
RAPPORT VACUUM THERAPY KIT (vacuum erection device system)	Tier 3	
Medical Supplies And Dme - Miscellaneous Other - Medical Supplies And Durable Medical Equipment		
AIRS PEDIATRIC DISPOSABLE MASK (nebulizer accessories)	Tier 3	
AMIELLE VAGINAL TRAINER KIT (medical supply, miscellaneous)	Tier 3	
ARGYLE TRACHEOSTOMY CARE TRAY (medical supply, miscellaneous)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIGFOOT UNITY PEN CAP-ADMELOG DEVICE (data transfer pen cap for insulin lispro, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-APIDRA DEVICE (data transfer pen cap for insulin glulisine, reusable, BT)	Tier 3	
BIGFOOT UNITY PEN CAP-ASPART DEVICE (data transfer pen cap for insulin aspart, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-BASAGLAR DEVICE (data transfr pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-FIASP DEVICE (data transfer pen cap for insulin aspart (B3), reusable, BT)	Tier 3	
BIGFOOT UNITY PEN CAP-HUMALOG DEVICE (data transfer pen cap for insulin lispro, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-LANTUS DEVICE (data transfr pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-LISPRO DEVICE (data transfer pen cap for insulin lispro, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-LYUMJEV DEVICE (data transfer pen cap for insulin lispro-aabc, reusable, BT)	Tier 3	
BIGFOOT UNITY PEN CAP-NOVOLOG DEVICE (data transfer pen cap for insulin aspart, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-TOUJEO DEVICE (data transfr pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-TOUJEOMX DEVICE (data transfr pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-TRESIBA DEVICE (data transfer pen cap for insulin degludec, reusable, BT)	Tier 3	
CEFALY COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	
ENFIT MEDICAL STRAW (medical supply, miscellaneous)	Tier 3	
ENFIT MEDICINE BOTTLE ADAPTER (adapter cap for bottle)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>eua patient assessment</i>	Tier 3	
PRO COMFORT TENS ELECTRODE PAD (tens unit electrodes)	Tier 3	
PRO COMFORT TENS UNIT COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	
PRO-CEPTION VAGINAL (medical supply, miscellaneous)	Tier 3	
RECONSTITUTE KIT (medical supply, miscellaneous)	Tier 3	
T.E.D. ANTI-EMBOLISM STOCKING (compression stocking, knee high, regular length, small)	Tier 3	
T:FLEX SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	KP
T:SLIM X2 SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	KP
TEMPO SMART BUTTON DEVICE (data transfer accessory (insulin pen), bluetooth)	Tier 3	
TENS 502 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
TENS 504 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
VIBRANT ORAL CAPSULE (vibrating transient device for constipation)	Tier 3	
VIBRANT STARTER KIT COMBO PACK (vibrating transient device for constipation)	Tier 3	
Medical Supplies And Dme - Nebulizers - Medical Supplies And Durable Medical Equipment		
AEROECLIPSE II NEBULIZER (nebulizer)	Tier 3	
AEROECLIPSE XL NEBULIZER (nebulizer)	Tier 3	
AERONEB GO NEBULIZER (nebulizer)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIRS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
ALTERA NEBULIZER HANDSET (nebulizer)	Tier 3	
ALTERA NEBULIZER SYSTEM (nebulizer)	Tier 3	
AURA PORTANEB (nebulizer)	Tier 3	
DEVILBISS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
INNOSPIRE GO NEBULIZER (nebulizer)	Tier 3	
LC PLUS (nebulizer)	Tier 3	
LC PLUS NEBULIZER-PED MASK (nebulizer)	Tier 3	
MC 300 NEBULIZER W-MOUTHPIECE (nebulizer)	Tier 3	
MC 300 NEBULIZER-UNVRSL TUBING (nebulizer)	Tier 3	
MICROAIR MESH NEBULIZER (nebulizer)	Tier 3	
MINI PLUS NEBULIZER (nebulizer)	Tier 3	
PARI LC SPRINT NEBULIZER SET (nebulizer)	Tier 3	
PARI LC SPRINT SINUS (nebulizer)	Tier 3	
PRODIGY MINI-MIST NEBULIZER (nebulizer)	Tier 3	
SIDESTREAM (nebulizer)	Tier 3	
SIDESTREAM NEBULIZER (nebulizer)	Tier 3	
SIDESTREAM PLUS (nebulizer)	Tier 3	
SINUSTAR NEBULIZER (nebulizer)	Tier 3	
SOOTHENEB MESH NEBULIZER (nebulizer)	Tier 3	
Medical Supplies And Dme - Needles And Syringes - Medical Supplies And Durable Medical Equipment		
ALLERGIST TRAY 1/2 ML 27GX3/8" SYRINGE 1/2 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 0.5 mL)	Tier 1	
ALLERGIST TRAY INTRADERMAL BEV SYRINGE 1 ML 26 GAUGE X 1/2", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALLERGIST TRAY REGULAR BEVEL SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ALLERGIST TRAY REG BEVEL SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ALLERGIST TRAY REG BEVEL TRAY 1/2 ML 27 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
BD ALLERGY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD BLUNT PLASTIC CANNULA SYRINGE 17 X 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
BD BULK SYRINGE SLIP TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD BULK SYRINGE SLIP TIP SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD ECCENTRIC TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD ECLIPSE LUER-LOK NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 23 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 23 X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD FILTER NEEDLE-5 MICRON NEEDLE 19 X 1 1/2 " (needles, filter)	Tier 3	
BD INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD INTEGRA SYRINGE SYRINGE 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
BD INTERLINK BLUNT PLASTIC CAN SYRINGE 17 X 5 ML (syringe with cannula, disposable, 5 mL)	Tier 1	
BD INTERLINK SYRINGE SYRINGE 17 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
BD LUER-LOK BULK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 1 ML 20 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 10 ML 20 X 1 1/2", 10 ML 20 X 1", 10 ML 21 GAUGE X 1", 10 ML 21 X 1 1/2" (syringe with needle,disposable, 10 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML 18 X 1 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2 ", 3 ML 25 X 5/8", 3 ML 26 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1" (syringe with needle,disposable, 5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD LUER-LOK TIP CONTROL SYRING SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD PRECISIONGLIDE NEEDLE 27 GAUGE X 3/8" (needles, disposable)	Tier 3	
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE NEEDLE NEEDLE 23 GAUGE X 1 1/2" (needles, safety)	Tier 3	
BD SAFETYGLIDE SHIELDING REG SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE SHIELDING REG SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD SAFETYGLIDE TB REG BEVEL SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE TUBERCULIN SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 1 ML 26 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
B-D SLIP TIP SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SLIP TIP SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SPECIALTY USE NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
BD SYRINGE CATH TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE CATHETER TIP SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD SYRINGE-DUAL CANNULA SYRINGE 10 ML 20 GAUGE AND 17 GAUGE (syringe with needle and cannula, disposable, 10 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD TUBERCULIN SLIP-TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD TUBERCULIN SLIP-TIP SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1 ML 21 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1/2 ML 27 X 1/2 " (syringe with needle,disposable, 0.5 mL)	Tier 1	
<i>blunt needle, disposable needle 18 x 1 1/2 "</i>	Tier 3	
CAREPOINT LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CAREPOINT LUER LOCK SYR-NEEDLE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
CAREPOINT LUER SLIP SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CAREPOINT LUER SLIP SYRING-NDL SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
CAREPOINT PRECISION LUER LOCK SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CAREPOINT PRECISION NEEDLE NEEDLE 20 GAUGE X 1", 21 GAUGE X 1" (needles, disposable)	Tier 3	
CAREPOINT PRECISION SAFETY SYRINGE 1 ML 23 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
CAREPOINT SAFETY LL SYR-NEEDLE SYRINGE 1 ML 25 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
CARETOUCH LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARETOUCH LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CARETOUCH LUER LOCK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
CARETOUCH LUER LOCK SYR-NEEDLE SYRINGE 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
DAVOL IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
DAVOL PISTON IRRIGATION SYRINGE (syringe disposable irrigation)	Tier 1	
DOVER BULB SYRINGE SYRINGE 60 ML (syringe disposable irrig,60 mL)	Tier 1	
DROPSAFE SICURA SAFETY NEEDLE NEEDLE 25 GAUGE X 1" (needles, safety)	Tier 3	
EASY GLIDE CATHETER TIP SYRING SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY GLIDE LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE LUER SLIP TB SYRING SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY TOUCH FLIPLOCK NEEDLE NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 10 ML 18 GAUGE X 1 1/2", 10 ML 18 GAUGE X 1", 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 3 ML 18 GAUGE X 1 1/2", 3 ML 18 GAUGE X 1", 3 ML 19 GAUGE X 1 1/2", 3 ML 19 GAUGE X 1", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 5 ML 18 GAUGE X 1", 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1", 5 ML 25 GAUGE X 5/8" (syringe,safety with needle,5 mL)	Tier 1	
EASY TOUCH FLURINGE FLIPLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH FLURINGE SHEATHLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH HYPODERMIC NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 10 ML 21 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 5 ML 21 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1" (syringe,safety with needle,5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
EASY TOUCH TUBERCULIN FLIPLOCK SYRINGE 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH TUBERCULIN SHEATHLK SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH UNI-SLIP SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASYPPOINT NEEDLE NEEDLE 25 GAUGE X 1 1/2" (needles, safety)	Tier 3	
ECLIPSE NEEDLE NEEDLE 23 GAUGE X 1", 25 GAUGE X 5/8" (needles, safety)	Tier 3	
ECLIPSE SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
EXCEL SYRINGE SYRINGE 3 ML 23 X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL HYPODERMIC NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXEL SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EXEL SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
EXEL SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
INTERLINK SYRINGE AND CANNULA SYRINGE 15 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
LUER LOCK SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
LUER SLIP TIP SYRINGE TRAY SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
LUER-LOK TIP SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
MAGELLAN SAFETY SYRINGE SYRINGE 1 ML 23 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT 140CC PISTON SYRINGE SYRINGE (syringe, disposable)	Tier 1	
MONOJECT 35CC SYRINGE CATH TIP SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT 3CC SYR 25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT ALLERGY TRAY DETACH TRAY 1 ML 27 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 0.5 ML 28 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 1 ML 28 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT CONTROL SYRINGE LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT DISPOSABLE SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT HYPODERMIC NEEDLES NEEDLE 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1 1/2", 27 GAUGE X 1/2", 30 GAUGE X 3/4" (needles, disposable)	Tier 3	
MONOJECT LUER-LOCK TIP SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT LUER-LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT MAGELLAN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT MAGELLAN SYRINGE SYRINGE 3 ML 20 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT PHARMACY TRAY LUER SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT PHARMACY TRAY REG TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SAFETY LUER LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SAFETY SYRINGES SYRINGE 12 ML 20 X 1 1/2", 12 ML 21X 1 1/2" (syringe,safety with needle,12 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 6 ML (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 12 ML (syringe with cannula,disposable 12 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 6 ML (syringe with cannula, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE REGULAR LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 12 ML 18 GAUGE X 1", 12 ML 20 X 1 1/2", 12 ML 21 GAUGE X 1 1/2", 12 ML 21 GAUGE X 1" (syringe with needle,disposable, 12 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 140 ML (syringe, disposable, 140 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 20 X 3/4", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/4", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML 20 X 1 1/2", 6 ML 21 X 1 1/2", 6 ML 21 X 1", 6 ML 22 X 1 1/2" (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE TOOMEY TYPE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT TB LUER LOK SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB REGULAR LUER TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT TB SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2", 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1/2 ML 28 X 1/2" (syringe with needle,disposable, 0.5 mL)	Tier 1	
NORM-JECT SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NORM-JECT SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
NORM-JECT TUBERKULIN SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
POLY HUB NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
SAFESNAP SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2" (syringe,needle,safety 1 mL,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 10 ML (syringe, safety 10 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 GAUGE X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1" (syringe,safety needle 10 mL and self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML (syringe, safety 3 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe 3 mL with safety needle,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 5 ML (syringe, safety 5 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1" (syringe, safety needle 5 mL and self-contained disposal unit)	Tier 1	
<i>safety needles needle 18 gauge x 1 1/2"</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURGUARD2 SAFETY NEEDLE 18 GAUGE X 1 1/2", 18 GAUGE X 1", 19 GAUGE X 1 1/2", 19 GAUGE X 1", 20 GAUGE X 1 1/2", 20 GAUGE X 1", 21 GAUGE X 1 1/2", 21 GAUGE X 1", 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1 1/2", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1/2", 27 GAUGE X 1/2" (needles, safety)	Tier 3	
SURGUARD2 SAFETY NEEDLE 30 GAUGE X 1 1/2" (needles, safety)	Tier 1	
SURGUARD2 SAFETY SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
<i>syringe (disposable) syringe 10 ml, 20 ml, 3 ml, 30 ml, 5 ml, 60 ml</i>	Tier 1	
SYRINGE 3CC/20GX1" SYRINGE 3 ML 20 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1" SYRINGE 3 ML 21 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1-1/2" SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/22GX1" SYRINGE 3 ML 22 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGE 3CC/22GX3/4" SYRINGE 3 ML 22 GAUGE X 3/4" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
<i>syringe with needle syringe 1 ml 25 gauge x 1", 10 ml 20 x 1", 3 ml 20 gauge x 1 1/2", 3 ml 22 x 1 1/2", 3 ml 23 x 1"</i>	Tier 1	
SYRINGE WITHOUT NEEDLE SYRINGE (syringe, disposable)	Tier 1	
TERUMO ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
TERUMO HYPODERMIC NEEDLE/SYRIN SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
TOOMEY SYRINGE SYRINGE 70 ML (syringe, disposable irrigation, 70 mL)	Tier 1	
TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
<i>tuberculin-allergy syringes syringe 1 ml 26 gauge x 3/8"</i>	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 1 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 3 ML 22 X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE SAFETY SYRINGE SYRINGE 3 ML (syringe, safety 3 mL)	Tier 1	
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
ULTICARE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE TB SAFETY SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 1 ML 25 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 3 ML 25 GAUGE X 1 1/2", 3 ML 27 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 5 mL)	Tier 1	
VANISHPOINT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme - Parenteral Therapy Supplies - Medical Supplies And Durable Medical Equipment		
INTERLINK LEVER LOCK CANNULA (syringe accessory)	Tier 3	
I-PORT (injection ports)	Tier 3	
I-PORT ADVANCE 6 MM INJEC PORT (injection ports)	Tier 3	
I-PORT ADVANCE 9 MM INJEC PORT (injection ports)	Tier 3	
KENDALL DISINFECTANT CAP (alcohol swab cap)	Tier 3	
MONOJECT LUER ADAPTER INTRAVENOUS ADMIX ACCESSORY (intravenous equipment)	Tier 3	
PHASEAL ASSEMBLY FIXTURE DEVICE (assembly system, vial to transfer device, closed system)	Tier 3	
PHASEAL CONNECTOR LUER LOCK (connector luer lock, closed system)	Tier 3	
PHASEAL INFUSION ADAPTER (infusion adapter, closed system)	Tier 3	
PHASEAL INFUSION CLAMP (clamp, IV tubing)	Tier 3	
PHASEAL INJECTOR LUER (needle injector, luer, closed system)	Tier 3	
PHASEAL INJECTOR LUER LOCK (needle injector, luer lock, closed system)	Tier 3	
PHASEAL PROTECTOR DEVICE 13 MM, 20 MM, 28 MM (transfer device, closed system)	Tier 3	
VARITHENA ADMINISTRATION PACK (transfer set/syringe, disposable/bandages,compression/tubing)	Tier 3	
Medical Supplies And Dme - Peak Flow Meters - Medical Supplies And Durable Medical Equipment		
AIRZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
ASTHMA CHECK METER DEVICE (peak flow meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASTHMAPACK CHILDREN'S KIT (peak flow meter/inhaler, assist devices)	DME	
CLEVER CHOICE PEAK FLOW METER DEVICE (peak flow meter)	DME	
IN-CHECK NASAL WITH MASK DEVICE (peak flow meter)	DME	
IN-CHECK ORAL FLOW METER DEVICE (peak flow meter)	DME	
MICROLIFE PEAK FLOW METER DEVICE (peak flow meter)	DME	
MINI WRIGHT PEAK FLOW METER DEVICE (peak flow meter)	DME	
PEAK AIR PEAK FLOW METER DEVICE (peak flow meter)	DME	
PERSONAL BEST FULL RANGE DEVICE (peak flow meter)	DME	
PERSONAL BEST LOW RANGE DEVICE (peak flow meter)	DME	
PIKO 1 DEVICE (peak flow meter)	DME	
POCKET PEAK FLOW METER DEVICE (peak flow meter)	DME	
PURECOMFORT PEAK FLOW METER DEVICE (peak flow meter)	DME	
TRUZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
Medical Supplies And Dme - Respiratory Therapy Supplies - Medical Supplies And Durable Medical Equipment		
A.I.R.S. NEBULIZER REPLACEMENT KIT (nebulizer accessories)	Tier 3	
ACE AEROSOL CLOUD ENHANCER SPACER (inhaler, assist devices)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AEROBIKA OSCILLATING PEP SYSTM DEVICE (mucus clearing device)	Tier 3	
AEROCHAMBER MECHANICAL VENT SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER MINI SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER MV SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS FLOW-VU SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,L MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,M MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,S MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT LG MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS Z STAT MD MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SM MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER Z-STAT PLUS-FLW SG SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER2GO SPACER (inhaler, assist devices)	Tier 3	
AERONEB GO (nebulizer accessories)	Tier 3	
AEROTRACH PLUS SPACER (inhaler, assist devices)	Tier 3	
AEROVENT PLUS SPACER (inhaler, assist devices)	Tier 3	
AIRS ADULT AEROSOL MASK (nebulizer accessories)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIRS PEDIATRIC DISPOSABLE MASK (nebulizer accessories)	Tier 3	
ALL FLOW 1000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 1000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 3000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 3000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 4000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 4000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 5000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 5000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 6000 PFT FILTER (nebulizer accessories)	Tier 3	
BREATHERITE MDI SPACER SPACER (inhaler, assist devices)	Tier 3	
BREATHERITE SPACER-MASK, NEO. SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE SPACER-MASK,ADULT SPACER (inhaler,assist device with large mask)	Tier 3	
BREATHERITE SPACER-MASK,CHILD SPACER (inhaler,assist device with medium mask)	Tier 3	
BREATHERITE SPACER-MASK,INFANT SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE SPACER-MASK,S.CHLD SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE VALVED MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
BREATHERITE VALVED MDI SPACER SPACER (inhaler, assist devices)	Tier 3	
CLEVER CHOICE CHAMBER-LRG MASK SPACER (inhaler,assist device with large mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE CHAMBER-MED MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
CLEVER CHOICE CHAMBER-SM MASK SPACER (inhaler,assist device with small mask)	Tier 3	
CLEVER CHOICE NEB KIT-ADULT (nebulizer accessories)	Tier 3	
CLEVER CHOICE NEB KIT-CHILD (nebulizer accessories)	Tier 3	
CLEVER CHOICE NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
CLEVER CHOICE WHISPER AIRE PED DEVICE (nebulizer and compressor)	Tier 3	
COMFORTSEAL LARGE MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
COMFORTSEAL MEDIUM MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
COMFORTSEAL SMALL MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
COMPACT SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
COMPACT SPACE CHAMBER-LRG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
COMPACT SPACE CHAMBER-MED MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
COMPACT SPACE CHAMBER-SM MASK SPACER (inhaler,assist device with small mask)	Tier 3	
COMP-AIR NEBULIZER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
DEVILBISS PULMO-AIDE COMPRESSR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS PULMOMATE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEVILBISS TRAVELER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
EASIVENT HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
EASIVENT MASK LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK MEDIUM DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK SMALL DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASY NEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
EBASE CONTROLLER DEVICE (compressor, for nebulizer)	Tier 3	
FLEXICHAMBER SPACER (inhaler, assist devices)	Tier 3	
FLEXICHAMBER-LG CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXICHAMBER-SM ADULT MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXICHAMBER-SM CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
HOME NEBULIZER PLUS SIDESTREAM DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE DELUXE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE ELEGANCE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE ESSENCE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE MINI DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE REPLACEMENT FILTER (nebulizer accessories)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INSPIRACHAMBER SPACER (inhaler, assist devices)	Tier 3	
INSPIRACHAMBER WITH MASK-LARGE SPACER (inhaler,assist device with large mask)	Tier 3	
INSPIRACHAMBER WITH MASK-MED SPACER (inhaler,assist device with medium mask)	Tier 3	
INSPIRACHAMBER WITH MASK-SMALL SPACER (inhaler,assist device with small mask)	Tier 3	
INSPIRATION ELITE FILTER (nebulizer accessories)	Tier 3	
LITE TOUCH-MEDIUM MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITEAIRE MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
LITETOUCH-LARGE MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITETOUCH-SMALL MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
MICROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
MICROSPACER SPACER (inhaler, assist devices)	Tier 3	
<i>nebulizer and compressor device</i>	Tier 3	
NOSE CLIP (nebulizer accessories)	Tier 3	
OMBRA COMPRESSOR SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
OPTICHAMBER ADULT MASK-LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
OPTICHAMBER DIAMOND LG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
OPTICHAMBER DIAMOND VHC SPACER (inhaler, assist devices)	Tier 3	
OPTICHAMBER DIAMOND-MED MSK SPACER (inhaler,assist device with medium mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTICHAMBER DIAMOND-SML MASK SPACER (inhaler,assist device with small mask)	Tier 3	
PARI BABY CONV KIT - SIZE 1 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 2 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 3 KIT (nebulizer accessories)	Tier 3	
PARI TREK S COMBO PACK DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S COMPACT COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S PORTABLE PWR KIT (nebulizer accessories)	Tier 3	
PEDIATRIC BEAR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PEDIATRIC COMP-AIR COMPRES NEB DEVICE (nebulizer and compressor)	Tier 3	
PFLEX INSPIRATORY TRAINER DEVICE (spirometers and accessories)	Tier 3	
PILLOW MASK CHILD (nebulizer accessories)	Tier 3	
POCKET CHAMBER SPACER (inhaler, assist devices)	Tier 3	
PRIMEAIRE SPACER (inhaler, assist devices)	Tier 3	
PROCARE COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE PEDIATRIC NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE SPACER WITH ADULT MASK SPACER (inhaler,assist device with large mask)	Tier 3	
PROCARE SPACER WITH CHILD MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
PROCHAMBER SPACER (inhaler, assist devices)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRONEB MAX COMPRESSOR-LC PLUS DEVICE (nebulizer and compressor)	Tier 3	
PRONEB MAX COMPRESSOR-LC SPRINT DEVICE (nebulizer and compressor)	Tier 3	
PRONEB ULTRA II FILTER ASSEM (nebulizer accessories)	Tier 3	
PROVENT NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PROVENT STARTER NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PULMO-AIDE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
PULMONEB LT COMPRESSOR NEBUL DEVICE (nebulizer and compressor)	Tier 3	
PUREAIR MINI NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
QUAKE VIBRATORY PEP DEVICE (mucus clearing device)	Tier 3	
REUSABLE NEBULIZER KIT KIT (nebulizer accessories)	Tier 3	
RITEFLO AEROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
RUBBER MOUTHPIECE (nebulizer accessories)	Tier 3	
SAMI THE SEAL DEVICE (nebulizer and compressor)	Tier 3	
SAMI THE SEAL MASK (nebulizer accessories)	Tier 3	
SIDESTREAM MASK (nebulizer accessories)	Tier 3	
SILICONE MASK (nebulizer accessories)	Tier 3	
SILICONE MASK - INFANT DEVICE (inhaler, assist devices, accessories)	Tier 3	
SMARTNEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOOTHENEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
SPACE CHAMBER WITH LARGE MASK SPACER (inhaler,assist device with large mask)	Tier 3	
SPACE CHAMBER WITH MEDIUM MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
SPACE CHAMBER WITH SMALL MASK SPACER (inhaler,assist device with small mask)	Tier 3	
SUNRISE COMPRESSOR-NEBULIZER DEVICE (compressor, for nebulizer)	Tier 3	
THRESHOLD IMT TRAINER DEVICE (spirometers and accessories)	Tier 3	
THRESHOLD PEP DEVICE DEVICE (spirometers and accessories)	Tier 3	
VIOS AEROSOL DELIVERY SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
VORTEX HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
VORTEX VHC PEDIATRIC MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
WILLIS THE WHALE COMPRESSR NEB DEVICE (nebulizer and compressor)	Tier 3	
Medical Supplies And Dme - Scar Treatments - Medical Supplies And Durable Medical Equipment		
CELACYN TOPICAL GEL WITH PUMP (emollient combination no.60)	Tier 3	
CELLPAD TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CICASIL TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CICATRACE PAD TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
DERM-SILK TOPICAL PAD 2.5 X 2 " (gel-matrix pad dressing, silicone)	Tier 3	
KELOTOP TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
NUVA III TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAGEL TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAZIL II TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
PROSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARCARE TOPICAL KIT 2 X 5.5 " (gel-matrix pad, silicone-dimethicone-dime-decameoct-oct-vit E)	Tier 3	
SCARCIN PAD PLUS TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARCINPAD TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARHEAL TOPICAL SHEET 2 X 2.5 " (silicone adhesive)	Tier 3	
SCARSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SILADERM TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
SILADONE TOPICAL SHEET 2 X 2.5 " (silicone adhesive)	Tier 3	
SIL-K TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SILTREX TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SZOSIL TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
SZOSIL TOPICAL STRIP 1.4 X 6 " (silicone adhesive)	Tier 3	
ZILACAINE PATCH TOPICAL COMBO PACK 5 % (lidocaine/silicone, adhesive)	Tier 3	
Medical Supplies And Dme - Subcutaneous Administration Supply - Medical Supplies And Durable Medical Equipment		
INSUFLON INFUSION SET 25 X 18 MM (subcutaneous administration set)	Tier 3	
Medical Supplies And Dme - Subcutaneous Insulin Delivery Devices - Medical Supplies And Durable Medical Equipment		
CEQUR SIMPLICITY DEVICE 2 UNIT (subcutaneous bolus insulin patch pump, 200 unit, disposable)	Tier 2	
ILET STARTER KIT CONTACT KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
ILET STARTER KIT-INSET KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
MODD1 PATIENT WELCOME KIT KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
OMNIPOD 5 (G6/LIBRE 2 PLUS) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,subcut automated dosing,BT,G6/L2)	Tier 2	KP
OMNIPOD 5 G6-G7 INTRO KT(GEN5) SUBCUTANEOUS CARTRIDGE (insulin pump cart,automated dosing,BT,G6/G7 with controller)	Tier 2	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNIPOD 5 G6-G7 PODS (GEN 5) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,subcut automated dosing,BT,G6/G7)	Tier 2	KP
OMNIPOD 5 INTRO(G6/LIBRE2PLUS) SUBCUTANEOUS CARTRIDGE (insulin pump cart,automated dosing,BT,G6/L2 with controller)	Tier 2	KP
OMNIPOD DASH INTRO KIT (GEN 4) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,continuous infusion,BT and controller)	Tier 2	KP
OMNIPOD DASH PODS (GEN 4) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,continuous subcut infusion,bluetooth)	Tier 2	KP
TWIST REFILL KT(CSST-NDL-SYR) KIT (insulin pump cartridge/insulin pump syringe/insulin needles)	Tier 3	
TWIST RFL(INFUS-CSST-NDL-SYR) KIT (insulin pump cartridge/insulin infusion set/syringe/needle)	Tier 3	
TWIST STARTER KIT KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
V-GO 20 DEVICE (sub-q insulin delivery device, 20 unit,disposable)	Tier 2	
V-GO 30 DEVICE (sub-q insulin delivery device, 30 unit, disposable)	Tier 2	
V-GO 40 DEVICE (sub-q insulin delivery device, 40 unit, disposable)	Tier 2	
Medical Supplies And Dme - Subcutaneous Insulin Pump - Medical Supplies And Durable Medical Equipment		
ILET INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
MINIMED 630G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED 770G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
MINIMED 780G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
T:SLIM X2 BASAL-IQ INSULIN PMP (subcutaneous insulin pump)	Tier 3	PA
T:SLIM X2 CONTROL-IQ (subcutaneous insulin pump)	Tier 3	PA
TANDEM MOBI SYSTEM (subcutaneous insulin pump)	Tier 3	PA
Medical Supplies And Dme - Tissue Bulking Implants - Medical Supplies And Durable Medical Equipment		
BARRIGEL IMPLANT GEL FOR IMPLANT IN SYRINGE 60 MG/3 ML (hyaluronate sodium, stabilized)	Tier 3	PA; KP
Medical Supplies And Dme - Urinary Catheters And Related Devices - Medical Supplies And Durable Medical Equipment		
ADVANCE PLUS INTERMITTENT 10 FR, 10-16 FR-", 12 FR, 12-16 FR-", 14-16 FR-", 16-16 FR-", 18-16 FR-", 6-16 FR-", 8-16 FR-" (catheter)	Tier 3	
ADVANCE PLUS INTERMITTENT COMBO PACK 6 FR, 8 FR- 16" (urinary bag/catheter)	Tier 3	
APOGEE IC INTERMIT CATHETER 14-6 FR-" (catheter)	Tier 3	
APOGEE PLUS INTERMITT CATHETER 16-16 FR-" (catheter)	Tier 3	
DOVER COATED LATEX FOLEY COMBO PACK (urinary bag/catheterization tray)	Tier 3	
DOVER LATEX FOLEY CATHETER 16 FR, 28 FR (catheter)	Tier 3	
DOVER RED RUBBER ROBINSON CATH 8 FR (catheter)	Tier 3	
DOVER UNIVERSAL TRAY (catheterization tray)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FEMALE CATHETER 14 FR (catheter)	Tier 3	
KENGUARD FOLEY CATHETER 18-16 FR-" (catheter)	Tier 3	
KENGUARD FOLEY CATHETER TRAY (catheterization tray)	Tier 3	
LOFRIC 12-16 FR-", 14-16 FR-" (catheter)	Tier 3	
LOFRIC ORIGO 14-16 FR-" (catheter)	Tier 3	
LOFRIC PRIMO NELATON CATHETER 16-16 FR-" (catheter)	Tier 3	
LOFRIC SENSE NELATON CATHETER 14-6 FR-" (catheter)	Tier 3	
MAGIC3 INTERMITTENT CATHETER 10-16 FR-", 12-16 FR-" (catheter)	Tier 3	
ROBINSON CLEAR VINYL CATHETER 16 FR (catheter)	Tier 3	
SELF-CATHETER, FEMALE 14 FR (catheter)	Tier 3	
SILASTIC FOLEY CATHETER 20 FR (catheter)	Tier 3	
SPEEDICATH (FEMALE) 16 FR (catheter)	Tier 3	
TOUCH-TROL 10 FR (catheter)	Tier 3	
VAPRO PLUS INTERMITT CATHETER COMBO PACK 12 FR- 8", 14 FR- 16", 14 FR- 8" (urinary bag/catheter)	Tier 3	
Medical Supplies And Dme - Urine Ketone Tests - Medical Supplies And Durable Medical Equipment		
KETONE CARE STRIP (urine acetone test strips)	DME	
KETONE URINE TEST STRIP (urine acetone test strips)	DME	
KETOSTIX STRIP (urine acetone test strips)	DME	
TRUEPLUS KETONE STRIP (urine acetone test strips)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Medical Supplies And Dme- Blood Collection Sets With Local Anesthetics - Medical Supplies And Durable Medical Equipment		
CADIRA COMPLIANT BLOOD STAT KIT 21 GAUGE X 3/4" -2.5 %-2.5 % (blood collection set/lidocaine/prilocaine)	Tier 3	
LIDO BDK KIT 21 GAUGE X 1"- 2.5 %-2.5 % (blood collection set/lidocaine/prilocaine)	Tier 3	
Medical Supplies And Dme-Eustachian Tube/Middle Ear Ventilator Devices - Medical Supplies And Durable Medical Equipment		
EAR POPPER INFLATION DEVICE NASAL DEVICE (middle ear inflation device)	Tier 3	
Medical Supplies And Dme-Glucose Monitoring And Insulin Admin Supplies - Medical Supplies And Durable Medical Equipment		
AUTOSOFT 30 INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT 90 INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
ILET INFUSION KIT-INSET 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
ILET INFUSION KIT-INSET 32" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ILET INFUSION-CONTACT DTCH 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
MEDTRONIC EXT INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MEDTRONIC EXT INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED MIO ADVANCE INF SET23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED MIO ADVANCE INF SET43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 23" INFUSION SET (infusion set for insulin pump)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED SURE T 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MODD1 SUPPLY KIT COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFT 30 KT 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFT XC KIT 5" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFT XC KT 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFT30 14PK 23 COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFTXC 14PK 23 COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFTXC 14PK 5" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI TRUSTEEL KIT 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT 30 PK10 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT 30 PK14 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT XC PK10 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT XC PK14 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM TRUSTL PK10 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TRUSTEEL INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUSTEEL INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
Tissue Bulking Implants - Anorectal - Medical Supplies And Durable Medical Equipment		
SOLESTA IMPLANT GEL FOR IMPLANT IN SYRINGE 50-15 MG/ML (4) (dextranomer microspheres/hyaluronate sod in 0.9 % sodium chl)	Tier 3	KP
Tissue Bulking Implants - Ureteral - Medical Supplies And Durable Medical Equipment		
DEFLUX IMPLANT GEL FOR IMPLANT IN SYRINGE 50-15 MG/ML (1) (dextranomer microspheres/hyaluronate sod in 0.9 % sodium chl)	Tier 3	KP
Medical Supply, Fdb Superset		
Medical Supply, Fdb Superset		
1ST TIER UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
1ST TIER UNIFINE PENTIPS PLUS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
2-IN-1 LANCET DEVICE 30 GAUGE (lancets)	DME	
2TEK CONTROL (HIGH-NORMAL) SOLUTION (blood glucose calibration control solution, high and normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
2TEK GLUCOSE/BLOOD PRESSURE KIT (blood-glucose meter and wrist blood pressure monitor)	DME	
A.I.R.S. NEBULIZER REPLACEMENT KIT (nebulizer accessories)	Tier 3	
ACCU-CHEK AVIVA CONTROL SOLN SOLUTION (blood glucose calibration control high and low)	DME	
ACCU-CHEK AVIVA PLUS TEST STRP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ACCU-CHEK FASTCLIX LANCET DRUM (lancets)	DME	
ACCU-CHEK FASTCLIX LANCING DEV KIT (lancing device/lancets)	DME	
ACCU-CHEK GUIDE GLUCOSE METER (blood-glucose meter)	DME	
ACCU-CHEK GUIDE L1-L2 CTRL SOL SOLUTION (blood glucose calibration control high and low)	DME	
ACCU-CHEK GUIDE ME GLUCOSE MTR (blood-glucose meter)	DME	
ACCU-CHEK GUIDE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACCU-CHEK SAFE-T-PRO 23 GAUGE (lancets)	DME	
ACCU-CHEK SAFE-T-PRO PLUS 23 GAUGE (lancets)	DME	
ACCU-CHEK SMARTVIEW CONTRL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
ACCU-CHEK SMARTVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ACCU-CHEK SOFT DEV LANCETS KIT (lancing device/lancets)	DME	
ACCU-CHEK SOFTCLIX LANCETS (lancets)	DME	
ACCUTREND GLUCOSE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ACCUTREND GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ACE AEROSOL CLOUD ENHANCER SPACER (inhaler, assist devices)	Tier 3	
ACTI-LANCE LANCETS 17 GAUGE, 23 GAUGE, 28 GAUGE (lancets)	DME	
ADJUSTABLE LANCING DEVICE (lancing device)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVANCE PLUS INTERMITTENT 10 FR, 10-16 FR-", 12 FR, 12-16 FR-", 14-16 FR-", 16-16 FR-", 18-16 FR-", 6-16 FR-", 8-16 FR-" (catheter)	Tier 3	
ADVANCE PLUS INTERMITTENT COMBO PACK 6 FR, 8 FR- 16" (urinary bag/catheter)	Tier 3	
ADVANCED ALL-IN-ONE METER KIT (blood-glucose meter)	DME	
ADVANCED GLUC METER TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ADVANCED GLUCOSE METER (blood-glucose meter)	DME	
ADVANCED LANCING DEVICE KIT (lancing device/lancets)	DME	
ADVANCED TRAVEL LANCETS 28 GAUGE (lancets)	DME	
ADVINOVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days)
ADVOCATE LANCET 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
ADVOCATE LANCING DEVICE (lancing device)	DME	
ADVOCATE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ADVOCATE REDI-CODE PLUS (blood-glucose meter)	DME	
ADVOCATE REDI-CODE PLUS CTRL L SOLUTION (blood glucose calibration control solution, low)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ADVOCATE REDI-CODE PLUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ADVOCATE REDI-CODE+ CTRL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
ADVOCATE SYRINGES SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ADVOCATE SYRINGES SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
AEROBIKA OSCILLATING PEP SYSTM DEVICE (mucus clearing device)	Tier 3	
AEROCHAMBER MECHANICAL VENT SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER MINI SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER MV SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS FLOW-VU SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,L MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS FLOW-VU,M MSK SPACER (inhaler,assist device with medium mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AEROCHAMBER PLUS FLOW-VU,S MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT LG MSK SPACER (inhaler,assist device with large mask)	Tier 3	
AEROCHAMBER PLUS Z STAT MD MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SM MSK SPACER (inhaler,assist device with small mask)	Tier 3	
AEROCHAMBER PLUS Z STAT SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER Z-STAT PLUS-FLW SG SPACER (inhaler, assist devices)	Tier 3	
AEROCHAMBER2GO SPACER (inhaler, assist devices)	Tier 3	
AEROECLIPSE II NEBULIZER (nebulizer)	Tier 3	
AEROECLIPSE XL NEBULIZER (nebulizer)	Tier 3	
AERONEB GO (nebulizer accessories)	Tier 3	
AERONEB GO NEBULIZER (nebulizer)	Tier 3	
AEROTRACH PLUS SPACER (inhaler, assist devices)	Tier 3	
AEROVENT PLUS SPACER (inhaler, assist devices)	Tier 3	
AGAMATRIX AMP TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
AGAMATRIX CONTROL SOLN-HIGH SOLUTION (blood glucose calibration control solution, high)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AGAMATRIX CONTROL SOLN-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
AGAMATRIX CONTROL SOLN-NORM-HI SOLUTION (blood glucose calibration control solution, high and normal)	DME	
AGAMATRIX JAZZ TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
AGAMATRIX JAZZ WIRELESS 2 MNTR KIT (blood-glucose meter)	DME	
AGAMATRIX PRESTO SYSTEM (blood-glucose meter)	DME	
AGAMATRIX PRESTO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
AGAMATRIX ULTRA-THIN LANCET 33 GAUGE (lancets)	DME	
AIMSCO LATEX CONDOM DEVICE (condoms, latex, lubricated)	PV	
AIRS ADULT AEROSOL MASK (nebulizer accessories)	Tier 3	
AIRS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
AIRS PEDIATRIC DISPOSABLE MASK (nebulizer accessories)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AIRZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
ALKALINE BATTERIES (diabetic supplies,miscell)	DME	
ALL FLOW 1000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 1000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 3000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 3000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 4000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 4000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 5000 KIT (nebulizer accessories)	Tier 3	
ALL FLOW 5000 PFT FILTER (nebulizer accessories)	Tier 3	
ALL FLOW 6000 PFT FILTER (nebulizer accessories)	Tier 3	
ALLERGIST TRAY 1/2 ML 27GX3/8" SYRINGE 1/2 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 0.5 mL)	Tier 1	
ALLERGIST TRAY INTRADERMAL BEV SYRINGE 1 ML 26 GAUGE X 1/2", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGIST TRAY REGULAR BEVEL SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
ALLEVYN ADHESIVE DRESSING TOPICAL BANDAGE 7 X 7 " (foam bandage)	Tier 3	
ALLEVYN LIFE DRESSING TOPICAL BANDAGE 4 X 4 " (foam bandage)	Tier 3	
ALTERA NEBULIZER HANDSET (nebulizer)	Tier 3	
ALTERA NEBULIZER SYSTEM (nebulizer)	Tier 3	
ALTERNATE SITE LANCET 26 GAUGE (lancets)	DME	
ALTERNATE SITE LANCING DEVICE (lancing device)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AMIELLE VAGINAL TRAINER KIT (medical supply, miscellaneous)	Tier 3	
APOGEE IC INTERMIT CATHETER 14-6 FR-" (catheter)	Tier 3	
APOGEE PLUS INTERMITT CATHETER 16-16 FR-" (catheter)	Tier 3	
AQINJECT PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
AQUA LANCE LANCING DEVICE (lancing device)	DME	
ARGYLE TRACHEOSTOMY CARE TRAY (medical supply, miscellaneous)	Tier 3	
ASSURE 4 CONTROL SOLUTION COMBO PACK (blood-glucose calib. control)	DME	
ASSURE 4 STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ASSURE DOSE NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ASSURE DOSE NORM-HI CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ASSURE ID DUO PRO SFTY PEN NDL NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
ASSURE ID PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
ASSURE ID PRO PEN NEEDLE NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
ASSURE LANCE 25 GAUGE, 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ASSURE LANCE PLUS 21 GAUGE, 25 GAUGE, 30 GAUGE (lancets)	DME	
ASSURE PLATINUM GLUCOSE METER (blood-glucose meter)	DME	
ASSURE PLATINUM TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ASSURE PRISM CONTROL 1-2 SOLN SOLUTION (blood glucose calibration control solution, high and normal)	DME	
ASSURE PRISM MULTI METER (blood-glucose meter)	DME	
ASSURE PRISM MULTI STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ASTHMA CHECK METER DEVICE (peak flow meter)	DME	
ASTHMAPACK CHILDREN'S KIT (peak flow meter/inhaler, assist devices)	DME	
AURA PORTANEB (nebulizer)	Tier 3	
AUTOJECT 2 INJECTION DEVICE SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTO-LANCET MINI (lancing device)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTOLET IMPRESSION LANC DEV KIT (lancing device/lancets)	DME	
AUTOLET LANCING DEVICE (lancing device)	DME	
AUTOLET LITE (lancing device)	DME	
AUTOPEN 1 TO 21 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOPEN 2 TO 42 UNITS SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
AUTOSHIELD DUO PEN NEEDLE NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
AUTOSOFT 30 INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT 90 INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
AUTOSOFT XC INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
BD ALLERGIST TRAY REG BEVEL SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ALLERGIST TRAY REG BEVEL TRAY 1/2 ML 27 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
BD ALLERGY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD BLUNT PLASTIC CANNULA SYRINGE 17 X 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
BD BULK SYRINGE SLIP TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD BULK SYRINGE SLIP TIP SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD ECCENTRIC TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD ECLIPSE LUER-LOK NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 1 ML 30 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 23 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD ECLIPSE LUER-LOK SYRINGE 3 ML 23 X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD FILTER NEEDLE-5 MICRON NEEDLE 19 X 1 1/2 " (needles, filter)	Tier 3	
BD INSYTE AUTOGUARD INFUSION SET 22 GAUGE X 1", 24 GAUGE X 3/4" (intravenous catheter)	Tier 3	
BD INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
BD INTEGRA SYRINGE SYRINGE 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
BD INTERLINK BLUNT PLASTIC CAN SYRINGE 17 X 5 ML (syringe with cannula, disposable, 5 mL)	Tier 1	
BD INTERLINK SYRINGE SYRINGE 17 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
BD LUER-LOK BULK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 1 ML 20 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD LUER-LOK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 10 ML 20 X 1 1/2", 10 ML 20 X 1", 10 ML 21 GAUGE X 1", 10 ML 21 X 1 1/2" (syringe with needle,disposable, 10 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 3 ML 18 X 1 1/2", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2 ", 3 ML 25 X 5/8", 3 ML 26 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
BD LUER-LOK SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD LUER-LOK TIP CONTROL SYRING SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD MICROTAINER LANCET 1.5 X 2 MM (blade lancet, safety)	DME	
BD MICROTAINER LANCET 21 GAUGE, 30 GAUGE (lancets)	DME	
BD PRECISIONGLIDE NEEDLE 27 GAUGE X 3/8" (needles, disposable)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SAFETYGLIDE ALLERGIST TRAY SYRINGE 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
BD SAFETYGLIDE NEEDLE NEEDLE 23 GAUGE X 1 1/2" (needles, safety)	Tier 3	
BD SAFETYGLIDE SHIELDING REG SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE SHIELDING REG SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 1 ML 27 GAUGE X 5/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
BD SAFETYGLIDE SYRINGE SYRINGE 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
BD SAFETYGLIDE TB REG BEVEL SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAFETYGLIDE TUBERCULIN SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SAF-T-INTIMA INFUSION SET 22 GAUGE X 3/4" (intravenous catheter kit)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SLIP TIP SYRINGE SYRINGE 1 ML 26 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
B-D SLIP TIP SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
BD SLIP TIP SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SPECIALTY USE NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
BD SYRINGE CATH TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE CATHETER TIP SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
BD SYRINGE LUER-LOK NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
BD SYRINGE LUER-LOK STERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
BD SYRINGE SLIP TIP NONSTERILE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
BD SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD SYRINGE-DUAL CANNULA SYRINGE 10 ML 20 GAUGE AND 17 GAUGE (syringe with needle and cannula, disposable, 10 mL)	Tier 1	
BD TUBERCULIN SLIP-TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
BD TUBERCULIN SLIP-TIP SYRINGE 1 ML 27 GAUGE X 3/8" (syringe with needle,disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1 ML 21 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
BD TUBERCULIN SYRINGE SYRINGE 1/2 ML 27 X 1/2 " (syringe with needle,disposable, 0.5 mL)	Tier 1	
BD VERITOR SARS-COV-2, FLU A-B KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
BD VERITOR SYSTEM SARS-COV-2 KIT (COVID-19 antigen immunoassay test)	Tier 3	
BIGFOOT UNITY KIT (flash glucose sensor/blood glucose test strips/pen needles)	Tier 3	
BIGFOOT UNITY PEN CAP-ADMELOG DEVICE (data transfer pen cap for insulin lispro, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-APIDRA DEVICE (data transfer pen cap for insulin glulisine, reusable, BT)	Tier 3	
BIGFOOT UNITY PEN CAP-ASPART DEVICE (data transfer pen cap for insulin aspart, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-BASAGLAR DEVICE (data transfr pen cap for insulin glargine,reusable,bluetooth)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIGFOOT UNITY PEN CAP-FIASP DEVICE (data transfer pen cap for insulin aspart (B3), reusable, BT)	Tier 3	
BIGFOOT UNITY PEN CAP-HUMALOG DEVICE (data transfer pen cap for insulin lispro, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-LANTUS DEVICE (data transf pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-LISPRO DEVICE (data transfer pen cap for insulin lispro, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-LYUMJEV DEVICE (data transfer pen cap for insulin lispro-aabc, reusable, BT)	Tier 3	
BIGFOOT UNITY PEN CAP-NOVOLOG DEVICE (data transfer pen cap for insulin aspart, reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-TOUJEO DEVICE (data transf pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-TOUJEOMX DEVICE (data transf pen cap for insulin glargine,reusable,bluetooth)	Tier 3	
BIGFOOT UNITY PEN CAP-TRESIBA DEVICE (data transfer pen cap for insulin degludec, reusable, BT)	Tier 3	
BINAXNOW COVD AG CARD HOME TST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
BINAXNOW COVID-19 AG CARD KIT (COVID-19 antigen immunoassay test)	Tier 3	
BINAXNOW COVID-19 AG SELF TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
BIONIME RIGHTEST GM300 SYSTEM KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIONIME RIGHTEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
BIOSTEP TOPICAL BANDAGE 2 X 2 ", 4 X 4 " (dressing, collagen/sodium alginate/carboxymethylcellulose)	Tier 3	
BIOTEL CARE BGM-4 METER (blood-glucose meter)	DME	
<i>blood glucose contrl hi,normal solution</i>	DME	
<i>blood glucose control, normal solution</i>	DME	
BLOOD GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
BLOOD GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
<i>blood-glucose meter</i>	DME	
<i>blood-glucose meter kit</i>	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BLULINK BG SYSTEM REFILL KIT 32 GAUGE (lancets with blood glucose test strips)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
BLULINK DIABETIC TEST BUNDLE KIT (blood-glucose meter)	DME	
BLULINK GLUCOSE MONITOR SYSTEM (blood-glucose meter)	DME	
BLULINK GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
<i>blunt needle, disposable needle 18 x 1 1/2 "</i>	Tier 3	
BOYS TRAINING PANTS 4T-5T (diaper/brief, infant-toddler, disposable)	Tier 3	
BREATHERITE MDI SPACER SPACER (inhaler, assist devices)	Tier 3	
BREATHERITE SPACER-MASK, NEO. SPACER (inhaler, assist device with small mask)	Tier 3	
BREATHERITE SPACER-MASK, ADULT SPACER (inhaler, assist device with large mask)	Tier 3	
BREATHERITE SPACER-MASK, CHILD SPACER (inhaler, assist device with medium mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BREATHERITE SPACER-MASK,INFANT SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE SPACER-MASK,S.CHLD SPACER (inhaler,assist device with small mask)	Tier 3	
BREATHERITE VALVED MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
BREATHERITE VALVED MDI SPACER SPACER (inhaler, assist devices)	Tier 3	
BREEZE 2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
BREEZE 2 CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
BREEZE 2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
BULLSEYE MINI SAFETY LANCETS 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
BUTTERFLY TOUCH LANCET 30 GAUGE (lancets)	DME	
CAREFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CAREONE LANCING DEVICE (lancing device)	DME	
CAREONE ULTRA THIN LANCET (lancets)	DME	
CAREPOINT LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CAREPOINT LUER LOCK SYR-NEEDLE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CAREPOINT LUER SLIP SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CAREPOINT LUER SLIP SYRING-NDL SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
CAREPOINT PRECISION LUER LOCK SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CAREPOINT PRECISION NEEDLE NEEDLE 20 GAUGE X 1", 21 GAUGE X 1" (needles, disposable)	Tier 3	
CAREPOINT PRECISION SAFETY SYRINGE 1 ML 23 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
CAREPOINT SAFETY LL SYR-NEEDLE SYRINGE 1 ML 25 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
CARESENS CONTROL A AND B SOLUTION (blood glucose calibration control solution, high and normal)	DME	
CARESENS LANCETS 30 GAUGE (lancets)	DME	
CARESENS N (blood-glucose meter)	DME	
CARESENS N FELIZ BT GLUC METER (blood-glucose meter)	DME	
CARESENS N FELIZ GLUCOSE METER (blood-glucose meter)	DME	
CARESENS N PLUS BT KIT (blood-glucose meter)	DME	
CARESENS N TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CARESENS N VOICE (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARESTART COVID-19 AG HOME TST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
CARETOUCH CONTROL SOLN L2-L3 SOLUTION (blood glucose calibration control solution, high and normal)	DME	
CARETOUCH GLUCOSE MONITORING KIT (blood-glucose meter)	DME	
CARETOUCH INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
CARETOUCH INSULIN SYRINGE SYRINGE 1 ML 28 X 5/16", 1 ML 29 GAUGE X 5/16, 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
CARETOUCH LANCING DEVICE (lancing device)	DME	
CARETOUCH LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CARETOUCH LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
CARETOUCH LUER LOCK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
CARETOUCH LUER LOCK SYR-NEEDLE SYRINGE 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/2", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
CARETOUCH LUER SLIP SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARETOUCH LUER SLIP SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
CARETOUCH PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CARETOUCH SAFETY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
CARETOUCH TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CARETOUCH TWIST LANCET 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
CARRASYN HYDROGEL WOUND DRESS TOPICAL GEL (gel dressing)	Tier 3	
CAYA CONTOURED VAGINAL DIAPHRAGM 65-80 MM (diaphragms, contoured)	PV	
CEFALY COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	
CELLPAD TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CEQUR SIMPLICITY DEVICE 2 UNIT (subcutaneous bolus insulin patch pump, 200 unit, disposable)	Tier 2	
CEQUR SIMPLICITY INSERTER (diabetic supplies,miscell)	DME	
CHEMSTRIP BG LOG BOOK (diabetic supplies,miscell)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CHOICE DM CLARUS NORM CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CHOICEDM CLARUS (blood-glucose meter)	DME	
CHOICEDM CLARUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CHOSEN LANCET 30 GAUGE (lancets)	DME	
CHOSEN LANCING DEVICE (lancing device)	DME	
CHOSEN SAFETY LANCET 28 GAUGE (lancets)	DME	
CICASIL TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
CICATRACE PAD TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
CLEVER CHEK BLOOD GLUCOSE (blood-glucose meter)	DME	
CLEVER CHEK BLOOD GLUCOSE SYST KIT (blood-glucose meter)	DME	
CLEVER CHEK LANCETS 30 GAUGE (lancets)	DME	
CLEVER CHOICE BLOOD GLUC SYS (blood-glucose meter)	DME	
CLEVER CHOICE CHAMBER-LRG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
CLEVER CHOICE CHAMBER-MED MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
CLEVER CHOICE CHAMBER-SM MASK SPACER (inhaler,assist device with small mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE GLUCOSE MONITOR (blood-glucose meter)	DME	
CLEVER CHOICE LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
CLEVER CHOICE LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
CLEVER CHOICE LEVEL 3 CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
CLEVER CHOICE MICRO (blood-glucose meter)	DME	
CLEVER CHOICE MICRO TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE NEB KIT-ADULT (nebulizer accessories)	Tier 3	
CLEVER CHOICE NEB KIT-CHILD (nebulizer accessories)	Tier 3	
CLEVER CHOICE NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
CLEVER CHOICE PEAK FLOW METER DEVICE (peak flow meter)	DME	
CLEVER CHOICE PRO (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE PRO STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE TALK GLUCOSE SYS (blood-glucose meter)	DME	
CLEVER CHOICE TALK TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CLEVER CHOICE VOICE PLUS TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CLEVER CHOICE WHISPER AIRE PED DEVICE (nebulizer and compressor)	Tier 3	
CLICKFINE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
CLINITEST COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
COAGUCHEK LANCETS (lancets)	DME	
COAGUCHEK XS (prothrombin time/INR test meter)	Tier 3	
COLOR LANCETS 21 GAUGE (lancets)	DME	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
COMFORT EZ INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
COMFORT EZ LANCETS 23 GAUGE, 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMFORT EZ PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
COMFORT EZ PRO SAFETY PEN NDL NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
COMFORT TOUCH PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 31 GAUGE X 5/32", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
COMFORT TOUCH PLUS SAFETY LANC 30 GAUGE (lancets)	DME	
COMFORT TOUCH ULT THIN LANCETS 31 GAUGE (lancets)	DME	
COMFORTSEAL LARGE MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
COMFORTSEAL MEDIUM MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
COMFORTSEAL SMALL MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
COMPACT SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
COMPACT SPACE CHAMBER-LRG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
COMPACT SPACE CHAMBER-MED MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
COMPACT SPACE CHAMBER-SM MASK SPACER (inhaler,assist device with small mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COMP-AIR NEBULIZER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
CONCEPTION KIT (conception assistance supplies combination no.1)	Tier 3	
CONTOUR CONTROL SOLUTION, HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
CONTOUR CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR CONTROL SOLUTION, NML SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR METER (blood-glucose meter)	DME	
CONTOUR NEXT EZ METER (blood-glucose meter)	DME	
CONTOUR NEXT GEN METER (blood-glucose meter)	DME	
CONTOUR NEXT GEN METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT GLUCOSE METER KIT (blood-glucose meter)	DME	
CONTOUR NEXT LEV 1 CONTROL SOL SOLUTION (blood glucose calibration control solution, low)	DME	
CONTOUR NEXT LEV 2 CONTROL SOL SOLUTION (blood glucose calibration control solution, normal)	DME	
CONTOUR NEXT LINK 2.4 KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT LINK KIT (blood-glucose meter, wireless)	DME	
CONTOUR NEXT METER (blood-glucose meter)	DME	
CONTOUR NEXT ONE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTOUR NEXT TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
CONTOUR PLUS BLUE METER (blood-glucose meter)	DME	
CONTOUR PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	
CONTOUR TEST STRIPS STRIP (blood sugar diagnostic)	DME	
CORDX COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
CORDX TYFAST FLU-COVID-19 TEST KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
COVID-19 AT-HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
<i>covid19 test adm.by pharmacist</i>	Tier 3	
CURAFIL GEL WOUND TOPICAL GEL (gel dressing)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL SPONGE 0.2 %- 2" X 2" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
CURITY AMD (WITH POLYHEXAMETH) TOPICAL STRIP 0.2 %- 1/2" X 3 FEET (polyhexamethylene biguanide/gauze bandage)	Tier 3	
CURITY AMD TOPICAL BANDAGE 1 X 5 "-YARD, 1/4 X 36 " (gauze bandage)	Tier 3	
CURITY DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CURITY IODOFORM PACKING STRIP TOPICAL BANDAGE 1 X 5 "-YARD, 1/2 X 5 "-YARD, 1/4 X 5 "-YARD, 2 X 5 "-YARD (iodoform)	Tier 3	
DAVOL IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
DAVOL PISTON IRRIGATION SYRINGE (syringe disposable irrigation)	Tier 1	
DERM-SILK TOPICAL PAD 2.5 X 2 " (gel-matrix pad dressing, silicone)	Tier 3	
DEVILBISS DISPOSABLE NEBULIZER (nebulizer)	Tier 3	
DEVILBISS PULMO-AIDE COMPRESSR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS PULMOMATE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
DEVILBISS TRAVELER COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
DEXCOM G6 RECEIVER (blood-glucose meter, receiver, continuous)	DME	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G6 SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G6 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G7 RECEIVER (blood-glucose meter, receiver, continuous)	DME	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
DEXCOM G7 SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DIAPERS, UNISEX SIZE 1 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 2 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 3 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 4 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 5 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIAPERS, UNISEX SIZE 6 (diaper/brief,infant-toddler, disposable)	Tier 3	
DIATRUE CONTROL SOLN NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
DIATRUE CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
DIATRUE CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
DIATRUE PLUS BLOOD GLUCOSE MET (blood-glucose meter)	DME	
DIATRUE PLUS TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
DOVER BULB SYRINGE SYRINGE 60 ML (syringe disposable irrig,60 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DOVER COATED LATEX FOLEY COMBO PACK (urinary bag/catheterization tray)	Tier 3	
DOVER LATEX FOLEY CATHETER 16 FR, 28 FR (catheter)	Tier 3	
DOVER RED RUBBER ROBINSON CATH 8 FR (catheter)	Tier 3	
DOVER UNIVERSAL TRAY (catheterization tray)	Tier 3	
DROPLET GENTEEL LANCING DEVICE (lancing device)	DME	
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 1/4", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16", 0.5ML 30 GAUGE X 15/64" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
DROPLET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
DROPLET LANCETS 30 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DROPLET LANCING DEVICE (lancing device)	DME	
DROPLET MICRON PEN NEEDLE NEEDLE 34 GAUGE X 9/64" (pen needle, diabetic)	Tier 1	
DROPLET PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
DROPSAFE ACTI-LANCE 23 GAUGE (lancets)	DME	
DROPSAFE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
DROPSAFE INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
DROPSAFE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
DROPSAFE SICURA SAFETY NEEDLE NEEDLE 25 GAUGE X 1" (needles, safety)	Tier 3	
DUREX AVANTI BARE REAL FEEL (condoms, non-latex, lubricated)	PV	
DUREX EXTRA SENSITIVE CONDOM DEVICE (condoms, latex, lubricated)	PV	
DUREX TROPICAL CONDOM DEVICE (condoms, latex, lubricated)	PV	
EAR POPPER INFLATION DEVICE NASAL DEVICE (middle ear inflation device)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASIVENT HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
EASIVENT MASK LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK MEDIUM DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASIVENT MASK SMALL DEVICE (inhaler, assist devices, accessories)	Tier 3	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16", 0.3 ML 31 X 1/2" (syringe with needle,insulin,0.3 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 29 X5/16 ", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY COMFORT INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 5/16, 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY COMFORT LANCETS 30 GAUGE (lancets)	DME	
EASY COMFORT PEN NEEDLES NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/32", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
EASY GLIDE CATHETER TIP SYRING SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY GLIDE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 15/64" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY GLIDE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY GLIDE LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY GLIDE LUER SLIP TB SYRING SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY GLIDE PEN NEEDLE NEEDLE 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EASY MINI EJECT LANCING DEVICE (lancing device)	DME	
EASY NEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
EASY PLUS II BLOOD GLUCOSE MET (blood-glucose meter)	DME	
EASY PLUS II HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY PLUS II LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY PLUS II TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY STEP BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EASY STEP HIGH CONTROL SOLN SOLUTION (blood glucose calibration control solution, high)	DME	
EASY STEP LOW CONTROL SOLUTION SOLUTION (blood glucose calibration control solution, low)	DME	
EASY STEP NORMAL CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY STEP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TALK BLOOD GLUCOSE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TALK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TALK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TALK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TALK PLUS II HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TALK PLUS II LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TALK PLUS II TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TOUCH BLU CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH BLULINK GLUC SYST (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH BLULINK TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH FLIPLOCK NEEDLE NEEDLE 30 X 1/2 " (needles, safety)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 10 ML 18 GAUGE X 1 1/2", 10 ML 18 GAUGE X 1", 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 3 ML 18 GAUGE X 1 1/2", 3 ML 18 GAUGE X 1", 3 ML 19 GAUGE X 1 1/2", 3 ML 19 GAUGE X 1", 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH FLIPLOCK SYRINGE SYRINGE 5 ML 18 GAUGE X 1", 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1", 5 ML 25 GAUGE X 5/8" (syringe,safety with needle,5 mL)	Tier 1	
EASY TOUCH FLURINGE FLIPLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SHEATHLOCK SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH FLURINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
EASY TOUCH GLUCOSE MONITOR (blood-glucose meter)	DME	
EASY TOUCH HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
EASY TOUCH HYPODERMIC NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
EASY TOUCH INSULIN SAFETY SYR SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
EASY TOUCH INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EASY TOUCH LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH LANCING DEVICE (lancing device)	DME	
EASY TOUCH LUER LOCK INSULIN SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 5 ML (syringe, disposable, 5 mL)	Tier 1	
EASY TOUCH LUER LOCK SYRINGE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
EASY TOUCH NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
EASY TOUCH SAFETY LANCETS 21 GAUGE, 23 GAUGE, 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE (lancets)	DME	
EASY TOUCH SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16", 30 GAUGE X 1/4", 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 10 ML 21 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1 1/2", 10 ML 25 GAUGE X 1" (syringe,safety with needle,10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRG-NDL SYRINGE 5 ML 21 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1 1/2", 5 ML 25 GAUGE X 1" (syringe,safety with needle,5 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TOUCH SHEATHLOCK SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
EASY TOUCH SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TOUCH SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
EASY TOUCH TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TOUCH TUBERCULIN FLIPLOCK SYRINGE 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH TUBERCULIN SHEATHLK SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
EASY TOUCH TWIST LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
EASY TOUCH UNI-SLIP SYRINGE 1 ML (syringe without needle,insulin disposable, 1 mL)	Tier 1	
EASY TOUCH UNI-SLIP SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EASY TRAK BLOOD GLUCOSE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASY TRAK GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TRAK HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
EASY TRAK II BLOOD GLUCOSE MTR (blood-glucose meter)	DME	
EASY TRAK II CTRL SOLN-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASY TRAK II TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASY TRAK LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EASY TWIST AND CAP LANCETS 28 GAUGE (lancets)	DME	
EASYGLUCO METER KIT (blood-glucose meter)	DME	
EASYGLUCO MONITORING SYSTEM KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASYGLUCO TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASYMAX 15 LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX 15 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASYMAX NG (blood-glucose meter)	DME	
EASYMAX NG KIT (blood-glucose meter)	DME	
EASYMAX NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EASYMAX STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EASYMAX T1 KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EASYMAX V SPEAKING GLUCOSE SYS (blood-glucose meter)	DME	
EASYPOINT NEEDLE NEEDLE 25 GAUGE X 1 1/2" (needles, safety)	Tier 3	
EASY-TOUCH BLOOD GLUCOSE METER (blood-glucose meter)	DME	
EBASE CONTROLLER DEVICE (compressor, for nebulizer)	Tier 3	
ECLIPSE NEEDLE NEEDLE 23 GAUGE X 1", 25 GAUGE X 5/8" (needles, safety)	Tier 3	
ECLIPSE SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
ELEMENT COMPACT GLUCOSE METER (blood-glucose meter)	DME	
ELEMENT COMPACT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ELEMENT COMPACT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT COMPACT TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ELEMENT COMPACT V GLUCOSE MTR (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELEMENT HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ELEMENT LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
ELEMENT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ELEMENT PLUS BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	
ELEMENT TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ELLUME COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
EMBRACE BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
EMBRACE BLOOD GLUCOSE SYSTEM STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE EVO BLOOD GLUCOSE KIT KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE EVO GLUCOSE MONITOR (blood-glucose meter)	DME	
EMBRACE EVO LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE EVO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE GLUCOSE CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE GLUCOSE CONTROL LOW SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE LANCETS 30 GAUGE (lancets)	DME	
EMBRACE LANCING DEVICE (lancing device)	DME	
EMBRACE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 3/16", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
EMBRACE PRO GLUCOSE METER (blood-glucose meter)	DME	
EMBRACE PRO SOLUTION (blood glucose calibration control solution, high and normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE PRO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE SAFETY LANCET 21 GAUGE, 28 GAUGE (lancets)	DME	
EMBRACE TALK BLOOD GLUCOSE SYS KIT (blood-glucose meter)	DME	
EMBRACE TALK CONTROL-HIGH (L2) SOLUTION (blood glucose calibration control solution, high)	DME	
EMBRACE TALK CONTROL-LOW (L1) SOLUTION (blood glucose calibration control solution, low)	DME	
EMBRACE TALK GLUCOSE MONITOR (blood-glucose meter)	DME	
EMBRACE TALK TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EMBRACE WAVE GLUCOSE TEST STRP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EMBRACE WAVE PLUS GLUCOSE MTR (blood-glucose meter)	DME	
ENFIT IRRIGAT SYRINGE-CONTAINR KIT (feeder irrigation kit)	Tier 3	
ENFIT MEDICAL STRAW (medical supply, miscellaneous)	Tier 3	
ENFIT MEDICINE BOTTLE ADAPTER (adapter cap for bottle)	Tier 3	
<i>enteral connector, enfit</i>	Tier 3	
ENTERAL GRAVITY BAG SET-ENFIT (feeder container with gravity set, ENFit)	Tier 3	
<i>eua patient assessment</i>	Tier 3	
EVENCARE G2 (blood-glucose meter)	DME	
EVENCARE G2 SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE G2 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVENCARE G3 CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE G3 GLUCOSE METER KIT (blood-glucose meter)	DME	
EVENCARE G3 TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVENCARE KIT (blood-glucose meter)	DME	
EVENCARE MINI GLUCOSE TEST STR STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVENCARE MINI MONITOR SYSTEM (blood-glucose meter)	DME	
EVENCARE PROVIEW TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EVENCARE SOLUTION (blood glucose calibration control high and low)	DME	
EVENCARE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EVERSENSE 365 SENSOR SUBCUTANEOUS DEVICE (glucose sensor,implantable,continuous/dexamethasone acetate)	Tier 3	PA; KP
EVERSENSE 365 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
EVOLUTION BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
EVOLUTION NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
EVOLUTION TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EXCEL SYRINGE SYRINGE 3 ML 23 X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL HYPODERMIC NEEDLES NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EXEL INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.3 mL)	Tier 1	
EXEL INSULIN SYRINGE 0.5 ML 30 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
EXEL INSULIN SYRINGE 1 ML 30 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
EXEL SYRINGE SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
EXEL SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
EXEL SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
EXEL SYRINGE SYRINGE 50 ML (syringe, disposable, 50 mL)	Tier 1	
EXTENDED RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
E-Z JECT LANCETS , 26 GAUGE, 30 GAUGE, 32 GAUGE, 33 GAUGE (lancets)	DME	
E-Z JECT THIN LANCETS 28 GAUGE (lancets)	DME	
EZ SMART CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
EZ SMART LANCETS 28 GAUGE (lancets)	DME	
EZ SMART PLUS SYSTEM KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
EZ SMART PLUS TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
EZ SMART SYSTEM KIT (blood-glucose meter)	DME	
EZ SMART TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FANTASY CONDOM DEVICE (condoms, latex, lubricated)	PV	
FASTEP COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
FC2 FEMALE CONDOM (condoms, female)	PV	
FEMALE CATHETER 14 FR (catheter)	Tier 3	
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (cervical cap)	PV	
FINGERSTIX LANCETS (lancets)	DME	
FLEXICHAMBER SPACER (inhaler, assist devices)	Tier 3	
FLEXICHAMBER-LG CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXICHAMBER-SM ADULT MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLEXICHAMBER-SM CHILD MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
FLEXI-SEAL SIGNAL FMS RECTAL (fecal collector with charcoal filter/catheter/syringe)	Tier 3	
FLOWFLEX COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
FLOWFLEX PLUS COVID-19 AND FLU KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
FORA 6 CONNECT GLUCOSE STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA 6CONN-GTEL-TN'G ADV STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA D40D GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	
FORA D40G GLUCOSE-BP MONITOR DEVICE (blood-glucose and blood pressure meter with adult cuff)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA D40-G31 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA G20 KIT (blood-glucose meter)	DME	
FORA G20 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA G30A (blood-glucose meter)	DME	
FORA GD50 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORA GD50 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA GTEL GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA GTEL MULTI-FUNCTN MONITOR DEVICE (blood ketone and glucose monitor)	DME	
FORA HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORA LANCING DEVICE (lancing device)	DME	
FORA LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORA NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORA PREMIUM V10 GLUCOSE METER (blood-glucose meter)	DME	
FORA TEST N'GO VOICE METER (blood-glucose meter)	DME	
FORA TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA TN'G ADV MOBILE MULTI MTR DEVICE (blood ketone and glucose monitor)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA TN'G ADVAN PRO TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA TN'G ADVANCE PRO MONITOR DEVICE (blood ketone and glucose monitor)	DME	
FORA TN'G VOICE METER (blood-glucose meter)	DME	
FORA TN'G VOICE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA V10 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORA V10-V12-D10-D20 STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORA V12 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
FORACARE GD20 GLUCOSE METER (blood-glucose meter)	DME	
FORACARE GD20 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORACARE GD40 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FORACARE GD40B GLUCOSE METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FORACARE GDH HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
FORACARE GDH LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
FORACARE GDH NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
FORACARE LANCETS 30 GAUGE (lancets)	DME	
FREESTYLE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
FREESTYLE FLASH SYSTEM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM KIT (blood-glucose meter)	DME	
FREESTYLE FREEDOM LITE KIT (blood-glucose meter)	DME	
FREESTYLE INSULINX (blood-glucose meter)	DME	
FREESTYLE INSULINX STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE INSULINX TEST STRIPS STRIP (blood sugar diagnostic)	DME	
FREESTYLE LANCETS 28 GAUGE (lancets)	DME	
FREESTYLE LIBRE 14 DAY READER (flash glucose scanning reader)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 14 DAY SENSOR KIT (flash glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE LIBRE 2 PLUS SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 2 READER (flash glucose scanning reader)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 2 SENSOR KIT (flash glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 3 PLUS SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 3 READER (blood-glucose meter, receiver, continuous)	DME	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LIBRE 3 SENSOR DEVICE (blood-glucose sensor)	Tier 2	HISTORY OF INSULIN USE OR SUBMIT A PA EXCEPTION REQUEST
FREESTYLE LITE METER KIT (blood-glucose meter)	DME	
FREESTYLE LITE STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE PRECISION NEO METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FREESTYLE PRECISION NEO STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE PRECISION SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
FREESTYLE PRECISION SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
FREESTYLE SIDEKICK II KIT (blood-glucose meter)	DME	
FREESTYLE SYSTEM KIT KIT (blood-glucose meter)	DME	
FREESTYLE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
FREESTYLE UNISTIK 2 (lancets)	DME	
GDRIVE KIT (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE100 BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GE100 BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GE100 CONTROL SOLUTION NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GE333 BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
GE333 BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GENABIO COVID-19 RAPID AT-HOME KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
GIRLS TRAINING PANTS 4T-5T (diaper/brief, infant-toddler, disposable)	Tier 3	
GLUCO NAVII GLUCOSE MONITOR KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCO NAVII TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD 01 HI-NORMAL CONTROL SOLUTION (blood glucose calibration control solution, high and normal)	DME	
GLUCOCARD 01 METER KIT (blood-glucose meter)	DME	
GLUCOCARD 01 NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD 01 SENSOR PLUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD EXPRESSION (blood-glucose meter)	DME	
GLUCOCARD EXPRESSION KIT (blood-glucose meter)	DME	
GLUCOCARD EXPRESSION SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD EXPRESSION STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD SHINE CONNEX METER (blood-glucose meter)	DME	
GLUCOCARD SHINE EXPRESS METER (blood-glucose meter)	DME	
GLUCOCARD SHINE METER (blood-glucose meter)	DME	
GLUCOCARD SHINE METER KIT KIT (blood-glucose meter)	DME	
GLUCOCARD SHINE SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCARD SHINE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD SHINE XL METER (blood-glucose meter)	DME	
GLUCOCARD VITAL KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCARD VITAL SENSOR STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCARD VITAL TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GLUCOCOM AUTOLINK (diabetic supplies, miscell)	DME	
GLUCOCOM BLOOD GLUCOSE KIT (blood-glucose meter)	DME	
GLUCOCOM CONTROL HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
GLUCOCOM CONTROL NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOCOM GLUCOSE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GLUCOCOM LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
GLUCOSE KETONE CONTROL SOLN SOLUTION (blood glucose calibration control solution, normal)	DME	
GM100 KIT (blood-glucose meter)	DME	
GM100 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GOJJI BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
GOJJI GLUCOSE CNTRL SOL-NORMAL SOLUTION (blood glucose calibration control solution, normal)	DME	
GOJJI LANCETS 30 GAUGE (lancets)	DME	
GOJJI LANCING DEVICE (lancing device)	DME	
GOJJI MULTI-FUNCTIONAL METER DEVICE (blood ketone and glucose monitor)	DME	
GOJJI MULTI-FUNCTIONAL METER KIT (blood ketone and glucose monitor)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GOTOKNOW COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days)
GUARDIAN 4 GLUCOSE SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
GUARDIAN 4 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN CONNECT TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN LINK 3 TRANSMITTER DEVICE (blood-glucose transmitter)	Tier 3	PA
GUARDIAN SENSOR 3 DEVICE (blood-glucose sensor)	Tier 3	PA
HARMONY GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
HEALTHPRO GLUCOSE MONITOR (blood-glucose meter)	DME	
HEALTHPRO HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
HEALTHPRO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEALTHWISE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
HEALTHWISE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
HEALTHWISE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
HOME NEBULIZER PLUS SIDESTREAM DEVICE (nebulizer and compressor)	Tier 3	
HYPOLANCE AST LANCING KIT (lancing device/lancets)	DME	
ID NOW COVID-19 TEST KIT KIT (COVID-19 molecular nucleic acid test assay)	Tier 3	
IHEALTH CONTROL SOLN LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	
IHEALTH COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
IHEALTH GLUCO PLUS METER KIT (blood-glucose meter)	DME	
IHEALTH GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ILET INFUSION KIT-INSET 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
ILET INFUSION KIT-INSET 32" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
ILET INFUSION-CONTACT DTCH 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
ILET INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
ILET STARTER KIT CONTACT KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
ILET STARTER KIT-INSET KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
IN-CHECK NASAL WITH MASK DEVICE (peak flow meter)	DME	
IN-CHECK ORAL FLOW METER DEVICE (peak flow meter)	DME	
INCONTROL LANCING DEVICE (lancing device)	DME	
INCONTROL PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INCONTROL SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
INCONTROL ULTRA THIN LANCETS 28 GAUGE (lancets)	DME	
INDICAID COVID-19 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
INFINITY CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
INFINITY CONTROL SOLUTION LOW SOLUTION (blood glucose calibration control solution, low)	DME	
INFINITY CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
INFINITY METER KIT KIT (blood-glucose meter)	DME	
INFINITY STARTER KIT KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFINITY TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
INJECT EASE LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
INNOSPIRE DELUXE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE ELEGANCE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE ESSENCE DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE GO NEBULIZER (nebulizer)	Tier 3	
INNOSPIRE MINI DEVICE (nebulizer and compressor)	Tier 3	
INNOSPIRE REPLACEMENT FILTER (nebulizer accessories)	Tier 3	
INPEN (FOR HUMALOG) BLUE SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin lispro)	DME	KP
INPEN (FOR HUMALOG) GREY SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin lispro)	DME	KP
INPEN (FOR HUMALOG) PINK SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin lispro)	DME	KP
INPEN (NOVOLOG OR FIASP) BLUE SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin aspart)	DME	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INPEN (NOVOLOG OR FIASP) GREY SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin aspart)	DME	KP
INPEN (NOVOLOG OR FIASP) PINK SUBCUTANEOUS INSULIN PEN (insulin pen, reusable, bluetooth for use with insulin aspart)	DME	KP
INSPIRACHAMBER SPACER (inhaler, assist devices)	Tier 3	
INSPIRACHAMBER WITH MASK-LARGE SPACER (inhaler,assist device with large mask)	Tier 3	
INSPIRACHAMBER WITH MASK-MED SPACER (inhaler,assist device with medium mask)	Tier 3	
INSPIRACHAMBER WITH MASK-SMALL SPACER (inhaler,assist device with small mask)	Tier 3	
INSPIRATION ELITE FILTER (nebulizer accessories)	Tier 3	
INSUFロン INFUSION SET 25 X 18 MM (subcutaneous administration set)	Tier 3	
INSUL-CAP (diabetic supplies,miscell)	DME	
INSUL-EZE (diabetic supplies,miscell)	DME	
<i>insulin syrlndl u100 half mark syringe 0.3 ml 31 gauge x 1/4"</i>	Tier 1	
INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 0.3 ml 29 gauge x 1/2", 0.3 ml 30, 0.3 ml 30 gauge x 1/2", 0.3 ml 30 gauge x 5/16", 0.3 ml 31 gauge x 1/4", 0.3 ml 31 gauge x 15/64", 0.3 ml 31 gauge x 5/16", 0.5 ml 29 gauge x 1/2", 0.5 ml 30 gauge x 1/2", 0.5 ml 30 gauge x 5/16", 0.5 ml 31 gauge x 5/16", 1 ml 27 gauge x 1/2", 1 ml 27 gauge x 5/8", 1 ml 28 gauge, 1 ml 28 gauge x 1/2", 1 ml 29 gauge x 1/2", 1 ml 29 gauge x 7/16", 1 ml 30 gauge x 1/2", 1 ml 30 gauge x 3/8", 1 ml 30 gauge x 5/16, 1 ml 30 gauge x 7/16", 1 ml 31 gauge x 1/4", 1 ml 31 gauge x 15/64", 1 ml 31 gauge x 5/16, 1/2 ml 27 gauge x 1/2", 1/2 ml 28 gauge, 1/2 ml 28 gauge x 1/2", 1/2 ml 29, 1/2 ml 30 gauge, 1/2 ml 31 gauge x 1/4", 1/2 ml 31 gauge x 15/64"</i>	Tier 1	
<i>insulin u-500 syringe-needle syringe 1/2 ml 31 gauge x 15/64"</i>	Tier 1	
INSUPEN PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
INSYTE IV CATHETER INFUSION SET 14 X 1.75 ", 20 X 1.16 " (intravenous catheter)	Tier 3	
INTEGRA SYRINGE SYRINGE 3 ML 21 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
INTELISWAB COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
INTERLINK LEVER LOCK CANNULA (syringe accessory)	Tier 3	
INTERLINK SYRINGE AND CANNULA SYRINGE 15 X 10 ML (syringe with cannula, disposable, 10 mL)	Tier 1	
INVACARE LANCETS 30 GAUGE (lancets)	DME	
I-PORT (injection ports)	Tier 3	
I-PORT ADVANCE 6 MM INJEC PORT (injection ports)	Tier 3	
I-PORT ADVANCE 9 MM INJEC PORT (injection ports)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
IRRIGATION SYRINGE SYRINGE (syringe disposable irrigation)	Tier 1	
IVENIX ADMIN SET 2INLET 2YSITE INFUSION SET (intravenous administration set)	Tier 3	
IVENIX ADMIN SET 2INLET Y-SITE INFUSION SET (intravenous administration set)	Tier 3	
IVENIX LVP EPIDURAL SET NRFIT EPIDURAL INFUSION SET (epidural administration set)	Tier 3	KP
KANGAROO 924 SAFETY SCREW (pump set)	Tier 3	
KANGAROO EPUMP SET (feeder container with pump set)	Tier 3	
KANGAROO GRAVITY SET (feeder container with gravity set)	Tier 3	
KELOTOP TOPICAL PAD 4.7 X 5.7 " (gel-matrix pad dressing, silicone)	Tier 3	
KENDALL DISINFECTANT CAP (alcohol swab cap)	Tier 3	
KENGUARD FOLEY CATHETER 18-16 FR-" (catheter)	Tier 3	
KENGUARD FOLEY CATHETER TRAY (catheterization tray)	Tier 3	
KERAGEL TOPICAL GEL (gel dressing)	Tier 3	
KERAGELT TOPICAL GEL (gel dressing)	Tier 3	
KERLIX AMD TOPICAL BANDAGE 0.2 %- 4.5" X 4.1 YARD (polyhexamethylene biguanide/gauze bandage)	Tier 3	
KERLIX AMD TOPICAL SPONGE 0.2 %- 6" X 6.75" (polyhexamethylene biguanide/gauze bandage)	Tier 3	
KETONE CARE STRIP (urine acetone test strips)	DME	
KETONE URINE TEST STRIP (urine acetone test strips)	DME	
KETOSTIX STRIP (urine acetone test strips)	DME	
KIMONO LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KIMONO MICROTHIN AQUA LUBE CON DEVICE (condoms, latex, lubricated)	PV	
KIMONO MICROTHIN CONDOMS DEVICE (condoms, latex, non-lubricated)	PV	
KIMONO MICROTHIN LARGE CONDOMS DEVICE (condoms, latex, lubricated)	PV	
KIMONO TEXTURED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
KIMONO THIN LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
<i>lancets , 21 gauge, 26 gauge, 28 gauge, 30 gauge, 33 gauge</i>	DME	
LANCETS, SUPER THIN (lancets)	DME	
LANCETS, THIN , 28 GAUGE (lancets)	DME	
LANCETS, ULTRA THIN (lancets)	DME	
<i>lancing device</i>	DME	
LANCING DEVICE WITH LANCETS (lancing device)	DME	
<i>lancing device with lancets kit</i>	DME	
LANCING SYSTEM (lancing device)	DME	
LANZO LANCING DEVICE KIT (lancing device/lancets)	DME	
LC PLUS (nebulizer)	Tier 3	
LC PLUS NEBULIZER-PED MASK (nebulizer)	Tier 3	
LITE TOUCH-MEDIUM MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITEAIRE MDI CHAMBER SPACER (inhaler, assist devices)	Tier 3	
LITETOUCH-LARGE MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	
LITETOUCH-SMALL MASK DEVICE (inhaler, assist devices, accessories)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOFRIC 12-16 FR-", 14-16 FR-" (catheter)	Tier 3	
LOFRIC ORIGO 14-16 FR-" (catheter)	Tier 3	
LOFRIC PRIMO NELATON CATHETER 16-16 FR-" (catheter)	Tier 3	
LOFRIC SENSE NELATON CATHETER 14-6 FR-" (catheter)	Tier 3	
LUCIRA CHECK-IT COVID HOME TST KIT (COVID-19 molecular nucleic acid test assay)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
LUER LOCK SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
LUER SLIP TIP SYRINGE TRAY SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
LUER-LOK TIP SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.3 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAGELLAN INSULIN SAFETY SYRNG SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
MAGELLAN SAFETY SYRINGE SYRINGE 1 ML 23 GAUGE X 1" (syringe,safety with needle,1 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.3 ML 30 X 5/16" (syringe with needle, insulin, safety, 0.3 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAGIC3 INTERMITTENT CATHETER 10-16 FR-", 12-16 FR-" (catheter)	Tier 3	
MAXICOMFORT II PEN NEEDLE NEEDLE 31 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MAXICOMFORT INSULIN SYRINGE SYRINGE 1/2 ML 27 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXI-COMFORT INSULIN SYRINGE SYRINGE 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16", 29 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
MC 300 NEBULIZER W-MOUTHPIECE (nebulizer)	Tier 3	
MC 300 NEBULIZER-UNVRSL TUBING (nebulizer)	Tier 3	
MEDIHONEY (CAL ALGINATE-HONEY) TOPICAL BANDAGE 2 X 2 ", 3/4 X 12 ", 4 X 5 " (calcium alginate/honey)	Tier 3	
MEDISENSE COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE CONTROLS 1-HI 1-LO COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE GLUCOSE KETONE COMBO PACK (blood-glucose calib. control)	DME	
MEDISENSE MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MEDISENSE THIN LANCETS 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MEDLANCE PLUS LANCETS 21 GAUGE, 25 GAUGE, 30 GAUGE (lancets)	DME	
MEDLANCE PLUS SPECIAL BLADE 0.8 X 2 MM (blade lancet, safety)	DME	
MEDTRONIC EXT INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MEDTRONIC EXT INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
METER-CHECK SOLUTION (blood glucose calibration control solution, normal)	DME	
MICRO BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
MICRO THIN LANCETS 33 GAUGE (lancets)	DME	
MICROAIR MESH NEBULIZER (nebulizer)	Tier 3	
MICROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
MICRODOT BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	
MICRODOT BLOOD GLUCOSE SYSTEM STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MICRODOT HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
MICRODOT NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
MICRODOT XTRA BLOOD GLUCOSE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
MICROLET 2 LANCING DEVICE KIT (lancing device/lancets)	DME	
MICROLET LANCET (lancets)	DME	
MICROLET NEXT LANCING DEVICE KIT (lancing device/lancets)	DME	
MICROLIFE PEAK FLOW METER DEVICE (peak flow meter)	DME	
MICROSPACER SPACER (inhaler, assist devices)	Tier 3	
MINI LANCING DEVICE (lancing device)	DME	
MINI PLUS NEBULIZER (nebulizer)	Tier 3	
MINI ULTRA-THIN II NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
MINI WRIGHT PEAK FLOW METER DEVICE (peak flow meter)	DME	
MINIMED 630G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
MINIMED 770G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MINIMED 780G INSULIN PUMP (subcutaneous insulin pump)	Tier 3	PA
MINIMED MIO ADVANCE INF SET23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED MIO ADVANCE INF SET43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED QUICK-SERTER (MMT-395) (diabetic supplies, miscell)	DME	
MINIMED SILHOUETTE 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SILHOUETTE 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 18" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
MINIMED SURE T 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
MOBILE LANCETS 30 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MODD1 PATIENT WELCOME KIT KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
MODD1 SUPPLY KIT COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
MONO-FLO DRAINAGE BAG 2,000 ML (drainage bag)	Tier 3	
MONOJECT 140CC PISTON SYRINGE SYRINGE (syringe, disposable)	Tier 1	
MONOJECT 35CC SYRINGE CATH TIP SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT 3CC SYR 25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT ALLERGY TRAY DETACH TRAY 1 ML 27 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 0.5 ML 28 X 1/2" (syring w-needl 0.5 mL,kit-tray)	Tier 1	
MONOJECT ALLERGY TRAY TRAY 1 ML 28 X 1/2" (syringe with needle 1 mL, disposable kit-tray)	Tier 1	
MONOJECT BLOOD COLLECTION NEEDLE 20 GAUGE X 1", 20 X 1 1/2 ", 21 GAUGE X 1", 22 GAUGE X 1" (needles, blood collection)	Tier 3	
MONOJECT CONTROL SYRINGE LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT DISPOSABLE SYRINGE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT ECCENTRIC NON-STERILE SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT HYPODERMIC NEEDLES NEEDLE 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1 1/2", 27 GAUGE X 1/2", 30 GAUGE X 3/4" (needles, disposable)	Tier 3	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SAFETY SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT INSULIN SYRINGE SYRINGE 1 ML , 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
MONOJECT LUER ADAPTER INTRAVENOUS ADMIX ACCESSORY (intravenous equipment)	Tier 3	
MONOJECT LUER-LOCK TIP SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT LUER-LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT MAGELLAN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT MAGELLAN SYRINGE SYRINGE 3 ML 20 GAUGE X 1" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT PHARMACY TRAY LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT PHARMACY TRAY REG TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT REG TIP NON-STERILE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT REGULAR LUER SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT REGULAR LUER SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SAFETY LUER LOCK TIP SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 12 ML (syringe, disposable, 12 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 12 ML 20 X 1 1/2", 12 ML 21X 1 1/2" (syringe,safety with needle,12 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
MONOJECT SAFETY SYRINGES SYRINGE 6 ML (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 12 ML (syringe with cannula,disposable 12 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 3 ML (syringe with cannula, disposable, 3 mL)	Tier 1	
MONOJECT SMARTIP CANNULA SYRINGE 6 ML (syringe with cannula, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 35 ML (syringe, disposable, 35 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE LUER LOK SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT SYRINGE REGULAR LUER SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT SYRINGE SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 12 ML 18 GAUGE X 1", 12 ML 20 X 1 1/2", 12 ML 21 GAUGE X 1 1/2", 12 ML 21 GAUGE X 1" (syringe with needle,disposable, 12 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 140 ML (syringe, disposable, 140 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 3 ML (syringe, disposable, 3 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 20 X 3/4", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 1 1/4", 3 ML 25 X 5/8", 3 ML 27 GAUGE X 1 1/4" (syringe with needle,disposable, 3 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML (syringe, disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE SYRINGE 6 ML 20 X 1 1/2", 6 ML 21 X 1 1/2", 6 ML 21 X 1", 6 ML 22 X 1 1/2" (syringe with needle,disposable, 6 mL)	Tier 1	
MONOJECT SYRINGE TOOMEY TYPE SYRINGE 60 ML (syringe, disposable, 60 mL)	Tier 1	
MONOJECT TB LUER LOK SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB REGULAR LUER TIP SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TB SAFETY SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
MONOJECT TB SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 X 1/2", 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
MONOJECT TUBERCULIN SYRINGE SYRINGE 1/2 ML 28 X 1/2" (syringe with needle,disposable, 0.5 mL)	Tier 1	
MONOJECT ULTRA COMFORT INSULIN SYRINGE 1/2 ML 28 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
MONOLET LANCETS 21 GAUGE (lancets)	DME	
MONOLET THIN LANCETS 28 GAUGE (lancets)	DME	
MULTI-LANCET DEVICE 2 KIT (lancing device/lancets)	DME	
MYGLUCOHEALTH CONTROL SOLUTION SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
MYGLUCOHEALTH KIT (blood-glucose meter)	DME	
MYGLUCOHEALTH LANCETS 30 GAUGE (lancets)	DME	
MYGLUCOHEALTH STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
NANO 2ND GEN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
NANO PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
nebulizer and compressor device	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NEUTEK 2TEK TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
NEXIVA INFUSION SET 18 X 1 1/4 ", 18 X 1 3/4 ", 20 GAUGE X 1", 20 X 1 1/4 ", 20 X 1 3/4 ", 22 GAUGE X 1", 24 GAUGE X 3/4", 24 X 0.56 " (intravenous catheter)	Tier 3	
NIGHTTIME UNDERPANTS L-XL (diaper,brief,youth,disposable)	Tier 3	
NORM-JECT SYRINGE 10 ML (syringe, disposable, 10 mL)	Tier 1	
NORM-JECT SYRINGE 20 ML (syringe, disposable, 20 mL)	Tier 1	
NORM-JECT TUBERKULIN SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	
NOSE CLIP (nebulizer accessories)	Tier 3	
NOVA MAX GLUCOSE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
NOVA MAX PLUS GLUC-KETON METER DEVICE (blood ketone and glucose monitor)	DME	
NOVA MAX PLUS GLUC-KETON METER KIT (blood ketone and glucose monitor)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NOVA SAFETY LANCETS 23 GAUGE, 28 GAUGE (lancets)	DME	
NOVA SUREFLEX LANCETS (lancets)	DME	
NOVAMAX PLUS GLU-KET SOLUTION (blood glucose and ketone control, normal)	DME	
NOVOFINE 32 NEEDLE 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
NOVOFINE PLUS NEEDLE 32 GAUGE X 1/6" (pen needle, diabetic)	Tier 1	
NOVOPEN ECHO SUBCUTANEOUS INSULIN PEN (insulin admin. supplies)	DME	
NUVA III TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAGEL TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
NUVAZIL II TOPICAL SHEET 10 CM X 12 CM (silicone adhesive)	Tier 3	
OASIS ULTRA FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX FENESTRATED TOPICAL SHEET 3 X 3.5 CM, 3 X 7 CM (porcine acellular small intestine submucosa, fenestrated)	Tier 3	
OASIS WOUND MATRIX MESHED TOPICAL SHEET 5 X 7 CM, 7 X 10 CM, 7 X 20 CM (porcine acell submucosa,meshed)	Tier 3	
OMBRA COMPRESSOR SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
OMNIPOD 5 (G6/LIBRE 2 PLUS) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,subcut automated dosing,BT,G6/L2)	Tier 2	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OMNIPOD 5 G6-G7 INTRO KT(GEN5) SUBCUTANEOUS CARTRIDGE (insulin pump cart,automated dosing,BT,G6/G7 with controller)	Tier 2	KP
OMNIPOD 5 G6-G7 PODS (GEN 5) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,subcut automated dosing,BT,G6/G7)	Tier 2	KP
OMNIPOD 5 INTRO(G6/LIBRE2PLUS) SUBCUTANEOUS CARTRIDGE (insulin pump cart,automated dosing,BT,G6/L2 with controller)	Tier 2	KP
OMNIPOD DASH INTRO KIT (GEN 4) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,continuous infusion,BT and controller)	Tier 2	KP
OMNIPOD DASH PDM KIT (GEN 4) (insulin pump controller)	Tier 2	
OMNIPOD DASH PODS (GEN 4) SUBCUTANEOUS CARTRIDGE (insulin pump cartridge,continuous subcut infusion,bluetooth)	Tier 2	KP
ON CALL EXPRESS CONTROL SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
ON CALL EXPRESS METER (blood-glucose meter)	DME	
ON CALL EXPRESS METER KIT (blood-glucose meter)	DME	
ON CALL EXPRESS TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ON CALL LANCET 30 GAUGE (lancets)	DME	
ON CALL LANCING DEVICE (lancing device)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH DELICA PLUS LANC DEV KIT (lancing device/lancets)	DME	
ONETOUCH DELICA PLUS LANCET 30 GAUGE, 33 GAUGE (lancets)	DME	
ONETOUCH DELICA SAFETY LANCET 30 GAUGE (lancets)	DME	
ONETOUCH ULTRA CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH ULTRA TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ONETOUCH ULTRA2 METER (blood-glucose meter)	DME	
ONETOUCH ULTRASOFT 2 LANCET 30 GAUGE (lancets)	DME	
ONETOUCH VERIO FLEX METER (blood-glucose meter)	DME	
ONETOUCH VERIO HIGH CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
ONETOUCH VERIO MID CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
ONETOUCH VERIO REFLECT METER (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ONETOUCH VERIO TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ON-GO COVID-19 AG AT HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
ON-THE-GO LANCETS 30 GAUGE (lancets)	DME	
OPTICHAMBER ADULT MASK-LARGE DEVICE (inhaler, assist devices, accessories)	Tier 3	
OPTICHAMBER DIAMOND LG MASK SPACER (inhaler,assist device with large mask)	Tier 3	
OPTICHAMBER DIAMOND VHC SPACER (inhaler, assist devices)	Tier 3	
OPTICHAMBER DIAMOND-MED MSK SPACER (inhaler,assist device with medium mask)	Tier 3	
OPTICHAMBER DIAMOND-SML MASK SPACER (inhaler,assist device with small mask)	Tier 3	
OPTIUM EZ STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPTIUM TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
OVAL TAPE (diabetic supplies, miscell)	DME	
PARADIGM RESERVOIR 1.8 ML (insulin pump syringe, 1.8 mL)	Tier 1	
PARADIGM RESERVOIR 3 ML (insulin pump syringe, 3 mL)	Tier 1	
PARI BABY CONV KIT - SIZE 1 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 2 KIT (nebulizer accessories)	Tier 3	
PARI BABY CONV KIT - SIZE 3 KIT (nebulizer accessories)	Tier 3	
PARI LC SPRINT NEBULIZER SET (nebulizer)	Tier 3	
PARI LC SPRINT SINUS (nebulizer)	Tier 3	
PARI TREK S COMBO PACK DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S COMPACT COMPRESSOR DEVICE (nebulizer and compressor)	Tier 3	
PARI TREK S PORTABLE PWR KIT (nebulizer accessories)	Tier 3	
PCCA ACCUPEN-15 DEVICE (topical cream metered-dose device)	Tier 3	
PEAK AIR PEAK FLOW METER DEVICE (peak flow meter)	DME	
PEDIATRIC BEAR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PEDIATRIC COMP-AIR COMPRES NEB DEVICE (nebulizer and compressor)	Tier 3	
PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
<i>pen needle, diabetic needle 29 gauge x 1/2", 30 gauge x 3/16", 30 gauge x 5/16", 31 gauge x 1/4", 31 gauge x 3/16", 31 gauge x 5/16", 31 gauge x 5/32", 32 gauge x 1/4", 32 gauge x 3/16", 32 gauge x 5/16", 32 gauge x 5/32", 33 gauge x 1/4", 33 gauge x 3/16", 33 gauge x 5/32"</i>	Tier 1	
<i>pen needle, diabetic needle 29 gauge x 15/32", 31 gauge x 1/3", 31 gauge x 1/6", 31 gauge x 13/64", 31 gauge x 15/64"</i>	Tier 1	
<i>pen needle, diabetic, safety needle 31 gauge x 3/16", 31 gauge x 5/32"</i>	Tier 1	
PENTIPS PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PERFECT POINT SAFETY LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
PERSONAL BEST FULL RANGE DEVICE (peak flow meter)	DME	
PERSONAL BEST LOW RANGE DEVICE (peak flow meter)	DME	
PETROLEUM GAUZE TOPICAL BANDAGE (petrolatum,white)	Tier 3	
PFLEX INSPIRATORY TRAINER DEVICE (spirometers and accessories)	Tier 3	
PHARMACIST CHOICE GLUCOSE SYS (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PHARMACIST CHOICE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PHASEAL ASSEMBLY FIXTURE DEVICE (assembly system, vial to transfer device, closed system)	Tier 3	
PHASEAL CONNECTOR LUER LOCK (connector luer lock, closed system)	Tier 3	
PHASEAL INFUSION ADAPTER (infusion adapter, closed system)	Tier 3	
PHASEAL INFUSION CLAMP (clamp, IV tubing)	Tier 3	
PHASEAL INJECTOR LUER (needle injector, luer, closed system)	Tier 3	
PHASEAL INJECTOR LUER LOCK (needle injector, luer lock, closed system)	Tier 3	
PHASEAL PROTECTOR DEVICE 13 MM, 20 MM, 28 MM (transfer device, closed system)	Tier 3	
PHASEAL SECONDARY SET INFUSION SET (intravenous piggyback administration set)	Tier 3	
PHASEAL Y-SITE (y-site line connector, closed system)	Tier 3	
PIKO 1 DEVICE (peak flow meter)	DME	
PILLOW MASK CHILD (nebulizer accessories)	Tier 3	
PILOT COVID-19 AT-HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
PIP BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PIP BLOOD GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PIP GLUCOSE CONTROL SOLN L1-L2 SOLUTION (blood glucose calibration control high and low)	DME	
PIP LANCET 28 GAUGE, 30 GAUGE (lancets)	DME	
PIP PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PIXEL COVID19 HOME COLLECT KIT (COVID-19 test specimen collection)	Tier 3	
PLATINUM TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
POCKET CHAMBER SPACER (inhaler, assist devices)	Tier 3	
POCKET PEAK FLOW METER DEVICE (peak flow meter)	DME	
POLY HUB NEEDLE NEEDLE 30 GAUGE X 1/2" (needles, disposable)	Tier 1	
PRECISION (blood-glucose meter)	DME	
PRECISION GLUCOSE CONTROL SOLN COMBO PACK (blood-glucose calib. control)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRECISION GLUCOSE/KETONE CONTR COMBO PACK (blood-glucose calib. control)	DME	
PRECISION PCX PLUS TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION PCX TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION POINT OF CARE TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRECISION Q-I-D TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRECISION XTRA KETONE-GLUCOSE KIT (blood ketone and glucose monitor)	DME	
PRECISION XTRA MONITOR (blood-glucose meter)	DME	
PRECISION XTRA TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PREMIER BLU GLUCOSE METER (blood-glucose meter)	DME	
PREMIER CLASSIC GLUCOSE METER (blood-glucose meter)	DME	
PREMIER COMPACT GLUCOSE METER KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMIER TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PREMIER VOICE GLUCOSE METER (blood-glucose meter)	DME	
PREMIUM BLOOD GLUCOSE MONITOR (blood-glucose meter)	DME	
PREMIUM V10 (blood-glucose meter)	DME	
PREMIUM V10 STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRESSURE ACTIVATED LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
PREVENT DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
PRIMEAIRE SPACER (inhaler, assist devices)	Tier 3	
PRO COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle, insulin, 0.5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRO COMFORT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PRO COMFORT LANCET 30 GAUGE, 31 GAUGE (lancets)	DME	
PRO COMFORT PEN NEEDLE NEEDLE 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PRO COMFORT SAFETY LANCET 30 GAUGE (lancets)	DME	
PRO COMFORT TENS ELECTRODE PAD (tens unit electrodes)	Tier 3	
PRO COMFORT TENS UNIT COMBO PACK (transcutaneous electrical nerve stimulators(TENS)/electrodes)	Tier 3	
PRO VOICE V8-V9 TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRO VOICE V9 GLUCOSE MONITOR (blood-glucose meter)	DME	
PROCARE COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE PEDIATRIC NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
PROCARE SPACER WITH ADULT MASK SPACER (inhaler,assist device with large mask)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROCARE SPACER WITH CHILD MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
PRO-CEPTION VAGINAL (medical supply, miscellaneous)	Tier 3	
PROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
PRODIGY AUTOCODE METER KIT (blood-glucose meter)	DME	
PRODIGY AUTOCODE MONITOR SYST (blood-glucose meter)	DME	
PRODIGY CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
PRODIGY CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
PRODIGY INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
PRODIGY INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
PRODIGY LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	
PRODIGY LANCING DEVICE (lancing device)	DME	
PRODIGY MINI-MIST NEBULIZER (nebulizer)	Tier 3	
PRODIGY NO CODING STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
PRODIGY POCKET METER KIT (blood-glucose meter)	DME	
PRODIGY TWIST TOP LANCET 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PRODIGY VOICE GLUCOSE METER KIT (blood-glucose meter)	DME	
PRONEB MAX COMPRESSOR-LC PLUS DEVICE (nebulizer and compressor)	Tier 3	
PRONEB MAX COMPRESSOR-LC SPRINT DEVICE (nebulizer and compressor)	Tier 3	
PRONEB ULTRA II FILTER ASSEM (nebulizer accessories)	Tier 3	
PROSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
PROVATE PELVIC ORGAN SUPPORT VAGINAL 61 MM, 67 MM, 73 MM, 79 MM, 85 MM, 91 MM (pessary)	Tier 3	
PROVENT NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PROVENT STARTER NASAL DEVICE (nasal exhalation resistance device)	Tier 3	
PULMO-AIDE COMPRESSOR DEVICE (compressor, for nebulizer)	Tier 3	
PULMONEB LT COMPRESSOR NEBUL DEVICE (nebulizer and compressor)	Tier 3	
PURE COMFORT LANCETS 30 GAUGE (lancets)	DME	
PURE COMFORT PEN NEEDLE NEEDLE 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
PURE COMFORT SAFETY LANCETS 30 GAUGE (lancets)	DME	
PURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
PUREAIR MINI NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PURECOMFORT PEAK FLOW METER DEVICE (peak flow meter)	DME	
PUSH BUTTON SAFETY LANCETS 28 GAUGE (lancets)	DME	
QUAKE VIBRATORY PEP DEVICE (mucus clearing device)	Tier 3	
QUICKVUE AT-HOME COVID-19 TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
QUICKVUE SARS ANTIGEN KIT (COVID-19 antigen immunoassay test)	Tier 3	
QUINTET AC (blood-glucose meter)	DME	
QUINTET AC STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
QUINTET BLOOD GLUCOSE METER (blood-glucose meter)	DME	
QUINTET GLUCOSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RAPID SARS-COV-2 AG HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RAPIDGO FLU AND COVID-19 TEST KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
RAPPORT VACUUM THERAPY KIT (vacuum erection device system)	Tier 3	
RECONSTITUTE KIT (medical supply, miscellaneous)	Tier 3	
REFUAH PLUS GLUCOSE CONTROL SOLUTION (blood glucose calibration control solution, high)	DME	
REFUAH PLUS GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
REFUAH PLUS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RELIAMED LANCET 28 GAUGE, 30 GAUGE (lancets)	DME	
RELIAMED MINI LANCING DEVICE (lancing device)	DME	
RELIAMED SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
RELION ALL-IN-ONE METER KIT (blood-glucose meter)	DME	
RELION CONFIRM KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RELION CONFIRM-MICRO STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RELION MICRO GLUCOSE MONITOR (blood-glucose meter)	DME	
RELION MICRO GLUCOSE MONITOR KIT (blood-glucose meter)	DME	
RELION PRIME METER (blood-glucose meter)	DME	
RELION PRIME TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RELION ULTIMA STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RELIZORB CARTRIDGE (enteral pump accessory for fat hydrolysis)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
REPLICARE DRESSING TOPICAL BANDAGE 1 1/2 X 2 1/2 " (hydrocolloid dressing)	Tier 3	
REPLICARE THIN TOPICAL BANDAGE 2 X 2 3/4 ", 3 1/2 X 5 1/2 ", 6 X 8 " (hydrocolloid dressing)	Tier 3	
REPLICARE ULTRA DRESSING TOPICAL BANDAGE 4 X 4 ", 7 X 8 " (hydrocolloid dressing)	Tier 3	
RESTORE TOPICAL BANDAGE 2 X 2 " (silver/calcium alginate)	Tier 3	
REUSABLE NEBULIZER KIT KIT (nebulizer accessories)	Tier 3	
REVEAL BLOOD GLUCOSE METER KIT (blood-glucose meter)	DME	
REVEAL TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RIGHTEST CONTROL SOLUTION HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
RIGHTEST CONTROL SOLUTION NORM SOLUTION (blood glucose calibration control solution, normal)	DME	
RIGHTEST GD500 LANCING DEVICE (lancing device)	DME	
RIGHTEST GL300 LANCETS 30 GAUGE (lancets)	DME	
RIGHTEST GM550 SYSTEM KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RIGHTEST GS550 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RIGHTEST GT333 GLUCOSE METER (blood-glucose meter)	DME	
RIGHTEST GT333 TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
RITEFLO AEROCHAMBER SPACER (inhaler, assist devices)	Tier 3	
ROBINSON CLEAR VINYL CATHETER 16 FR (catheter)	Tier 3	
RUBBER MOUTHPIECE (nebulizer accessories)	Tier 3	
SAFESNAP INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16" (syringe w-needle 0.3 mL,insulin,safety w-self-cont.dis.unit)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16" (insulin syringe-needle,safety,disposal unit,0.5 mL)	Tier 1	
SAFESNAP INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle 1 mL,insulin,safety w-self-con.disp.unit)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SAFESNAP SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 GAUGE X 1/2" (syringe,needle,safety 1 mL,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 10 ML (syringe, safety 10 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2", 10 ML 21 GAUGE X 1", 10 ML 22 GAUGE X 1 1/2", 10 ML 22 GAUGE X 1" (syringe,safety needle 10 mL and self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML (syringe, safety 3 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe 3 mL with safety needle,self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 5 ML (syringe, safety 5 mL, self-contained disposal unit)	Tier 1	
SAFESNAP SYRINGE SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 GAUGE X 1" (syringe, safety needle 5 mL and self-contained disposal unit)	Tier 1	
SAFETY LANCETS 21 GAUGE, 28 GAUGE (lancets)	DME	
<i>safety needles needle 18 gauge x 1 1/2"</i>	Tier 3	
SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 3/16" (pen needle, diabetic, safety)	Tier 1	
SAFETY SEAL LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SAFETY-LET LANCETS 30 GAUGE (lancets)	DME	
SAMI THE SEAL DEVICE (nebulizer and compressor)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SAMI THE SEAL MASK (nebulizer accessories)	Tier 3	
SCARCIN PAD PLUS TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARCINPAD TOPICAL PAD 1.57 X 5.12 " (gel-matrix pad dressing, silicone)	Tier 3	
SCARHEAL TOPICAL SHEET 2 X 2.5 " (silicone adhesive)	Tier 3	
SCARSILK TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SECURESAFE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
SECURESAFE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
SECURESAFE PEN NEEDLE NEEDLE 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
SELF-CATHETER, FEMALE 14 FR (catheter)	Tier 3	
SIDESTREAM (nebulizer)	Tier 3	
SIDESTREAM MASK (nebulizer accessories)	Tier 3	
SIDESTREAM NEBULIZER (nebulizer)	Tier 3	
SIDESTREAM PLUS (nebulizer)	Tier 3	
SILADERM TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
SILADONE TOPICAL SHEET 2 X 2.5 " (silicone adhesive)	Tier 3	
SILASTIC FOLEY CATHETER 20 FR (catheter)	Tier 3	
SILICONE MASK (nebulizer accessories)	Tier 3	
SILICONE MASK - INFANT DEVICE (inhaler, assist devices, accessories)	Tier 3	
SIL-K TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	
SILTREX TOPICAL PAD 2 X 5.5 " (gel-matrix pad dressing, silicone)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SIMPLERA SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
SIMPLERA SYNC SENSOR DEVICE (blood-glucose sensor)	Tier 3	PA
SIMPLI PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SINGLE-LET (lancets)	DME	
SINUSTAR NEBULIZER (nebulizer)	Tier 3	
SKY SAFETY PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
SMART SENSE LANCETS 21 GAUGE, 26 GAUGE, 33 GAUGE (lancets)	DME	
SMART SENSE MONITORING SYSTEM (blood-glucose meter)	DME	
SMART SENSE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SMARTDIABETES VANTAGE (lancing device)	DME	
SMARTEST CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
SMARTEST EJECT KIT (blood-glucose meter)	DME	
SMARTEST LANCET (lancets)	DME	
SMARTEST PERSONA GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PERSONA STARTER KIT (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SMARTEST PRONTO GLUCOSE METER (blood-glucose meter)	DME	
SMARTEST PRONTO STARTER KIT (blood-glucose meter)	DME	
SMARTEST PROTEGE KIT (blood-glucose meter)	DME	
SMARTEST SMART CODE METER KIT (blood-glucose meter)	DME	
SMARTEST TALKING METER KIT (blood-glucose meter)	DME	
SMARTEST TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SMARTNEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
SOFIA SARS ANTIGEN FIA KIT (COVID-19 antigen immunoassay test)	Tier 3	
SOFIA2 FLU-SARS ANTIGEN FIA KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
SOLUS V2 AUDIBLE METER (blood-glucose meter)	DME	
SOLUS V2 AUDIBLE METER KIT (blood-glucose meter)	DME	
SOLUS V2 CONTROL SOLUTION, LOW SOLUTION (blood glucose calibration control solution, low)	DME	
SOLUS V2 CONTROL SOLUTION,HIGH SOLUTION (blood glucose calibration control solution, high)	DME	
SOLUS V2 LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SOLUS V2 LANCING DEVICE KIT (lancing device/lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOLUS V2 TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SOOTHENEB COMPRESSOR NEBULIZER DEVICE (nebulizer and compressor)	Tier 3	
SOOTHENEB MESH NEBULIZER (nebulizer)	Tier 3	
SPACE CHAMBER SPACER (inhaler, assist devices)	Tier 3	
SPACE CHAMBER WITH LARGE MASK SPACER (inhaler,assist device with large mask)	Tier 3	
SPACE CHAMBER WITH MEDIUM MASK SPACER (inhaler,assist device with medium mask)	Tier 3	
SPACE CHAMBER WITH SMALL MASK SPACER (inhaler,assist device with small mask)	Tier 3	
SPECTRAGEL TOPICAL GEL (gel dressing)	Tier 3	
SPEEDICATH (FEMALE) 16 FR (catheter)	Tier 3	
SPEEDYSWAB COVID-19 AND FLU KIT (COVID-19, influenza A, influenza B antigen immunoassay test)	Tier 3	
SPEEDYSWAB COVID-19 HOME TEST KIT (COVID-19 antigen immunoassay test)	Tier 3	QL (8 EA per 30 days); Age (Min 2 Years)
STERILANCE TL 30 GAUGE, 32 GAUGE (lancets)	DME	
STERILE DROPTAINERS (eye drop dispenser)	Tier 3	
STRATACTX TOPICAL GEL (gel dressing)	Tier 3	
STRATAGRT TOPICAL GEL (gel dressing)	Tier 3	
STRATAXRT TOPICAL GEL (gel dressing)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUNRISE COMPRESSOR-NEBULIZER DEVICE (compressor, for nebulizer)	Tier 3	
SUPER THIN LANCETS 28 GAUGE, 30 GAUGE (lancets)	DME	
SURE COMFORT INS. SYR. U-100 SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 1/4", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
SURE COMFORT LANCETS 18 GAUGE, 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
SURE COMFORT LANCING PEN (lancing device)	DME	
SURE COMFORT PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 30 GAUGE X 5/16", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
SURE-FINE PEN NEEDLES NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SUREFLEX DEVICE WITH LANCETS KIT (lancing device/lancets)	DME	
SUREFLEX LANCING DEVICE (lancing device)	DME	
SURE-JECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
SURE-JECT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
SURE-LANCE , 26 GAUGE, 28 GAUGE (lancets)	DME	
SURE-LANCE ULTRA THIN 30 GAUGE (lancets)	DME	
SURE-PEN LANCING DEVICE (lancing device)	DME	
SURE-TEST EASYPLUS MINI METER (blood-glucose meter)	DME	
SURE-TEST EASYPLUS MINI SOLUTION (blood glucose calibration control solution, normal)	DME	
SURE-TEST EASYPLUS MINI STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
SURE-TOUCH LANCET (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SURGUARD2 SAFETY NEEDLE 18 GAUGE X 1 1/2", 18 GAUGE X 1", 19 GAUGE X 1 1/2", 19 GAUGE X 1", 20 GAUGE X 1 1/2", 20 GAUGE X 1", 21 GAUGE X 1 1/2", 21 GAUGE X 1", 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1 1/2", 23 GAUGE X 1", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1/2", 27 GAUGE X 1/2" (needles, safety)	Tier 3	
SURGUARD2 SAFETY NEEDLE 30 GAUGE X 1 1/2" (needles, safety)	Tier 1	
SURGUARD2 SAFETY SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 26 GAUGE X 3/8", 1 ML 27 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 10 ML 20 GAUGE X 1 1/2", 10 ML 20 GAUGE X 1", 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 3 ML 20 GAUGE X 1 1/2", 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
SURGUARD2 SAFETY SYRINGE 5 ML 20 GAUGE X 1 1/2", 5 ML 20 GAUGE X 1", 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
<i>syringe (disposable) syringe 10 ml, 20 ml, 3 ml, 30 ml, 5 ml, 60 ml</i>	Tier 1	
SYRINGE 3CC/20GX1" SYRINGE 3 ML 20 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1" SYRINGE 3 ML 21 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/21GX1-1/2" SYRINGE 3 ML 21 GAUGE X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/22GX1" SYRINGE 3 ML 22 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SYRINGE 3CC/22GX3/4" SYRINGE 3 ML 22 GAUGE X 3/4" (syringe with needle,disposable, 3 mL)	Tier 1	
SYRINGE 3CC/25GX1" SYRINGE 3 ML 25 GAUGE X 1" (syringe with needle,disposable, 3 mL)	Tier 1	
<i>syringe with needle syringe 1 ml 25 gauge x 1", 10 ml 20 x 1", 3 ml 20 gauge x 1 1/2", 3 ml 22 x 1 1/2", 3 ml 23 x 1"</i>	Tier 1	
SYRINGE WITHOUT NEEDLE SYRINGE (syringe, disposable)	Tier 1	
SZOSIL TOPICAL SHEET 5 CM X 14 CM (silicone adhesive)	Tier 3	
SZOSIL TOPICAL STRIP 1.4 X 6 " (silicone adhesive)	Tier 3	
T.E.D. ANTI-EMBOLISM STOCKING (compression stocking, knee high, regular length, small)	Tier 3	
T.E.D. KNEE LENGTH-M-LONG (compression stocking,knee high,long length,small circumferen)	Tier 3	
T.E.D. KNEE LENGTH-S-REGULAR (compression stocking, knee high, regular length, small)	Tier 3	
T:FLEX SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	KP
T:SLIM X2 BASAL-IQ INSULIN PMP (subcutaneous insulin pump)	Tier 3	PA
T:SLIM X2 CONTROL-IQ (subcutaneous insulin pump)	Tier 3	PA
T:SLIM X2 SUBCUTANEOUS CARTRIDGE (insulin pump cartridge)	Tier 3	KP
TANDEM MOBI AUTOSOFT 30 KT 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFT XC KIT 5" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFT XC KT 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TANDEM MOBI AUTOSOFT30 14PK 23 COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFTXC 14PK 23 COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI AUTOSOFTXC 14PK 5" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM MOBI SYSTEM (subcutaneous insulin pump)	Tier 3	PA
TANDEM MOBI TRUSTEEL KIT 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT 30 PK10 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT 30 PK14 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT XC PK10 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM ASFT XC PK14 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TANDEM T:SLIM TRUSTL PK10 23" COMBO PACK (infusion set for insulin pump/insulin pump cartridge)	Tier 3	
TD GOLD LEVEL 1 CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
TD GOLD LEVEL 2 CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.5 mL (half unit mark))	Tier 1	
TECHLITE LANCETS 26 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
TECHLITE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TECHLITE PLUS PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TELCARE CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
TELCARE LANCETS 30 GAUGE (lancets)	DME	
TELCARE TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
TEMPO REFILL KIT WITH GAUZE KIT (lancets/blood glucose test strips/pen needles/gauze)	DME	
TEMPO SMART BUTTON DEVICE (data transfer accessory (insulin pen), bluetooth)	Tier 3	
TEMPO WELCOME KIT KIT (blood glucose meter/insulin data transf accessory, bluetooth)	Tier 3	
TENS 502 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TENS 504 DEVICE (Transcutaneous Electrical Nerve Stimulators (TENS Units))	Tier 3	
TENSCARE ITOUCH SURE VAGINAL DEVICE (incont device,muscle toner,elt)	Tier 3	
TERUMO ALLERGY SYRINGE SYRINGE 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
TERUMO HYPODERMIC NEEDLE/SYRIN SYRINGE 5 ML 20 X 1 1/2", 5 ML 20 X 1", 5 ML 21 GAUGE X 1 1/2", 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2", 5 ML 22 X 1" (syringe with needle,disposable, 5 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.3 ML 30 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
TERUMO INSULIN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
TERUMO SYRINGE SYRINGE 30 ML (syringe, disposable, 30 mL)	Tier 1	
TEST N'GO BLOOD GLUCOSE SYSTEM (blood-glucose meter)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TEST N'GO TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
THERAHONEY TOPICAL BANDAGE 4 X 5 " (honey)	Tier 3	
THIN LANCETS 26 GAUGE (lancets)	DME	
THINPRO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 X 3/8", 0.3 ML 31 X 3/8" (syringe with needle,insulin,0.3 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 X 3/8", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8" (syringe with needle,insulin,0.5 mL)	Tier 1	
THINPRO INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 3/8", 1 ML 31 X 3/8" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
THRESHOLD IMT TRAINER DEVICE (spirometers and accessories)	Tier 3	
THRESHOLD PEP DEVICE DEVICE (spirometers and accessories)	Tier 3	
TOOMEY SYRINGE SYRINGE 70 ML (syringe, disposable irrigation, 70 mL)	Tier 1	
TOPCARE CLICKFINE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPCARE ULTRA COMFORT SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TOPCARE ULTRA COMFORT SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TOPCARE UNIVERSAL1 LANCET , 33 GAUGE (lancets)	DME	
TOUCH-TROL 10 FR (catheter)	Tier 3	
TROJAN ULTRA RIBBED CONDOM DEVICE (condoms, latex, lubricated)	PV	
TRUE COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUE COMFORT LANCET 30 GAUGE (lancets)	DME	
TRUE COMFORT PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUE COMFORT PRO INS SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1 ML 32 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE COMFORT SAFE INSULIN SYRG SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle, insulin, safety, 0.5 mL)	Tier 1	
TRUE COMFORT SAFE INSULIN SYRG SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16", 1 ML 32 GAUGE X 5/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
TRUE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
TRUE COVER CONDOM DEVICE (condoms, latex, lubricated)	PV	
TRUE METRIX AIR GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX AIR GLUCOSE METER KIT (blood-glucose meter)	DME	
TRUE METRIX GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX GLUCOSE TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
TRUE METRIX GO GLUCOSE METER (blood-glucose meter)	DME	
TRUE METRIX LEVEL 1 SOLUTION (blood glucose calibration control solution, low)	DME	
TRUE METRIX LEVEL 2 SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUE METRIX LEVEL 3 SOLUTION (blood glucose calibration control solution, high)	DME	
TRUE2GO BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUEDRAW LANCING DEVICE (lancing device)	DME	
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
TRUEPLUS INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
TRUEPLUS INSULIN SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
TRUEPLUS KETONE STRIP (urine acetone test strips)	DME	
TRUEPLUS LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
TRUEPLUS PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
TRUERESULT BLOOD GLUCOSE SYSTM KIT (blood-glucose meter)	DME	
TRUETEST TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TRUETRACK BLOOD GLUCOSE SYSTEM KIT (blood-glucose meter)	DME	
TRUETRACK SMART SYSTEM KIT (blood-glucose meter)	DME	
TRUETRACK TEST STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
TRUSTEEL INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
TRUSTEEL INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
TRUSTEX LATEX CONDOM DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX NON-LUB CONDOMS DEVICE (condoms, latex, non-lubricated)	PV	
TRUSTEX-RIA LUB/SPERMICIDE DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX-RIA LUBRICATED CONDOMS DEVICE (condoms, latex, lubricated)	PV	
TRUSTEX-RIA NON-LUB CONDOMS DEVICE (condoms, latex, non-lubricated)	PV	
TRUZONE PEAK FLOW METER DEVICE (peak flow meter)	DME	
TUBERCULIN SYRINGE SYRINGE 1 ML (syringe, disposable, 1 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 1", 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
<i>tuberculin-allergy syringes syringe 1 ml 26 gauge x 3/8"</i>	Tier 1	
TWIIST REFILL KT(CSST-NDL-SYR) KIT (insulin pump cartridge/insulin pump syringe/insulin needles)	Tier 3	
TWIIST RFL(INFUS-CSST-NDL-SYR) KIT (insulin pump cartridge/insulin infusion set/syringe/needle)	Tier 3	
TWIIST STARTER KIT KIT (insulin pump/insulin cartridge/infusion set/syringe/needle)	Tier 3	
TWIST LANCETS 30 GAUGE, 32 GAUGE (lancets)	DME	
ULTICARE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 1 ML 31 GAUGE X 1/4" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTICARE INSULIN SYRINGE SYRINGE 1/2 ML 31 GAUGE X 1/4" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTICARE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 1/4" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 1 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE LOW DEAD SPACE SYRING SYRINGE 3 ML 22 X 1 1/2" (syringe with needle,disposable, 3 mL)	Tier 1	
ULTICARE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTICARE SAFETY PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16" (pen needle, diabetic, safety)	Tier 1	
ULTICARE SAFETY SYRINGE SYRINGE 3 ML (syringe, safety 3 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTICARE SAFETY SYRINGE SYRINGE 3 ML 21 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 3 ML 22 GAUGE X 1", 3 ML 23 GAUGE X 1", 3 ML 25 GAUGE X 1", 3 ML 25 GAUGE X 5/8" (syringe,safety with needle,3 mL)	Tier 1	
ULTICARE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTICARE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTICARE SYRINGE 1 ML 25 GAUGE X 5/8" (syringe with needle,disposable, 1 mL)	Tier 1	
ULTICARE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTICARE TB SAFETY SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2" (syringe,safety with needle,1 mL)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 0.3 ML 30 X 1/2", 0.3 ML 31 X 5/16" (syringe with needle,insulin disposable,0.3 mL/empty containr)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1 ML 30 X 1/2", 1 ML 31 X 5/16" (syringe with needle, insulin,1 mL and sharps container)	Tier 1	
ULTIGUARD SAFEPAK-INSULIN SYR SYRINGE 1/2 ML 30 X 1/2", 1/2 ML 31 X 5/16" (syringe-needle,insulin,0.5 mL/container,empty)	Tier 1	
ULTIGUARD SAFEPAK-PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic, remover and disposal unit)	Tier 1	
ULTI-LANCE (lancing device)	DME	
ULTI-LANCE KIT (lancing device/lancets)	DME	
ULTILET BASIC LANCETS 30 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTILET CLASSIC LANCETS , 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE, 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTILET INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 29 (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTILET INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTILET LANCETS 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
ULTILET PEN NEEDLE NEEDLE 29 GAUGE, 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTILET SAFETY LANCETS 23 GAUGE (lancets)	DME	
ULTIMA MONITOR (blood-glucose meter)	DME	
ULTIMA TEST STRIPS STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ULTRA CMFT INS SYR (HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30, 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 28 GAUGE, 1/2 ML 28 GAUGE X 1/2", 1/2 ML 29, 1/2 ML 30 GAUGE (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA COMFORT INSULIN SYRINGE SYRINGE 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 30 GAUGE X 7/16", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA FLO INSUL SYR(HALF UNIT) SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA FLO INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA FLO PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA THIN II LANCETS 30 GAUGE (lancets)	DME	
ULTRA THIN LANCETS , 28 GAUGE, 30 GAUGE, 31 GAUGE (lancets)	DME	
ULTRA THIN PEN NEEDLE NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA THIN PLUS LANCETS 33 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA TLC LANCETS (lancets)	DME	
ULTRACARE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRACARE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-CARE LANCETS 30 GAUGE (lancets)	DME	
ULTRACARE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
ULTRA-FINE INS SYR (HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin 0.3 mL (half unit mark))	Tier 1	
ULTRA-FINE INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA-FINE INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1/2 ML 31 GAUGE X 15/64" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-FINE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-FINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4" (pen needle, diabetic)	Tier 1	
ULTRALANCE LANCETS 26 GAUGE, 28 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II (SHORT) INS SYR SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-THIN II (SHORT) PEN NDL NEEDLE 31 GAUGE X 5/16" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INS PEN NEEDLES NEEDLE 29 GAUGE X 1/2" (pen needle, diabetic)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
ULTRA-THIN II INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
ULTRA-THIN II LANCETS 28 GAUGE (lancets)	DME	
ULTRATRAK GLUCOSE METER (blood-glucose meter)	DME	
ULTRATRAK GLUCOSE METER KIT (blood-glucose meter)	DME	
ULTRATRAK HIGH-LOW CONTROL SOLUTION (blood glucose calibration control high and low)	DME	
ULTRATRAK NORMAL CONTROL SOLUTION (blood glucose calibration control solution, normal)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ULTRATRAK STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
ULTRATRAK ULTIMATE (blood-glucose meter)	DME	
ULTRATRAK ULTIMATE SOLUTION (blood glucose calibration control high and low)	DME	
ULTRATRAK ULTIMATE STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
UNIFINE OTC PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS MAXFLOW NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PENTIPS PLUS MAXFLOW NEEDLE 30 GAUGE X 3/16" (pen needle, diabetic)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNIFINE PENTIPS PLUS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNIFINE PROTECT NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
UNIFINE SAFECONTROL PEN NEEDLE NEEDLE 30 GAUGE X 3/16", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic, safety)	Tier 1	
UNIFINE ULTRA PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
UNILET COMFORTOUCH LANCET , 26 GAUGE (lancets)	DME	
UNILET GP LANCET (lancets)	DME	
UNILET LANCET 28 GAUGE, 33 GAUGE (lancets)	DME	
UNILET LANCETS 30 GAUGE (lancets)	DME	
UNILET SUPER THIN LANCETS 30 GAUGE (lancets)	DME	
UNISTIK 2 DEVICE KIT (lancing device/lancets)	DME	
UNISTIK 2 EXTRA LANCET 21 GAUGE (lancets)	DME	
UNISTIK 2 NORMAL LANCET 21 GAUGE (lancets)	DME	
UNISTIK 3 COMFORT LANCET 28 GAUGE (lancets)	DME	
UNISTIK 3 EXTRA LANCET 21 GAUGE (lancets)	DME	
UNISTIK 3 GENTLE 30 GAUGE (lancets)	DME	
UNISTIK 3 NORMAL LANCET 23 GAUGE (lancets)	DME	
UNISTIK COMFORT LANCETS 28 GAUGE (lancets)	DME	
UNISTIK CZT LANCET 23 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK EXTRA LANCETS 21 GAUGE (lancets)	DME	
UNISTIK NORMAL LANCETS 23 GAUGE (lancets)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UNISTIK PRO LANCET 21 GAUGE, 25 GAUGE, 28 GAUGE (lancets)	DME	
UNISTIK SAFETY 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTIK TOUCH LANCETS 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
UNISTRIp LOW CONTROL SOLUTION (blood glucose calibration control solution, low)	DME	
UNISTRIp1 TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
UNIVERSAL 1 LANCETS 21 GAUGE, 26 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
VANISHPOINT INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 3/16" (syringe with needle, insulin, safety, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2" (syringe with needle,insulin,0.5 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 1 ML 25 GAUGE X 1" (syringe with needle,disposable, 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2" (syringe with needle,disposable,insulin 1 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 10 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,10 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VANISHPOINT SYRINGE SYRINGE 3 ML 20 GAUGE X 1", 3 ML 21 GAUGE X 1 1/2", 3 ML 21 GAUGE X 1", 3 ML 22 GAUGE X 1", 3 ML 22 X 1 1/2", 3 ML 23 GAUGE X 1 1/2", 3 ML 23 X 1", 3 ML 25 GAUGE X 1", 3 ML 25 X 5/8" (syringe with needle,disposable, 3 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 3 ML 25 GAUGE X 1 1/2", 3 ML 27 GAUGE X 1 1/2" (syringe,safety with needle,3 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 5 ML 21 GAUGE X 1 1/2" (syringe,safety with needle,5 mL)	Tier 1	
VANISHPOINT SYRINGE SYRINGE 5 ML 21 GAUGE X 1", 5 ML 22 GAUGE X 1 1/2" (syringe with needle,disposable, 5 mL)	Tier 1	
VANISHPOINT TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 27 X 1/2" (syringe with needle,disposable, 1 mL)	Tier 1	
VAPRO PLUS INTERMITT CATHETER COMBO PACK 12 FR- 8", 14 FR- 16", 14 FR- 8" (urinary bag/catheter)	Tier 3	
VARISOFT INFUSION SET 23" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 32" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARISOFT INFUSION SET 43" INFUSION SET (infusion set for insulin pump)	Tier 3	
VARITHENA ADMINISTRATION PACK (transfer set/syringe, disposable/bandages,compression/tubing)	Tier 3	
VERIFINE INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.3 mL)	Tier 1	
VERIFINE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16" (syringe with needle,insulin,0.5 mL)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VERIFINE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 (syringe with needle,disposable,insulin 1 mL)	Tier 1	
VERIFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VERIFINE PLUS PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32" (pen needle, diabetic)	Tier 1	
VERIFINE PLUS PEN NEEDLE-SHARP NEEDLE 32 GAUGE X 5/32" (pen needle, diabetic, remover and disposal unit)	Tier 1	
VERIFINE SAFETY LANCET MINI 21 GAUGE, 23 GAUGE, 28 GAUGE, 30 GAUGE (lancets)	DME	
VERIFINE UNIVERSAL LANCET 28 GAUGE, 30 GAUGE, 33 GAUGE (lancets)	DME	
V-GO 20 DEVICE (sub-q insulin delivery device, 20 unit,disposable)	Tier 2	
V-GO 30 DEVICE (sub-q insulin delivery device, 30 unit, disposable)	Tier 2	
V-GO 40 DEVICE (sub-q insulin delivery device, 40 unit, disposable)	Tier 2	
VIBRANT ORAL CAPSULE (vibrating transient device for constipation)	Tier 3	
VIBRANT STARTER KIT COMBO PACK (vibrating transient device for constipation)	Tier 3	
VIOS AEROSOL DELIVERY SYSTEM DEVICE (nebulizer and compressor)	Tier 3	
VIVAGUARD INO CTRL SOLN-L1,2,3 SOLUTION (blood glucose calibration control solutions high,normal,low)	DME	
VIVAGUARD INO CTRL SOLN-L1,L3 SOLUTION (blood glucose calibration control high and low)	DME	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIVAGUARD INO CTRL SOLN-L2 SOLUTION (blood glucose calibration control solution, normal)	DME	
VIVAGUARD INO GLUCOSE METER (blood-glucose meter)	DME	
VIVAGUARD INO SMART GLUC METER (blood-glucose meter)	DME	
VIVAGUARD INO TEST STRIP STRIP (blood sugar diagnostic)	DME	ST: Requires prior prescription for Contour Test Strip, Contour Next, Contour Plus, Freestyle Insulinx, Freestyle Lite, Freestyle Precision Neo, Freestyle Test Strips, or Precision Xtra within the past 120 days
VIVAGUARD LANCET 30 GAUGE (lancets)	DME	
VIVAGUARD LANCING DEVICE (lancing device)	DME	
VIVAGUARD SAFETY LANCET 28 GAUGE (lancets)	DME	
VORTEX HOLDING CHAMBER SPACER (inhaler, assist devices)	Tier 3	
VORTEX VHC PEDIATRIC MASK SPACER (inhaler, assist device with medium mask)	Tier 3	
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 60 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 65 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 70 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 75 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 80 MM (diaphragms, wide seal)	PV	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 85 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 90 MM (diaphragms, wide seal)	PV	
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 95 MM (diaphragms, wide seal)	PV	
WILLIS THE WHALE COMPRESSR NEB DEVICE (nebulizer and compressor)	Tier 3	
XEROFORM PETROLATUM DRESSING TOPICAL BANDAGE 1 X 8 ", 2 X 2 ", 4 X 3 "-YARD, 4 X 4 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM PETROLATUM OVERWRAP TOPICAL BANDAGE 1 X 8 ", 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
XEROFORM TOPICAL BANDAGE 5 X 9 " (bismuth tribromophenate/petrolatum,white)	Tier 3	
YONI FIT BLADDER SUPPORT VAGINAL 34-38 MM, 34-38-42 MM, 42-45 MM, 45-48-52 MM, 48-52 MM (pessary)	Tier 3	
ZENPHOR TOPICAL BANDAGE 2 X 4.7 " (gel dressing)	Tier 3	
ZENPHOR TOPICAL GEL (gel dressing)	Tier 3	
Metabolic Disease Enzyme Replacement Agents - Drugs For Metabolic Disease		
Metabolic Disease Enzyme Replacement, Hypophosphatasia - Drugs For Metabolic Disease		
STRENSIQ SUBCUTANEOUS SOLUTION 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML (asfotase alfa)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Metabolic Disease Enzyme Replacement, Molybdenum Cofactor Deficiency - Drugs For Metabolic Disease		
NULIBRY INTRAVENOUS RECON SOLN 9.5 MG (fosdenopterin hydrobromide)	Tier 3	PA; KP
Metabolic Dx Enzyme Replacement, Severe Combined Immune Deficiency - Drugs For Metabolic Disease		
REVCovi INTRAMUSCULAR SOLUTION 2.4 MG/1.5 ML (1.6 MG/ML) (elapegademase-lvlr)	Tier 3	PA; KP
Metabolic Modifiers		
Metabolic Modifier - Neimann Pick Disease Type C (Npc)		
AQNEURSA ORAL GRANULES IN PACKET 1 GRAM (levacetylleucine)	Tier 3	PA
MIPLYFFA ORAL CAPSULE 124 MG, 47 MG, 62 MG, 93 MG (arimoclomol citrate)	Tier 3	PA
Metabolic Modifier - Pompe Disease - Gcs Inhibitor		
OPFOLDA ORAL CAPSULE 65 MG (miglustat)	Tier 3	PA
Metabolic Modifiers - Drugs That Alter Metabolism		
Hyperparathyroid Treatment Agents - Vitamin D Analog-Type - Drugs That Alter Metabolism		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	Tier 1	
<i>calcitriol oral solution 1 mcg/ml</i>	Tier 1	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	Tier 1	
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RAYALDEE ORAL CAPSULE,EXTENDED RELEASE 24 HR 30 MCG (calcifediol)	Tier 2	QL (2 EA per 1 day)
ROCALTROL ORAL SOLUTION 1 MCG/ML (calcitriol)	Tier 3	
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG (paricalcitol)	Tier 3	
Metabolic Modifier - Carnitine Replenisher Agents - Drugs That Alter Metabolism		
CARNITOR (SUGAR-FREE) ORAL SOLUTION 100 MG/ML (levocarnitine)	Tier 3	
CARNITOR ORAL SOLUTION 100 MG/ML (levocarnitine (with sugar))	Tier 3	
CARNITOR ORAL TABLET 330 MG (levocarnitine)	Tier 3	
<i>levocarnitine (with sugar) oral solution 100 mg/ml</i>	Tier 1	
<i>levocarnitine oral solution 100 mg/ml</i>	Tier 1	
<i>levocarnitine oral tablet 330 mg</i>	Tier 1	
Metabolic Modifier - Gaucher's Disease, Type-1, Substrate Reduction Tx - Drugs That Alter Metabolism		
CERDELGA ORAL CAPSULE 84 MG (eliglustat tartrate)	Tier 3	
<i>miglustat oral capsule 100 mg</i>	Tier 3	PA
miglustat (Yargesa Oral Capsule 100 Mg)	Tier 3	PA
ZAVESCA ORAL CAPSULE 100 MG (miglustat)	Tier 3	PA
Metabolic Modifier - Hereditary Orotic Aciduria Treatment Agents - Drugs That Alter Metabolism		
XURIDEN ORAL GRANULES IN PACKET 2 GRAM (uridine triacetate)	Tier 3	PA
Metabolic Modifier - Homocystinuria Treatment Agents - Drugs That Alter Metabolism		
<i>betaine oral powder 1 gram/scoop</i>	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CYSTADANE ORAL POWDER 1 GRAM/SCOOP (betaine)	Tier 3	PA
Metabolic Modifier - Phosphatidylinositol-3-Kinase (Pi3k) Inhibitors - Drugs That Alter Metabolism		
JOENJA ORAL TABLET 70 MG (leniolisib phosphate)	Tier 3	PA
VIJOICE ORAL GRANULES IN PACKET 50 MG (alpelisib)	Tier 3	PA
VIJOICE ORAL TABLET 125 MG, 250 MG/DAY (200 MG X1-50 MG X1), 50 MG (alpelisib)	Tier 3	PA
Metabolic Modifier - Tyrosine Metabolism Disorder Agents - Drugs That Alter Metabolism		
HARLIKU ORAL TABLET 2 MG (nitisinone)	Tier 3	PA
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	Tier 3	PA
NITYR ORAL TABLET 10 MG, 2 MG, 5 MG (nitisinone)	Tier 3	PA
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG (nitisinone)	Tier 3	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (nitisinone)	Tier 3	PA
Metabolic Modifier - Urea Cycle Disorder Agents-Conjugating Agents - Drugs That Alter Metabolism		
BUPHENYL ORAL POWDER 0.94 GRAM/GRAM (sodium phenylbutyrate)	Tier 3	PA
BUPHENYL ORAL TABLET 500 MG (sodium phenylbutyrate)	Tier 3	PA
OLPRUVA ORAL PELLETS IN PACKET 2 GRAM, 3 GRAM, 4 GRAM, 5 GRAM, 6 GRAM, 6.67 GRAM (sodium phenylbutyrate)	Tier 3	PA
PHEBURANE ORAL GRANULES 483 MG/GRAM (sodium phenylbutyrate)	Tier 3	PA
RAVICTI ORAL LIQUID 1.1 GRAM/ML (glycerol phenylbutyrate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium phenylbutyrate oral powder 0.94 gram/gram</i>	Tier 3	PA
<i>sodium phenylbutyrate oral tablet 500 mg</i>	Tier 3	PA
Metabolic Modifier-Carbamoyl Phosphate Synthetase 1 (Cps 1) Activator - Drugs That Alter Metabolism		
CARBAGLU ORAL TABLET, DISPERSIBLE 200 MG (carglumic acid)	Tier 3	PA
<i>carglumic acid oral tablet, dispersible 200 mg</i>	Tier 3	PA
Pharmacoenhancer - Cytochrome P450 Inhibitors - Drugs That Alter Metabolism		
TYBOST ORAL TABLET 150 MG (cobicistat)	Tier 2	
Pharmacological Chaperone Tx - Alpha-Galactosidase A Enzyme Stabilizer - Drugs That Alter Metabolism		
GALAFOLD ORAL CAPSULE 123 MG (migalastat HCl)	Tier 3	PA
Phenylketonuria(Pku) Tx Agents - Cofactor Of Phenylalanine Hydroxylase - Drugs That Alter Metabolism		
sapropterin dihydrochloride (Javygtor Oral Powder In Packet 100 Mg, 500 Mg)	Tier 3	
sapropterin dihydrochloride (Javygtor Oral Tablet,Soluble 100 Mg)	Tier 3	
KUVAN ORAL POWDER IN PACKET 100 MG, 500 MG (sapropterin dihydrochloride)	Tier 3	
KUVAN ORAL TABLET,SOLUBLE 100 MG (sapropterin dihydrochloride)	Tier 3	
<i>sapropterin oral powder in packet 100 mg, 500 mg</i>	Tier 3	
<i>sapropterin oral tablet,soluble 100 mg</i>	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEPHIENCE ORAL POWDER IN PACKET 1,000 MG, 250 MG (sepiapterin)	Tier 3	PA
Phenylketonuria(Pku) Tx Agents - Phenylalanine Ammonia Lyase - Drugs That Alter Metabolism		
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML, 2.5 MG/0.5 ML, 20 MG/ML (pegvaliase-pqpz)	Tier 3	PA; KP
Progeria Syndrome Treatment Agents - Farnyltransferase Inhibitor - Drugs That Alter Metabolism		
ZOKINVY ORAL CAPSULE 50 MG, 75 MG (lonafarnib)	Tier 3	PA
Mouth-Throat-Dental - Preparations - Drugs For The Mouth And Throat		
Dental Product - Fluoride Preparations - Drugs For The Mouth And Throat		
CLINPRO 5000 DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
DENTA 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 1	
DENTA 5000 PLUS SENSITIVE DENTAL PASTE 1.1-5 % (sodium fluoride/potassium nitrate)	Tier 1	
DENTAGEL DENTAL GEL 1.1 % (fluoride (sodium))	Tier 1	
<i>fluoride (sodium) dental cream 1.1 %</i>	Tier 1	
<i>fluoride (sodium) dental gel 1.1 %</i>	Tier 1	
<i>fluoride (sodium) dental paste 1.1 %</i>	Tier 1	
<i>fluoride (sodium) dental solution 0.2 %</i>	Tier 1	
<i>fluoride (sodium) oral drops 0.5 mg (1.1 mg sod.fluorid)/ml</i>	PV	\$0 COPAY IF 6 MONTHS TO 6 YEARS OF AGE

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluoride (sodium) oral tablet, chewable 0.25 mg(0.55 mg sod. fluoride), 0.5 mg (1.1 mg sodium fluorid), 1 mg (2.2 mg sod. fluoride)</i>	Tier 3	\$0 COPAY IF 6 MONTHS TO 6 YEARS OF AGE
FLUORIDEX DAILY DEFENSE DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
FLUORIDEX SENSITIVITY RELIEF DENTAL PASTE 1.1-5 % (sodium fluoride/potassium nitrate)	Tier 3	
FLUORIMAX 5000 DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
FLUORIMAX 5000 SENSITIVE DENTAL PASTE 1.1-5 % (sodium fluoride/potassium nitrate)	Tier 3	
FRAICHE 5000 DENTAL GEL 1.1 % (fluoride (sodium))	Tier 3	
FRAICHE 5000 PREVI DENTAL GEL 1.1-3 % (sodium fluoride/hydroxyapatite)	Tier 3	
FRAICHE 5000 SENSITIVE DENTAL GEL 1.1-4.5 % (sodium fluoride/potassium nitrate)	Tier 3	
JUST RIGHT 5000 DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
PREVIDENT 5000 BOOSTER PLUS DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
PREVIDENT 5000 DRY MOUTH DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
PREVIDENT 5000 ENAMEL PROTECT DENTAL PASTE 1.1-5 % (sodium fluoride/potassium nitrate)	Tier 3	
PREVIDENT 5000 ORTHO DEFENSE DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
PREVIDENT 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 3	
PREVIDENT 5000 SENSITIVE DENTAL PASTE 1.1-5 % (sodium fluoride/potassium nitrate)	Tier 3	
PREVIDENT DENTAL GEL 1.1 % (fluoride (sodium))	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREVIDENT DENTAL SOLUTION 0.2 % (fluoride (sodium))	Tier 3	
PREVIDENT KIDS DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 3	
SF 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 1	
SF DENTAL GEL 1.1 % (fluoride (sodium))	Tier 1	
SODIUM FLUORIDE 5000 DRY MOUTH DENTAL PASTE 1.1 % (fluoride (sodium))	Tier 1	
SODIUM FLUORIDE 5000 PLUS DENTAL CREAM 1.1 % (fluoride (sodium))	Tier 1	
<i>sodium fluoride-pot nitrate dental paste 1.1-5 %</i>	Tier 1	
Mouth And Throat - Antifungals - Drugs For The Mouth And Throat		
<i>clotrimazole mucous membrane troche 10 mg</i>	Tier 1	
<i>nystatin oral suspension 100,000 unit/ml</i>	Tier 1	
Mouth And Throat - Anti-Infective Mixtures - Drugs For The Mouth And Throat		
DEBACTEROL MUCOUS MEMBRANE SOLUTION 30-50 % (sulfuric acid/sulfonated phenol)	Tier 3	
Mouth And Throat - Antiseptics - Drugs For The Mouth And Throat		
<i>chlorhexidine gluconate mucous membrane mouthwash 0.12 %</i>	Tier 1	
PERIDEX MUCOUS MEMBRANE MOUTHWASH 0.12 % (chlorhexidine gluconate)	Tier 3	
chlorhexidine gluconate (Periogard Mucous Membrane Mouthwash 0.12 %)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Mouth And Throat - Artificial Saliva - Drugs For The Mouth And Throat		
AQUORAL MUCOUS MEMBRANE AEROSOL, SPRAY (saliva substitute combo no.3)	Tier 3	
CAPHOSOL MUCOUS MEMBRANE SOLUTION (saliva substitute combo no.2)	Tier 3	
MUCOSITISRX MUCOUS MEMBRANE POWDER IN PACKET 351 MG (saliva substitute combination no.11)	Tier 3	
NUMOISYN MUCOUS MEMBRANE LIQUID (flaxseed)	Tier 3	
NUMOISYN MUCOUS MEMBRANE LOZENGE 0.3 GRAM (sorbitol/saliva stimulant comb no. 1/malic acid/calcium phos)	Tier 3	
SALIVAMAX MUCOUS MEMBRANE POWDER IN PACKET 351 MG (saliva substitute combination no.11)	Tier 3	
Mouth And Throat - Glucocorticoids - Drugs For The Mouth And Throat		
triamcinolone acetonide (Oralene Dental Paste 0.1 %)	Tier 1	
<i>triamcinolone acetonide dental paste 0.1 %</i>	Tier 1	
Mouth And Throat - Local Anesthetic Amides - Drugs For The Mouth And Throat		
<i>lidocaine hcl mucous membrane jelly 2 %</i>	Tier 1	
<i>lidocaine hcl mucous membrane solution 2 %, 4 % (40 mg/ml)</i>	Tier 1	
lidocaine HCl (Lidocaine Viscous Mucous Membrane Solution 2 %)	Tier 1	
Mouth And Throat - Mucositis-Stomatitis Agents - Drugs For The Mouth And Throat		
GELCLAIR MUCOUS MEMBRANE GEL IN PACKET (potassium sorbate/hydroxyethylcellulose/povidone/hyaluronic)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MUGARD MUCOUS MEMBRANE SOLUTION (glycerin/carbomer homopolymer type A/potassium hydroxide)	Tier 3	
ORAMAGICRX MUCOUS MEMBRANE MOUTHWASH (potassium sorbate/maltodextrin/aloe vera/mann ps)	Tier 3	
ORAPEUTIC MUCOUS MEMBRANE GEL (xylitol/pectin/acemannan/sodium bicarbonate)	Tier 3	
Mouth And Throat - Protectants - Drugs For The Mouth And Throat		
MUGARD MUCOUS MEMBRANE SOLUTION (glycerin/carbomer homopolymer type A/potassium hydroxide)	Tier 3	
PROTHELIAL MUCOUS MEMBRANE PASTE 1 GRAM/10 ML (sucralfate malate, polymerized)	Tier 3	
Mouth And Throat - Saliva Stimulants - Drugs For The Mouth And Throat		
<i>cevimeline oral capsule 30 mg</i>	Tier 1	
EVOXAC ORAL CAPSULE 30 MG (cevimeline HCl)	Tier 3	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	Tier 1	
SALAGEN (PILOCARPINE) ORAL TABLET 5 MG, 7.5 MG (pilocarpine HCl)	Tier 3	
THERABREATH DRY MOUTH MUCOUS MEMBRANE LOZENGE (saliva stimulant combination no.11)	Tier 3	
THERABREATH MUCOUS MEMBRANE LOZENGE (saliva stimulant combination no.10)	Tier 3	
XYLIGEL MUCOUS MEMBRANE GEL (saliva stimulant combination no.9)	Tier 3	
XYLIMELTS MUCOUS MEMBRANE MUCO-ADHESIVE BUCCAL TABLET 500 MG (xylitol)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Periodontal Product - Tetracycline Antiinfective, Local - Drugs For The Mouth And Throat		
ARESTIN DENTAL CARTRIDGE 1 MG (minocycline HCl microspheres)	Tier 3	PA
Periodontal Product - Tetracycline-Type, Collagenase Inhibitors - Drugs For The Mouth And Throat		
<i>doxycycline hyclate oral tablet 20 mg</i>	Tier 1	
Therapy For Drooling- Primary Or Secondary Sialorrhea-Anticholinergic - Drugs For The Mouth And Throat		
CUVPOSA ORAL SOLUTION 1 MG/5 ML (0.2 MG/ML) (glycopyrrolate)	Tier 3	
<i>glycopyrrolate oral solution 1 mg/5 ml (0.2 mg/ml)</i>	Tier 1	
Multiple Sclerosis Agents - Drugs For The Nervous System		
Multiple Sclerosis Agent - Cd20 Specific Monoclonal Antibody - Drugs For Multiple Sclerosis		
KESIMPTA PEN SUBCUTANEOUS PEN INJECTOR 20 MG/0.4 ML (ofatumumab)	Tier 3	PA; KP
Multiple Sclerosis Agent - Interferons - Drugs For Multiple Sclerosis		
AVONEX INTRAMUSCULAR PEN INJECTOR 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA; KP
AVONEX INTRAMUSCULAR PEN INJECTOR KIT 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AVONEX INTRAMUSCULAR SYRINGE 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA
AVONEX INTRAMUSCULAR SYRINGE KIT 30 MCG/0.5 ML (interferon beta-1a)	Tier 2	PA
BETASERON SUBCUTANEOUS KIT 0.3 MG (interferon beta-1b)	Tier 2	PA
PLEGRIDY INTRAMUSCULAR SYRINGE 125 MCG/0.5 ML (peginterferon beta-1a)	Tier 3	PA; KP
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML (peginterferon beta-1a)	Tier 2	PA; KP
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML (peginterferon beta-1a)	Tier 2	PA
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML (peginterferon beta-1a)	Tier 2	PA; KP
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML (peginterferon beta-1a)	Tier 2	PA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 22 MCG/0.5 ML (interferon beta-1a/albumin human)	Tier 2	PA
REBIF (WITH ALBUMIN) SUBCUTANEOUS SYRINGE 44 MCG/0.5 ML (interferon beta-1a/albumin human)	Tier 2	PA; KP
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6) (interferon beta-1a/albumin human)	Tier 2	PA
REBIF TITRATION PACK SUBCUTANEOUS SYRINGE 8.8MCG/0.2ML-22 MCG/0.5ML (6) (interferon beta-1a/albumin human)	Tier 2	PA
Multiple Sclerosis Agent - Others - Drugs For Multiple Sclerosis		
BAFIERTAM ORAL CAPSULE,DELAYED RELEASE(DR/EC) 95 MG (monomethyl fumarate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML (glatiramer acetate)	Tier 2	PA
<i>dimethyl fumarate oral capsule, delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg</i>	Tier 1	PA
<i>glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml</i>	Tier 1	PA
glatiramer acetate (Glatopa Subcutaneous Syringe 20 Mg/ML, 40 Mg/ML)	Tier 1	PA
TECFIDERA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG (dimethyl fumarate)	Tier 2	PA
VUMERITY ORAL CAPSULE, DELAYED RELEASE(DR/EC) 231 MG (diroximel fumarate)	Tier 3	PA
Multiple Sclerosis Agent - Potassium Channel Blocker - Drugs For Multiple Sclerosis		
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HR 10 MG (dalfampridine)	Tier 3	PA
<i>dalfampridine oral tablet extended release 12 hr 10 mg</i>	Tier 1	PA
Multiple Sclerosis Agent - Purine Nucleoside Analogs - Drugs For Multiple Sclerosis		
MAVENCLAD (10 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA
MAVENCLAD (4 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA
MAVENCLAD (5 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA
MAVENCLAD (6 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA
MAVENCLAD (7 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA
MAVENCLAD (8 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (9 TABLET PACK) ORAL TABLET 10 MG (cladribine)	Tier 3	PA
Multiple Sclerosis Agent - Pyrimidine Synthesis Inhibitors - Drugs For Multiple Sclerosis		
AUBAGIO ORAL TABLET 14 MG, 7 MG (teriflunomide)	Tier 2	PA
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	Tier 1	PA
Multiple Sclerosis Agent - Sphingosine 1-Phosphate Receptor Modulator - Drugs For Multiple Sclerosis		
<i>fingolimod oral capsule 0.5 mg</i>	Tier 1	PA
GILENYA ORAL CAPSULE 0.25 MG (fingolimod HCl)	Tier 3	PA
GILENYA ORAL CAPSULE 0.5 MG (fingolimod HCl)	Tier 2	PA
MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG (siponimod)	Tier 3	PA
MAYZENT STARTER(FOR 1MG MAINT) ORAL TABLETS,DOSE PACK 0.25 MG (7 TABS) (siponimod)	Tier 3	PA
MAYZENT STARTER(FOR 2MG MAINT) ORAL TABLETS,DOSE PACK 0.25 MG (12 TABS) (siponimod)	Tier 3	PA
PONVORY 14-DAY STARTER PACK ORAL TABLETS,DOSE PACK 2 MG (2) - 10 MG (3) (ponesimod)	Tier 3	PA
PONVORY ORAL TABLET 20 MG (ponesimod)	Tier 3	PA
TASCENSO ODT ORAL TABLET,DISINTEGRATING 0.25 MG, 0.5 MG (fingolimod lauryl sulfate)	Tier 3	PA
ZEPOSIA ORAL CAPSULE 0.92 MG (ozanimod hydrochloride)	Tier 3	PA
ZEPOSIA STARTER KIT (28-DAY) ORAL CAPSULE,DOSE PACK 0.23 MG-0.46 MG -0.92 MG (21) (ozanimod hydrochloride)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZEPOSIA STARTER PACK (7-DAY) ORAL CAPSULE,DOSE PACK 0.23 MG (4)- 0.46 MG (3) (ozanimod hydrochloride)	Tier 3	PA
Ophthalmic Agents		
Ophthalmic - Adrenergic-Carbonic Anhydrase Inhib-Prostaglandin Analog		
<i>brimonidine-dorzol-bimatoprost ophthalmic (eye) drops 0.1-2-0.01 %</i>	Tier 1	
Ophthalmic - Trpm8 Agonist		
TRYPTYR OPHTHALMIC (EYE) DROPPERETTE 0.003 % (acoltremon)	Tier 3	PA
Ophthalmic Antiparasitics		
XDEMVI OPHTHALMIC (EYE) DROPS 0.25 % (lotilaner)	Tier 3	PA
Ophthalmic Agents - Drugs For The Eye		
Artificial Tears And Lubricant Single Agents - Drugs For The Eye		
KLARITY (CHONDROITIN) (PF) OPHTHALMIC (EYE) DROPS 0.25 % (chondroitin sulfate A sodium/PF)	Tier 3	
MIEBO (PF) OPHTHALMIC (EYE) DROPS 100 % (perfluorohexyloctane/PF)	Tier 2	
Miotics - Cholinesterase Inhibitors - Drugs For Glaucoma		
PHOSPHOLINE IODIDE OPHTHALMIC (EYE) DROPS 0.125 % (echothiophate iodide)	Tier 3	
Miotics - Direct Acting - Drugs For Glaucoma		
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Mydriatic And Cycloplegic Combinations - Drugs For The Eye		
CYCLOMYDRIL OPHTHALMIC (EYE) DROPS 0.2-1 % (cyclopentolate HCl/phenylephrine HCl)	Tier 3	
<i>cyclopen-tropic-phenyleph-watr ophthalmic (eye) drops 1-1-2.5 %</i>	Tier 3	
<i>cyclopent-tropic-phen-ketr-wat ophthalmic (eye) drops 1 %-1 %-10 %- 0.5 %, 1 %-1 %-2.5 %- 0.5 %</i>	Tier 1	
<i>cyclop-trop-propa-phen-ket-wat ophthalmic (eye) drops 1 %-1 %-0.1 %- 2.5 %-0.4 %</i>	Tier 1	
MYDCOMBI OPHTHALMIC (EYE) CARTRIDGE 2.5-1 % (phenylephrine HCl/tropicamide)	Tier 3	
<i>phenyleph-tropicamide in water ophthalmic (eye) drops 2.5-1 %</i>	Tier 1	
Ophth - Beta Blocker-Adrenergic-Carbonic Anhyd Inh-Prostaglandin Analog - Drugs For Glaucoma		
<i>timol-brimon-dorzol-bimato(pf) ophthalmic (eye) drops 0.5 %-0.15 %- 2 %-0.01 %</i>	Tier 1	
<i>timolol-brimon-dorzol-bimatop ophthalmic (eye) drops 0.5-0.1-2-0.01 %</i>	Tier 1	
<i>timolol-brimonidine-dorzolamid ophthalmic (eye) drops 0.5-0.1-2 %</i>	Tier 1	
Ophthalmic - Adrenergic Receptor Agonist - Drugs For The Eye		
UPNEEQ (PF) OPHTHALMIC (EYE) DROPPERETTE 0.1 % (oxymetazoline HCl/PF)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Adrenergic-Carbonic Anhydrase Inhibitor Combinations - Drugs For Glaucoma		
<i>brimonidine-dorzolamide (pf) ophthalmic (eye) drops 0.15-2 %</i>	Tier 1	
<i>brimonidine-dorzolamide ophthalmic (eye) drops 0.1-2 %</i>	Tier 1	
SIMBRINZA OPHTHALMIC (EYE) DROPS,SUSPENSION 1-0.2 % (brinzolamide/brimonidine tartrate)	Tier 2	
Ophthalmic - Agents For Corneal Collagen Cross-Linking - Drugs For The Eye		
PHOTREXA CROSS-LINKING KIT OPHTHALMIC (EYE) COMBO, DROPS AND DROPS VISCOUS 0.146 % -0.146 % (riboflavin 5-phosphate sodium in 20 % dextran)	Tier 3	
Ophthalmic - Agents For Presbyopia - Drugs For The Eye		
<i>pilocarpine hcl ophthalmic (eye) drops 1.25 %</i>	Tier 1	QL (10 ML per 30 days)
QLOSI OPHTHALMIC (EYE) DROPPERETTE 0.4 % (pilocarpine HCl)	Tier 3	ST: Requires prior prescription for generic Pilocarpine Ophthalmic solution within the past 120 days; QL (2 EA per 1 day)
VIZZ OPHTHALMIC (EYE) DROPPERETTE 1.44 % (aceclidine HCl)	Tier 3	QL (1 EA per 1 day)
VUITY OPHTHALMIC (EYE) DROPS 1.25 % (pilocarpine HCl)	Tier 3	QL (10 ML per 30 days)
Ophthalmic - Antibacterial-Glucocorticoid Combinations - Anti-Infective/Anti-Inflammatories		
BLEPHAMIDE S.O.P. OPHTHALMIC (EYE) OINTMENT 10-0.2 % (sulfacetamide sodium/prednisolone acetate)	Tier 2	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAXITROL OPHTHALMIC (EYE) DROPS,SUSPENSION 3.5MG/ML-10,000 UNIT/ML-0.1 % (neomycin/polymyxin B sulfate/dexamethasone)	Tier 3	
<i>neomycin-bacitracin-poly-hc ophthalmic (eye) ointment 3.5-400-10,000 mg-unit/g-1%</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) drops,suspension 3.5mg/ml-10,000 unit/ml-0.1 %</i>	Tier 1	
<i>neomycin-polymyxin b-dexameth ophthalmic (eye) ointment 3.5 mg/g-10,000 unit/g-0.1 %</i>	Tier 1	
<i>neomycin-polymyxin-hc ophthalmic (eye) drops,suspension 3.5-10,000-10 mg-unit-mg/ml</i>	Tier 1	
neomycin sulfate/bacitracin zinc/polymyxin B/hydrocortisone (Neo-Polycin Hc Ophthalmic (Eye) Ointment 3.5-400-10,000 Mg-Unit/G-1%)	Tier 1	
PRED-G S.O.P. OPHTHALMIC (EYE) OINTMENT 0.3-0.6 % (gentamicin sulfate/prednisolone acetate)	Tier 3	
<i>prednisolone sod ph-moxiflox ophthalmic (eye) drops 1-0.5 %</i>	Tier 1	
<i>prednisolone-moxifloxacin hcl ophthalmic (eye) drops,suspension 1-0.5 %</i>	Tier 1	
<i>sulfacetamide-prednisolone ophthalmic (eye) drops 10 %-0.23 % (0.25 %)</i>	Tier 1	
TOBRADEX OPHTHALMIC (EYE) OINTMENT 0.3-0.1 % (tobramycin/dexamethasone)	Tier 2	
TOBRADEX ST OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.05 % (tobramycin/dexamethasone)	Tier 3	ST: Requires prior prescription for generic ophthalmic Tobramycin/Dexamethasone drops within the past 120 days
<i>tobramycin-dexamethasone ophthalmic (eye) drops,suspension 0.3-0.1 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZYLET OPHTHALMIC (EYE) DROPS,SUSPENSION 0.3-0.5 % (tobramycin/loteprednol etabonate)	Tier 3	
Ophthalmic - Antibacterial-Glucocorticoid-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
<i>prednisoln sp-moxiflox-bromfen ophthalmic (eye) drops 1-0.5-0.075 %</i>	Tier 1	
<i>prednisolone-moxiflo-nepafenac ophthalmic (eye) drops,suspension 1-0.5-0.1 %</i>	Tier 1	
<i>prednisolone-moxiflox-bromfen ophthalmic (eye) drops,suspension 1-0.5-0.075 %</i>	Tier 1	
<i>prednisolon-moxiflox-ketorolac ophthalmic (eye) drops 1-0.5-0.5 %</i>	Tier 1	
Ophthalmic - Antibacterial-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
<i>moxifloxacin-bromfenac ophthalmic (eye) drops 0.5-0.075 %</i>	Tier 1	
Ophthalmic Antibiotic - Vancomycin And Derivatives - Anti-Infective/Anti-Inflammatories		
<i>tobramycin-vancomycin ophthalmic (eye) drops 1.5-5 %</i>	Tier 1	
Ophthalmic - Anticholinergics - Drugs For The Eye		
<i>atropine ophthalmic (eye) drops 0.01 %, 0.025 %, 0.05 %</i>	Tier 1	
<i>atropine ophthalmic (eye) drops 1 %</i>	Tier 1	
<i>atropine sulfate (pf) ophthalmic (eye) dropperette 1 %</i>	Tier 1	
<i>cyclopentolate HCl (Cyclogyl Ophthalmic (Eye) Drops 0.5 %, 1 %, 2 %)</i>	Tier 3	
<i>cyclopentolate ophthalmic (eye) drops 1 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HOMATROPAIRE OPHTHALMIC (EYE) DROPS 5 % (homatropine Hbr)	Tier 1	
tropicamide (Mydriacyl Ophthalmic (Eye) Drops 1 %)	Tier 3	
<i>tropicamide ophthalmic (eye) drops 0.5 %, 1 %</i>	Tier 1	
Ophthalmic - Antifibrotic Agents - Drugs For The Eye		
<i>mitomycin (pf) in water ophthalmic (eye) syringe 0.2 mg/ml, 0.4 mg/ml</i>	Tier 3	
MITOSOL OPHTHALMIC (EYE) KIT 0.2 MG (mitomycin)	Tier 3	
Ophthalmic - Antihistamines - Drugs For Itchy Eye		
<i>azelastine ophthalmic (eye) drops 0.05 %</i>	Tier 1	QL (12 ML per 30 days)
<i>bepotastine besilate ophthalmic (eye) drops 1.5 %</i>	Tier 1	ST: Requires prior prescription for a generic ophthalmic antihistamine (Azelastine, Epinastine, or Olopatadine) within the past 120 days; QL (10 ML per 30 days)
BEPREVE OPHTHALMIC (EYE) DROPS 1.5 % (bepotastine besilate)	Tier 3	ST: Requires prior prescription for a generic ophthalmic antihistamine (Azelastine, Epinastine, or Olopatadine) within the past 120 days; QL (10 ML per 30 days)
<i>epinastine ophthalmic (eye) drops 0.05 %</i>	Tier 1	QL (10 ML per 30 days)
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	Tier 1	
<i>olopatadine ophthalmic (eye) drops 0.2 %</i>	Tier 1	QL (3 ML per 30 days)
ZERVIAE OPHTHALMIC (EYE) DROPPERETTE 0.24 % (cetirizine HCl)	Tier 3	QL (60 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Anti-Inflammatory, Glucocorticoids - Anti-Infective/Anti-Inflammatories		
ALREX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.2 % (loteprednol etabonate)	Tier 3	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (10 ML per 14 days)
<i>clobetasol ophthalmic (eye) drops,suspension 0.05 %</i>	Tier 1	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (3.5 ML per 14 days)
<i>dexamethasone sodium phosphate ophthalmic (eye) drops 0.1 %</i>	Tier 1	QL (15 ML per 14 days)
DEXTENZA INTRACANALICULAR INSERT 0.4 MG (dexamethasone)	Tier 3	
<i>difluprednate ophthalmic (eye) drops 0.05 %</i>	Tier 1	QL (10 ML per 14 days)
DUREZOL OPHTHALMIC (EYE) DROPS 0.05 % (difluprednate)	Tier 3	QL (10 ML per 14 days)
EYSUVIS OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 % (loteprednol etabonate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FLAREX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (fluorometholone acetate)	Tier 3	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (15 ML per 14 days)
<i>fluorometholone ophthalmic (eye) drops,suspension 0.1 %</i>	Tier 1	QL (10 ML per 14 days)
FML FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 % (fluorometholone)	Tier 3	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (10 ML per 14 days)
FML LIQUIFILM OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (fluorometholone)	Tier 3	QL (10 ML per 14 days)
INVELTYS OPHTHALMIC (EYE) DROPS,SUSPENSION 1 % (loteprednol etabonate)	Tier 3	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (5.6 ML per 14 days)
LOTEMAX OPHTHALMIC (EYE) DROPS,GEL 0.5 % (loteprednol etabonate)	Tier 3	QL (10 GM per 14 days)
LOTEMAX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.5 % (loteprednol etabonate)	Tier 3	QL (20 ML per 14 days)
LOTEMAX OPHTHALMIC (EYE) OINTMENT 0.5 % (loteprednol etabonate)	Tier 2	QL (7 GM per 14 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LOTEMAX SM OPHTHALMIC (EYE) DROPS,GEL 0.38 % (loteprednol etabonate)	Tier 2	QL (10 GM per 14 days)
<i>loteprednol etabonate ophthalmic (eye) drops,gel 0.5 %</i>	Tier 1	QL (10 GM per 14 days)
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.2 %</i>	Tier 1	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (10 ML per 14 days)
<i>loteprednol etabonate ophthalmic (eye) drops,suspension 0.5 %</i>	Tier 1	QL (20 ML per 14 days)
MAXIDEX OPHTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (dexamethasone)	Tier 3	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (25 ML per 14 days)
PRED FORTE OPHTHALMIC (EYE) DROPS,SUSPENSION 1 % (prednisolone acetate)	Tier 3	QL (20 ML per 14 days)
PRED MILD OPHTHALMIC (EYE) DROPS,SUSPENSION 0.12 % (prednisolone acetate)	Tier 3	ST: Requires prior prescription for generic ophthalmic Fluorometholone 0.1%, Dexamethasone 0.1%, or Prednisolone 1% within the past 120 days; QL (20 ML per 14 days)
<i>prednisolone acetate (pf) ophthalmic (eye) drops,suspension 1 %</i>	Tier 1	QL (20 ML per 14 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisolone acetate ophthalmic (eye) drops,suspension 1 %</i>	Tier 1	QL (20 ML per 14 days)
<i>prednisolone sodium phosphate ophthalmic (eye) drops 1 %</i>	Tier 1	QL (20 ML per 14 days)
Ophthalmic - Anti-Inflammatory, Immunomodulators - Anti-Infective/Anti-Inflammatories		
CEQUA OPHTHALMIC (EYE) DROPPERETTE 0.09 % (cyclosporine)	Tier 3	ST: At least 2 prior prescriptions for Cyclosporine/Restasis, Miebo, Tyrvaya, or Xiidra within the past 365 days; QL (60 EA per 30 days)
CYCLOSPORINE IN KLARITY OPHTHALMIC (EYE) DROPS 0.1-0.25 % (cyclosporine/chondroitin sulfate A sodium)	Tier 1	
<i>cyclosporine ophthalmic (eye) dropperette 0.05 %</i>	Tier 1	QL (60 EA per 30 days)
RESTASIS MULTIDOSE OPHTHALMIC (EYE) DROPS 0.05 % (cyclosporine)	Tier 2	QL (5.5 ML per 30 days)
RESTASIS OPHTHALMIC (EYE) DROPPERETTE 0.05 % (cyclosporine)	Tier 1	QL (60 EA per 30 days)
VERKAZIA OPHTHALMIC (EYE) DROPPERETTE 0.1 % (cyclosporine)	Tier 3	PA
VEVYE OPHTHALMIC (EYE) DROPS 0.1 % (cyclosporine)	Tier 3	PA
Ophthalmic - Anti-Inflammatory, Lfa-1 Antagonists - Anti-Infective/Anti-Inflammatories		
XIIDRA OPHTHALMIC (EYE) DROPPERETTE 5 % (lifitegrast)	Tier 2	QL (60 EA per 30 days)
Ophthalmic - Anti-Inflammatory, Nsaids - Anti-Infective/Anti-Inflammatories		
ACULAR LS OPHTHALMIC (EYE) DROPS 0.4 % (ketorolac tromethamine)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ACULAR OPHTHALMIC (EYE) DROPS 0.5 % (ketorolac tromethamine)	Tier 3	QL (20 ML per 30 days)
ACUVAIL (PF) OPHTHALMIC (EYE) DROPPERETTE 0.45 % (ketorolac tromethamine/PF)	Tier 3	ST: Requires prior prescriptions for Ilevro 0.3% and one of the following: Diclofenac 0.1% or Ketorolac 0.5% within the past 365 days; QL (60 EA per 15 days)
<i>bromfenac ophthalmic (eye) drops 0.07 %</i>	Tier 1	ST: Requires prior prescription for generic Ketorolac or Diclofenac ophthalmic drops within the past 120 days; QL (3 ML per 16 days)
<i>bromfenac ophthalmic (eye) drops 0.075 %</i>	Tier 1	ST: Requires prior prescription for generic Ketorolac or Diclofenac ophthalmic drops within the past 120 days; QL (5 ML per 16 days)
<i>bromfenac ophthalmic (eye) drops 0.09 %</i>	Tier 1	ST: Requires prior prescription for generic Ketorolac or Diclofenac ophthalmic drops within the past 120 days; QL (3.4 ML per 16 days)
BROMSITE OPHTHALMIC (EYE) DROPS 0.075 % (bromfenac sodium)	Tier 3	ST: Requires prior prescription for generic Ketorolac or Diclofenac ophthalmic drops within the past 120 days; QL (5 ML per 16 days)
<i>diclofenac sodium ophthalmic (eye) drops 0.1 %</i>	Tier 1	QL (10 ML per 14 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>flurbiprofen sodium ophthalmic (eye) drops 0.03 %</i>	Tier 1	
ILEVRO OPTHALMIC (EYE) DROPS,SUSPENSION 0.3 % (nepafenac)	Tier 2	QL (3.4 ML per 16 days)
<i>ketorolac ophthalmic (eye) drops 0.4 %</i>	Tier 1	
<i>ketorolac ophthalmic (eye) drops 0.5 %</i>	Tier 1	QL (20 ML per 30 days)
NEVANAC OPTHALMIC (EYE) DROPS,SUSPENSION 0.1 % (nepafenac)	Tier 3	ST: Requires prior prescriptions for Ilevro 0.3% and one of the following: Diclofenac 0.1% or Ketorolac 0.5% within the past 365 days; QL (9 ML per 16 days)
PROLENSA OPTHALMIC (EYE) DROPS 0.07 % (bromfenac sodium)	Tier 3	ST: Requires prior prescription for generic Ketorolac or Diclofenac ophthalmic drops within the past 120 days; QL (3 ML per 16 days)
Ophthalmic - Beta Blocker-Adrenergic-Carbonic Anhydrase Inhibitor Comb - Drugs For Glaucoma		
<i>timolol-brimonidi-dorzolam(pf) ophthalmic (eye) drops 0.5-0.15-2 %</i>	Tier 1	
Ophthalmic - Beta Blocker-Carbonic Anhydrase Inh-Prostaglandin Analog - Drugs For Glaucoma		
<i>timolol-dorzolam-bimatopro(pf) ophthalmic (eye) drops 0.5-2-0.01 %</i>	Tier 1	
<i>timolol-dorzolamide-bimatopros ophthalmic (eye) drops 0.5-2-0.01 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Beta Blockers-Adrenergic Combinations - Drugs For Glaucoma		
<i>brimonidine-timolol ophthalmic (eye) drops 0.2-0.5 %</i>	Tier 1	
COMBIGAN OPHTHALMIC (EYE) DROPS 0.2-0.5 % (brimonidine tartrate/timolol maleate)	Tier 3	
Ophthalmic - Beta Blockers-Carbonic Anhydrase Inhibitor Combinations - Drugs For Glaucoma		
COSOPT (PF) OPHTHALMIC (EYE) DROPPERETTE 2-0.5 % (dorzolamide HCl/timolol maleate/PF)	Tier 3	ST: Requires prior prescription for Dorzolamide/Timolol within the past 120 days; QL (2 EA per 1 day)
COSOPT OPHTHALMIC (EYE) DROPS 22.3-6.8 MG/ML (dorzolamide HCl/timolol maleate)	Tier 3	
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette 2-0.5 %</i>	Tier 1	ST: Requires prior prescription for Dorzolamide/Timolol within the past 120 days; QL (2 EA per 1 day)
<i>dorzolamide-timolol ophthalmic (eye) drops 22.3-6.8 mg/ml</i>	Tier 1	
Ophthalmic - Beta Blockers-Prostaglandin Analog Combinations - Drugs For Glaucoma		
<i>timolol-bimatoprost ophthalmic (eye) drops 0.5-0.01 %</i>	Tier 1	
Ophthalmic - Carbonic Anhydrase Inhibitors - Drugs For Glaucoma		
AZOPT OPHTHALMIC (EYE) DROPS,SUSPENSION 1 % (brinzolamide)	Tier 3	
<i>brinzolamide ophthalmic (eye) drops,suspension 1 %</i>	Tier 1	
<i>dorzolamide (pf) ophthalmic (eye) drops 2 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>dorzolamide ophthalmic (eye) drops 2 %</i>	Tier 1	
Ophthalmic - Cystine Depleting Agents - Drugs For The Eye		
CYSTADROPS OPHTHALMIC (EYE) DROPS 0.37 % (cysteamine HCl)	Tier 3	PA
CYSTARAN OPHTHALMIC (EYE) DROPS 0.44 % (cysteamine HCl)	Tier 3	PA
Ophthalmic - Decongestants - Drugs For Itchy Eye		
<i>phenylephrine hcl ophthalmic (eye) drops 10 %, 2.5 %</i>	Tier 1	
Ophthalmic - Diagnostic Agents - Drugs For The Eye		
ALTAFLUOR BENOX OPHTHALMIC (EYE) DROPS 0.25-0.4 % (benoxinate HCl/fluorescein sodium)	Tier 1	
<i>fluorescein-benoxinate ophthalmic (eye) drops 0.3-0.4 %</i>	Tier 1	
<i>fluorescein-proparacaine ophthalmic (eye) drops 0.25-0.5 %</i>	Tier 1	
Ophthalmic - Glucocorticoid-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
<i>prednisolone acetate-bromfenac ophthalmic (eye) drops,suspension 1-0.075 %</i>	Tier 1	
<i>prednisolone acetate-nepafenac ophthalmic (eye) drops,suspension 1-0.1 %</i>	Tier 1	
<i>prednisolone sod ph-bromfenac ophthalmic (eye) drops 1-0.075 %</i>	Tier 1	
Ophthalmic - Human Nerve Growth Factor (Hngf) - Drugs For The Eye		
OXERVATE OPHTHALMIC (EYE) DROPS 0.002 % (cenegermin-bkbj)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-Blockers - Drugs For Glaucoma		
<i>betaxolol ophthalmic (eye) drops 0.5 %</i>	Tier 1	
BETIMOL OPHTHALMIC (EYE) DROPS 0.25 %, 0.5 % (timolol)	Tier 3	
BETOPTIC S OPHTHALMIC (EYE) DROPS,SUSPENSION 0.25 % (betaxolol HCl)	Tier 3	
<i>carteolol ophthalmic (eye) drops 1 %</i>	Tier 1	
ISTALOL OPHTHALMIC (EYE) DROPS, ONCE DAILY 0.5 % (timolol maleate)	Tier 3	
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>timolol maleate (pf) ophthalmic (eye) dropperette 0.25 %, 0.5 %</i>	Tier 1	QL (2 EA per 1 day)
<i>timolol maleate ophthalmic (eye) drops 0.25 %, 0.5 %</i>	Tier 1	
<i>timolol maleate ophthalmic (eye) drops, once daily 0.5 %</i>	Tier 1	
<i>timolol maleate ophthalmic (eye) gel forming solution 0.25 %, 0.5 %</i>	Tier 1	
<i>timolol ophthalmic (eye) drops 0.5 %</i>	Tier 1	
TIMOPTIC OCUDOSE (PF) OPHTHALMIC (EYE) DROPPERETTE 0.25 %, 0.5 % (timolol maleate/PF)	Tier 3	QL (2 EA per 1 day)
Ophthalmic - Local Anesthetic Combinations - Drugs For The Eye		
ALTAFLUOR BENOX OPHTHALMIC (EYE) DROPS 0.25-0.4 % (benoxinate HCl/fluorescein sodium)	Tier 1	
<i>fluorescein-benoxinate ophthalmic (eye) drops 0.3-0.4 %</i>	Tier 1	
Ophthalmic - Local Anesthetic Esters - Drugs For The Eye		
proparacaine HCl (Alcaine Ophthalmic (Eye) Drops 0.5 %)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ALTACAINE OPHTHALMIC (EYE) DROPS 0.5 % (tetracaine HCl)	Tier 1	
IHEEZO (PF) OPHTHALMIC (EYE) DROPPERETTE, GEL 3 % (chloroprocaine HCl/PF)	Tier 3	
<i>proparacaine ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>tetracaine hcl (pf) ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>tetracaine hcl ophthalmic (eye) drops 0.5 %</i>	Tier 1	
Ophthalmic - Local Anesthetic, Amides - Drugs For The Eye		
AKTEN (PF) OPHTHALMIC (EYE) GEL 3.5 % (lidocaine HCl/PF)	Tier 3	
Ophthalmic - Macular Degeneration, Age-Related, Therapy Agents - Drugs For The Eye		
SUSVIMO (INITIAL FILL) INTRAVITREAL SOLUTION 10 MG/0.1 ML (ranibizumab/needle, initial fill, filter)	Tier 3	PA; KP
SUSVIMO INTRAVITREAL SOLUTION 10 MG/0.1 ML (ranibizumab)	Tier 3	PA; KP
Ophthalmic - Mast Cell Stabilizers - Drugs For Itchy Eye		
<i>cromolyn ophthalmic (eye) drops 4 %</i>	Tier 1	QL (50 ML per 30 days)
Ophthalmic - Mydriatic-Nsaid Combinations - Anti-Infective/Anti-Inflammatories		
MYDRIATIC4(TROP-PROP-PE-KTRLC) OPHTHALMIC (EYE) DROPS 1-0.5-2.5-0.5 % (tropicamide/proparacaine/phenylephrine/ketorolac in water)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic - Rho Kinase Inhibitor And Prostaglandin Analog Combination - Drugs For Glaucoma		
ROCKLATAN OPHTHALMIC (EYE) DROPS 0.02-0.005 % (netarsudil mesylate/latanoprost)	Tier 3	ST: Requires prior prescriptions for Latanoprost and one of the following: Alphagan P 0.1%, Azopt, Brimonidine 0.2%, Combigan, Lumigan 0.01%, Simbrinza, or Travatan Z within the past 365 days; QL (2.5 ML per 25 days)
Ophthalmic - Surgical Aids Other - Drugs For The Eye		
GELFILM OPHTHALMIC (EYE) FILM (gelatin)	Tier 3	
Ophthalmic - Viscoelastic Agents - Drugs For The Eye		
AMVISC INTRAOCULAR SYRINGE 12 MG/ML (hyaluronate sodium)	Tier 3	KP
AMVISC PLUS INTRAOCULAR SYRINGE 16 MG/ML (hyaluronate sodium)	Tier 3	KP
BIOLON INTRAOCULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	KP
HEALON GV PRO INTRAOCULAR SYRINGE 18 MG/ML (hyaluronate sodium)	Tier 3	KP
HEALON PRO INTRAOCULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	KP
HEALON5 PRO INTRAOCULAR SYRINGE 23 MG/ML (hyaluronate sodium)	Tier 3	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PROVISC INTRAOCULAR SYRINGE 10 MG/ML (hyaluronate sodium)	Tier 3	KP
TOTALVISC INTRAOCULAR SYRINGE 2.5 % (1 ML) 1 % (1 ML) (hyaluronate sodium)	Tier 3	KP
Ophthalmic Antibacterial Mixtures - Anti-Infective/Anti-Inflammatories		
<i>bacitracin-polymyxin b ophthalmic (eye) ointment 500-10,000 unit/gram</i>	Tier 1	
<i>neomycin-bacitracin-polymyxin ophthalmic (eye) ointment 3.5-400-10,000 mg-unit-unit/g</i>	Tier 1	
<i>neomycin-polymyxin-gramicidin ophthalmic (eye) drops 1.75 mg-10,000 unit-0.025mg/ml</i>	Tier 1	
neomycin sulfate/bacitracin/polymyxin B (Neo-Polycin Ophthalmic (Eye) Ointment 3.5-400-10,000 Mg-Unit-Unit/G)	Tier 1	
bacitracin/polymyxin B sulfate (Polycin Ophthalmic (Eye) Ointment 500-10,000 Unit/Gram)	Tier 1	
<i>polymyxin b sulf-trimethoprim ophthalmic (eye) drops 10,000 unit- 1 mg/ml</i>	Tier 1	
<i>tobramycin-vancomycin ophthalmic (eye) drops 1.5-5 %</i>	Tier 1	
Ophthalmic Antibiotic - Aminoglycosides - Anti-Infective/Anti-Inflammatories		
<i>gentamicin ophthalmic (eye) drops 0.3 %</i>	Tier 1	
<i>tobramycin ophthalmic (eye) drops 0.3 %</i>	Tier 1	
<i>tobramycin-vancomycin ophthalmic (eye) drops 1.5-5 %</i>	Tier 1	
TOBREX OPHTHALMIC (EYE) OINTMENT 0.3 % (tobramycin)	Tier 2	
Ophthalmic Antibiotic - Dehydropeptidase Inhibitors - Anti-Infective/Anti-Inflammatories		
<i>bacitracin ophthalmic (eye) ointment 500 unit/gram</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic Antibiotic - Fluoroquinolones - Anti-Infective/Anti-Inflammatories		
BESIVANCE OPHTHALMIC (EYE) DROPS,SUSPENSION 0.6 % (besifloxacin HCl)	Tier 2	
CILOXAN OPHTHALMIC (EYE) OINTMENT 0.3 % (ciprofloxacin HCl)	Tier 2	
<i>ciprofloxacin hcl ophthalmic (eye) drops 0.3 %</i>	Tier 1	
<i>gatifloxacin ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>levofloxacin ophthalmic (eye) drops 0.5 %, 1.5 %</i>	Tier 1	
<i>moxifloxacin ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>moxifloxacin ophthalmic (eye) drops, viscous 0.5 %</i>	Tier 1	
OCUFLOX OPHTHALMIC (EYE) DROPS 0.3 % (ofloxacin)	Tier 3	
<i>ofloxacin ophthalmic (eye) drops 0.3 %</i>	Tier 1	
VIGAMOX OPHTHALMIC (EYE) DROPS 0.5 % (moxifloxacin HCl)	Tier 3	
Ophthalmic Antibiotic - Macrolides - Anti-Infective/Anti-Inflammatories		
AZASITE OPHTHALMIC (EYE) DROPS 1 % (azithromycin)	Tier 3	
<i>erythromycin ophthalmic (eye) ointment 5 mg/gram (0.5 %)</i>	Tier 1	
Ophthalmic Antibiotic - Sulfonamides - Anti-Infective/Anti-Inflammatories		
<i>sulfacetamide sodium ophthalmic (eye) drops 10 %</i>	Tier 1	
<i>sulfacetamide sodium ophthalmic (eye) ointment 10 %</i>	Tier 1	
Ophthalmic Antifungals - Anti-Infective/Anti-Inflammatories		
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 % (natamycin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic Antifungals - Tetraene Polyene-Type - Drugs For The Eye		
NATACYN OPHTHALMIC (EYE) DROPS,SUSPENSION 5 % (natamycin)	Tier 3	
Ophthalmic Antiseptics - Anti-Infective/Anti-Inflammatories		
BETADINE OPHTHALMIC PREP OPHTHALMIC (EYE) SOLUTION 5 % (povidone-iodine)	Tier 3	
<i>povidone-iodine ophthalmic (eye) solution 5 %</i>	Tier 1	
Ophthalmic Antivirals - Anti-Infective/Anti-Inflammatories		
<i>trifluridine ophthalmic (eye) drops 1 %</i>	Tier 1	
ZIRGAN OPHTHALMIC (EYE) GEL 0.15 % (ganciclovir)	Tier 3	ST: Requires prior prescription for oral Acyclovir, Famciclovir, or Valacyclovir within the past 120 days
Ophthalmic-Intraocular Press. Reducing, Sel. Alpha Adrenergic Agonists - Drugs For Glaucoma		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %, 0.15 % (brimonidine tartrate)	Tier 3	
<i>apraclonidine ophthalmic (eye) drops 0.5 %</i>	Tier 1	
<i>brimonidine ophthalmic (eye) drops 0.1 %, 0.15 %, 0.2 %</i>	Tier 1	
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE 1 % (apraclonidine HCl)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs - Drugs For Glaucoma		
<i>bimatoprost ophthalmic (eye) drops 0.03 %</i>	Tier 1	QL (1 ML per 12 days)
IYUZEH (PF) OPHTHALMIC (EYE) DROPPERETTE 0.005 % (latanoprost/PF)	Tier 3	ST: Requires prior prescriptions for a generic prostaglandin analog and Lumigan within the past 365 days; QL (1 EA per 1 day)
<i>latanoprost ophthalmic (eye) drops 0.005 %</i>	Tier 1	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 % (bimatoprost)	Tier 2	QL (2.5 ML per 25 days)
<i>tafluprost (pf) ophthalmic (eye) dropperette 0.0015 %</i>	Tier 1	QL (1 EA per 1 day)
TRAVATAN Z OPHTHALMIC (EYE) DROPS 0.004 % (travoprost)	Tier 3	QL (2.5 ML per 25 days)
<i>travoprost ophthalmic (eye) drops 0.004 %</i>	Tier 1	QL (2.5 ML per 25 days)
VYZULTA OPHTHALMIC (EYE) DROPS 0.024 % (latanoprostene bunod)	Tier 3	ST: Requires prior prescriptions for a generic prostaglandin analog and Lumigan within the past 365 days; QL (2.5 ML per 30 days)
XALATAN OPHTHALMIC (EYE) DROPS 0.005 % (latanoprost)	Tier 3	
XELPROS OPHTHALMIC (EYE) DROPS, EMULSION 0.005 % (latanoprost)	Tier 3	ST: Requires prior prescriptions for a generic prostaglandin analog and Lumigan within the past 365 days; QL (2.5 ML per 25 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ZIOPTAN (PF) OPHTHALMIC (EYE) DROPPERETTE 0.0015 % (tafluprost/PF)	Tier 3	QL (1 EA per 1 day)
Ophthalmic-Intraocular Pressure Reducing Agents, Rho Kinase Inhibitors - Drugs For Glaucoma		
RHOPRESSA OPHTHALMIC (EYE) DROPS 0.02 % (netarsudil mesylate)	Tier 3	ST: Requires prior prescriptions for Latanoprost and one of the following: Alphagan P 0.1%, Azopt, Combigan, Lumigan 0.01%, Travatan Z, or Simbrinza within the past 365 days; QL (2.5 ML per 30 days)
Vascular Endothelial Growth Factor (Vegf-A) Receptor Antagonists - Drugs For The Eye		
SUSVIMO (INITIAL FILL) INTRAVITREAL SOLUTION 10 MG/0.1 ML (ranibizumab/needle, initial fill, filter)	Tier 3	PA; KP
SUSVIMO INTRAVITREAL SOLUTION 10 MG/0.1 ML (ranibizumab)	Tier 3	PA; KP
Organ Preservation Solutions		
Microplegic Solutions		
<i>microplegic solution no.1 perfusion solution 7.84 %-8.56 % (0.92 molar)</i>	Tier 1	KP
Organ Preservation Solutions - Drugs For The Heart		
Cardioplegic Solutions - Drugs For The Heart		
CARDIOPLEGIA DEL NIDO FORMULA PERFUSION SOLUTION 26 MEQ/1,052.8 ML (POTASSIUM) (cardioplegic solution no.16)	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CARDIOPLEGIA DEL NIDO-ISOLYT S PERFUSION SOLUTION 26 MEQ/1,052.8 ML (POTASSIUM) (cardioplegic solution no.35)	Tier 3	KP
CARDIOPLEGIA HIGH POTASSIUM PERFUSION SOLUTION 108 MEQ/500 ML (POTASSIUM) (cardioplegic solution no.10)	Tier 1	KP
CARDIOPLEGIA IND 4:1 PLASMALYT PERFUSION SOLUTION 30 MEQ/542 ML (POTASSIUM) (cardioplegic no.23 (induction 4:1))	Tier 1	KP
CARDIOPLEGIA IND 8:1 NON-ENRCH PERFUSION SOLUTION 70 MEQ/300 ML (POTASSIUM) (cardioplegic solution no.18 (induction 8:1))	Tier 1	KP
CARDIOPLEGIA INDUCTION 4:1 PERFUSION SOLUTION 30 MEQ/415 ML (POTASSIUM) (cardioplegic solution no.22 (induction 4:1))	Tier 1	KP
CARDIOPLEGIA MAINTENANCE 4:1 PERFUSION SOLUTION 20 MEQ/810 ML (POTASSIUM) (cardioplegic solution no.20 (maintenance 4:1))	Tier 1	KP
CARDIOPLEGIA MAINTENANCE 4:1 PERFUSION SOLUTION 36 MEQ/L (POTASSIUM) (cardioplegic solution no.26 (maintenance 4:1))	Tier 1	KP
CARDIOPLEGIA REPERFUSATE 4:1 PERFUSION SOLUTION 15 MEQ/477.5 ML (POTASSIUM) (cardioplegic no.21 (reperfusate 4:1))	Tier 1	KP
CARDIOPLEGIA WARM INDUCT 4:1 PERFUSION SOLUTION 40 MEQ/500 ML (POTASSIUM) (cardioplegic solution no.33 (warm induction 4:1))	Tier 3	KP
<i>cardioplegic no.17(induct 4:1) perfusion solution 50 meq/500 ml (potassium)</i>	Tier 1	KP
<i>cardioplegic no.19 (maint 4:1) perfusion solution 40 meq/l (potassium)</i>	Tier 1	KP
<i>cardioplegic soln perfusion solution 16 meq/l (= k+)</i>	Tier 1	KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cardioplegic solution no.25 perfusion solution 29 mmol/l (potassium)</i>	Tier 1	KP
PLEGISOL PERFUSION SOLUTION 16 MEQ/L (= K+) (cardioplegic solution no.1)	Tier 3	KP
Otic (Ear) - Drugs For The Ear		
Otic (Ear) - Anti-Infective-Glucocorticoid Combinations - Anti-Infective/Anti-Inflammatories		
CIPRO HC OTIC (EAR) DROPS,SUSPENSION 0.2-1 % (ciprofloxacin HCl/hydrocortisone)	Tier 3	
<i>ciprofloxacin-dexamethasone otic (ear) drops,suspension 0.3-0.1 %</i>	Tier 1	
<i>ciprofloxacin-fluocinolone otic (ear) solution 0.3-0.025 % (0.25 ml)</i>	Tier 1	
CORTISPORIN-TC OTIC (EAR) DROPS,SUSPENSION 3.3-3-10-0.5 MG/ML (neomycin sulf/colistin sul/hydrocortisone ac/thonzonium brom)	Tier 3	
<i>neomycin-polymyxin-hc otic (ear) drops,suspension 3.5-10,000-1 mg/ml-unit/ml-%</i>	Tier 1	
<i>neomycin-polymyxin-hc otic (ear) solution 3.5-10,000-1 mg/ml-unit/ml-%</i>	Tier 1	
OTOVEL OTIC (EAR) SOLUTION 0.3-0.025 % (0.25 ML) (ciprofloxacin HCl/fluocinolone acetone)	Tier 3	
Otic (Ear) - Anti-Infectives Other - Antibiotics		
<i>acetic acid otic (ear) solution 2 %</i>	Tier 1	
Otic (Ear) - Fluoroquinolones - Antibiotics		
CETRAXAL OTIC (EAR) DROPPERETTE 0.2 % (ciprofloxacin HCl)	Tier 3	
<i>ciprofloxacin hcl otic (ear) dropperette 0.2 %</i>	Tier 1	
<i>ofloxacin otic (ear) drops 0.3 %</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Otic (Ear) - Glucocorticoids - Anti-Infective/Anti-Inflammatories		
DERMOTIC OIL OTIC (EAR) DROPS 0.01 % (fluocinolone acetonide oil)	Tier 3	
fluocinolone acetonide oil (Flac Otic Oil Otic (Ear) Drops 0.01 %)	Tier 3	
<i>fluocinolone acetonide oil otic (ear) drops 0.01 %</i>	Tier 1	
<i>hydrocortisone-acetic acid otic (ear) drops 1-2 %</i>	Tier 1	
Otic (Ear) - Pinna Combinations - Antibiotics		
CORTANE-B TOPICAL LOTION 1-1-0.1 % (hydrocortisone/pramoxine HCl/chloroxylenol)	Tier 3	
Respiratory Therapy Agents		
Asthma/Copd - Phosphodiesterase-3 And -4 (Pde3 And Pde4) Inhibitors		
OHTUVAYRE INHALATION SUSPENSION FOR NEBULIZATION 3 MG/2.5 ML (ensifentrine)	Tier 3	PA
Bronchiectasis Therapy Agents		
BRINSUPRI ORAL TABLET 10 MG, 25 MG (brensocatib)	Tier 3	PA; QL (1 EA per 1 day)
Respiratory Therapy Agents - Drugs For The Lungs		
1st Generation Antihistamine-Decongestant Combinations - Drugs For Cough And Cold		
<i>promethazine-phenylephrine oral syrup 6.25-5 mg/5 ml</i>	Tier 1	
1st Generation Antihistamine-Decongestant-Anticholinergic Combinations - Drugs For Cough And Cold		
RESPA-AR ORAL TABLET EXTENDED RELEASE 12 HR 8-90-0.24 MG (pseudoephedrine HCl/chlorpheniramine maleate/bellad alk)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
2Nd Generation Antihistamine-Decongestant Combinations - Drugs For Cough And Cold		
CLARINEX-D 12 HOUR ORAL TABLET, ER MULTIPHASE 12 HR 2.5-120 MG (desloratadine/pseudoephedrine sulfate)	Tier 3	ST: Requires prior prescription for Desloratadine or Levocetirizine tablets within the past 120 days
Antihistamine - 1St Generation - Alkylamines - Drugs For Allergies		
<i>dexchlorpheniramine maleate oral solution 2 mg/5 ml</i>	Tier 3	QL (236 ML per 1 FILL)
Antihistamine - 1St Generation - Ethanolamines - Drugs For Allergies		
<i>carbinoxamine maleate oral liquid 4 mg/5 ml</i>	Tier 1	Age (Min 2 Years)
<i>carbinoxamine maleate oral suspension, extended rel 12 hr 4 mg/5 ml</i>	Tier 1	ST: Requires prior prescription for immediate release Carbinoxamine Maleate oral solution within the past 120 days; QL (960 ML per 30 days); Age (Min 2 Years)
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	Age (Min 2 Years)
<i>carbinoxamine maleate oral tablet 6 mg</i>	Tier 3	ST: Requires prior prescriptions for Carbinoxamine 4mg tablets and IR solution within the past 365 days; QL (4 EA per 1 day); Age (Min 2 Years)
carbinoxamine maleate (Carbzah Oral Liquid 4 Mg/5 Ml)	Tier 1	Age (Min 2 Years)
<i>clemastine oral syrup 0.5 mg/5 ml</i>	Tier 3	
<i>clemastine oral tablet 2.68 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
clemastine fumarate (Clemasz Oral Tablet 2.68 Mg)	Tier 1	
clemastine fumarate (Clemsza Oral Tablet 2.68 Mg)	Tier 1	
diphenhydramine HCl (Diphen Oral Elixir 12.5 Mg/5 ML)	Tier 1	
KARBINAL ER ORAL SUSPENSION,EXTENDED REL 12 HR 4 MG/5 ML (carbinoxamine maleate)	Tier 3	ST: Requires prior prescription for immediate release Carbinoxamine Maleate oral solution within the past 120 days; QL (960 ML per 30 days); Age (Min 2 Years)
Antihistamine - 1St Generation - Phenothiazines - Drugs For Allergies		
promethazine HCl (Phenergan Injection Solution 25 Mg/ML, 50 Mg/ML)	Tier 3	KP
<i>promethazine injection solution 25 mg/ml, 50 mg/ml</i>	Tier 1	KP
<i>promethazine oral syrup 6.25 mg/5 ml</i>	Tier 1	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
promethazine HCl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg, 50 Mg)	Tier 1	
Antihistamine - 1St Generation - Piperidines - Drugs For Allergies		
<i>cyproheptadine oral syrup 2 mg/5 ml</i>	Tier 1	
<i>cyproheptadine oral tablet 4 mg</i>	Tier 1	
Antihistamines - 1St Generation - Drugs For Allergies		
<i>carbinoxamine maleate oral liquid 4 mg/5 ml</i>	Tier 1	Age (Min 2 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbinoxamine maleate oral suspension,extended rel 12 hr 4 mg/5 ml</i>	Tier 1	ST: Requires prior prescription for immediate release Carbinoxamine Maleate oral solution within the past 120 days; QL (960 ML per 30 days); Age (Min 2 Years)
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	Age (Min 2 Years)
<i>carbinoxamine maleate oral tablet 6 mg</i>	Tier 3	ST: Requires prior prescriptions for Carbinoxamine 4mg tablets and IR solution within the past 365 days; QL (4 EA per 1 day); Age (Min 2 Years)
carbinoxamine maleate (Carbzah Oral Liquid 4 Mg/5 ML)	Tier 1	Age (Min 2 Years)
<i>clemastine oral syrup 0.5 mg/5 ml</i>	Tier 3	
<i>clemastine oral tablet 2.68 mg</i>	Tier 1	
clemastine fumarate (Clemasz Oral Tablet 2.68 Mg)	Tier 1	
clemastine fumarate (Clemsza Oral Tablet 2.68 Mg)	Tier 1	
<i>cyproheptadine oral syrup 2 mg/5 ml</i>	Tier 1	
<i>cyproheptadine oral tablet 4 mg</i>	Tier 1	
<i>dexchlorpheniramine maleate oral solution 2 mg/5 ml</i>	Tier 3	QL (236 ML per 1 FILL)
diphenhydramine HCl (Diphen Oral Elixir 12.5 Mg/5 ML)	Tier 1	
KARBINAL ER ORAL SUSPENSION,EXTENDED REL 12 HR 4 MG/5 ML (carbinoxamine maleate)	Tier 3	ST: Requires prior prescription for immediate release Carbinoxamine Maleate oral solution within the past 120 days; QL (960 ML per 30 days); Age (Min 2 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
promethazine HCl (Phenergan Injection Solution 25 Mg/ML, 50 Mg/ML)	Tier 3	KP
<i>promethazine injection solution 25 mg/ml, 50 mg/ml</i>	Tier 1	KP
<i>promethazine oral syrup 6.25 mg/5 ml</i>	Tier 1	
<i>promethazine oral tablet 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>promethazine rectal suppository 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
promethazine HCl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg, 50 Mg)	Tier 1	
Antihistamines - 2Nd Generation - Drugs For Allergies		
<i>cetirizine oral solution 1 mg/ml</i>	Tier 1	
CLARINEX ORAL TABLET 5 MG (desloratadine)	Tier 3	
<i>desloratadine oral tablet 5 mg</i>	Tier 1	
<i>desloratadine oral tablet, disintegrating 2.5 mg, 5 mg</i>	Tier 1	ST: Requires prior prescription for Desloratadine or Levocetirizine tablets within the past 120 days
<i>levocetirizine oral solution 2.5 mg/5 ml</i>	Tier 1	ST: Requires prior prescription for Desloratadine or Levocetirizine tablets within the past 120 days
<i>levocetirizine oral tablet 5 mg</i>	Tier 1	
Antihistamines - 2Nd Generation - Piperazines - Drugs For Allergies		
<i>cetirizine oral solution 1 mg/ml</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levocetirizine oral solution 2.5 mg/5 ml</i>	Tier 1	ST: Requires prior prescription for Desloratadine or Levocetirizine tablets within the past 120 days
<i>levocetirizine oral tablet 5 mg</i>	Tier 1	
Antihistamines - 2Nd Generation - Piperidines - Drugs For Allergies		
CLARINEX ORAL TABLET 5 MG (desloratadine)	Tier 3	
<i>desloratadine oral tablet 5 mg</i>	Tier 1	
<i>desloratadine oral tablet, disintegrating 2.5 mg, 5 mg</i>	Tier 1	ST: Requires prior prescription for Desloratadine or Levocetirizine tablets within the past 120 days
Antitussives - Non-Opioid - Drugs For Allergies		
<i>benzonatate oral capsule 100 mg, 150 mg, 200 mg</i>	Tier 1	
Asthma Therapy - 5-Lipoxygenase Inhibitors - Drugs For Asthma/Copd		
<i>zileuton oral tablet, er multiphase 12 hr 600 mg</i>	Tier 3	ST: Requires prior prescriptions for Montelukast and Zafirlukast within the past 365 days; QL (2 EA per 1 day)
ZYFLO ORAL TABLET 600 MG (zileuton)	Tier 3	ST: Requires prior prescriptions for Montelukast and Zafirlukast within the past 365 days; QL (4 EA per 1 day)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma Therapy - Alpha/Beta Adrenergic Agents - Drugs For Asthma/Copd		
<i>epinephrine injection syringe 0.1 mg/ml</i>	Tier 1	KP
Asthma Therapy - Immunoglobulin E (Ige) Inhibitors, Mab - Drugs For Asthma/Copd		
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML (omalizumab)	Tier 3	PA; KP
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML (omalizumab)	Tier 3	PA; KP
Asthma Therapy - Inhaled Corticosteroids (Glucocorticoids) - Drugs For Asthma/Copd		
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION, 80 MCG/ACTUATION (ciclesonide)	Tier 3	ST: At least 2 prior prescriptions for Asmanex, Qvar, or Arnuity Ellipta within the past 365 days; QL (12.2 GM per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION (fluticasone furoate)	Tier 3	QL (30 EA per 30 days)
ASMANEX HFA INHALATION HFA AEROSOL INHALER 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION (mometasone furoate)	Tier 2	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60) (mometasone furoate)	Tier 2	QL (1 EA per 30 days)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml, 1 mg/2 ml</i>	Tier 1	QL (120 ML per 30 days)
<i>fluticasone propionate inhalation blister with device 100 mcg/actuation, 50 mcg/actuation</i>	Tier 1	QL (60 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone propionate inhalation blister with device 250 mcg/actuation</i>	Tier 1	QL (120 EA per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i>	Tier 1	QL (12 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i>	Tier 1	QL (24 GM per 30 days)
<i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i>	Tier 1	QL (21.2 GM per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION, 90 MCG/ACTUATION (budesonide)	Tier 3	ST: At least 2 prior prescriptions for Asmanex, Qvar, or Arnuity Ellipta within the past 365 days; QL (1 EA per 30 days)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML, 1 MG/2 ML (budesonide)	Tier 3	QL (120 ML per 30 days)
QVAR REDHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION, 80 MCG/ACTUATION (beclomethasone dipropionate)	Tier 2	QL (21.2 GM per 30 days)
Asthma Therapy - Interleukin-4 (Il-4) Receptor Alpha Antagonists, Mab - Drugs For Asthma/Copd		
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML (dupilumab)	Tier 3	PA; KP
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML, 300 MG/2 ML (dupilumab)	Tier 3	PA; KP
Asthma Therapy - Interleukin-5 (Il-5) Inhibitors, Mab - Drugs For Asthma/Copd		
NUCALA SUBCUTANEOUS AUTO-INJECTOR 100 MG/ML (mepolizumab)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML (mepolizumab)	Tier 3	PA; KP
Asthma Therapy - Interleukin-5 (Il-5) Receptor Alpha Antagonists, Mab - Drugs For Asthma/Copd		
FASENRA PEN SUBCUTANEOUS AUTO-INJECTOR 30 MG/ML (benralizumab)	Tier 3	PA; KP
Asthma Therapy - Leukotriene Receptor Antagonists - Drugs For Asthma/Copd		
ACCOLATE ORAL TABLET 10 MG, 20 MG (zafirlukast)	Tier 3	
<i>montelukast oral granules in packet 4 mg</i>	Tier 1	
<i>montelukast oral tablet 10 mg</i>	Tier 1	
<i>montelukast oral tablet, chewable 4 mg, 5 mg</i>	Tier 1	
SINGULAIR ORAL GRANULES IN PACKET 4 MG (montelukast sodium)	Tier 3	
SINGULAIR ORAL TABLET 10 MG (montelukast sodium)	Tier 3	
SINGULAIR ORAL TABLET, CHEWABLE 4 MG, 5 MG (montelukast sodium)	Tier 3	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	Tier 1	
Asthma Therapy - Mast Cell Stabilizers - Drugs For Asthma/Copd		
<i>cromolyn inhalation solution for nebulization 20 mg/2 ml</i>	Tier 1	
Asthma Therapy - Thymic Stromal Lymphopoietin Inhibitor, Mab - Drugs For Asthma/Copd		
TEZSPIRE SUBCUTANEOUS PEN INJECTOR 210 MG/1.91 ML (110 MG/ML) (tezepelumab-ekko)	Tier 3	PA; KP

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma Therapy - Xanthines - Drugs For Asthma/Copd		
theophylline anhydrous (Elixophyllin Oral Elixir 80 Mg/15 MI)	Tier 1	
THEO-24 ORAL CAPSULE,EXTENDED RELEASE 24HR 100 MG, 200 MG, 300 MG, 400 MG (theophylline anhydrous)	Tier 2	
<i>theophylline oral elixir 80 mg/15 ml</i>	Tier 1	
<i>theophylline oral solution 80 mg/15 ml</i>	Tier 1	
<i>theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg, 450 mg</i>	Tier 1	
<i>theophylline oral tablet extended release 24 hr 400 mg, 600 mg</i>	Tier 1	
Asthma/Copd - Phosphodiesterase-4 (Pde4) Inhibitors - Drugs For Asthma/Copd		
DALIRESP ORAL TABLET 250 MCG, 500 MCG (roflumilast)	Tier 3	QL (1 EA per 1 day)
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	Tier 1	QL (1 EA per 1 day)
Asthma/Copd - Anticholinergic Agents, Inhaled Long Acting - Drugs For Asthma/Copd		
INCRUSE ELLIPTA INHALATION BLISTER WITH DEVICE 62.5 MCG/ACTUATION (umeclidinium bromide)	Tier 2	QL (30 EA per 30 days)
SPIRIVA RESPIMAT INHALATION MIST 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION (tiotropium bromide)	Tier 2	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER INHALATION CAPSULE, W/INHALATION DEVICE 18 MCG (tiotropium bromide)	Tier 3	QL (30 EA per 30 days)
<i>tiotropium bromide inhalation capsule, w/inhalation device 18 mcg</i>	Tier 1	QL (30 EA per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATION (aclidinium bromide)	Tier 3	ST: Requires prior prescription for Spiriva Respimat or Incruse Ellipta within the past 120 days; QL (1 EA per 30 days)
YUPELRI INHALATION SOLUTION FOR NEBULIZATION 175 MCG/3 ML (revefenacin)	Tier 3	QL (90 ML per 30 days)
Asthma/Copd - Anticholinergic Agents, Inhaled Short Acting - Drugs For Asthma/Copd		
ATROVENT HFA INHALATION HFA AEROSOL INHALER 17 MCG/ACTUATION (ipratropium bromide)	Tier 2	QL (25.8 GM per 30 days)
<i>ipratropium bromide inhalation solution 0.02 %</i>	Tier 1	
Asthma/Copd - Beta 2-Adrenergic Agents, Inhaled, Ultra-Long Acting - Drugs For Asthma/Copd		
STRIVERDI RESPIMAT INHALATION MIST 2.5 MCG/ACTUATION (olodaterol HCl)	Tier 2	QL (4 GM per 30 days)
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Long Acting - Drugs For Asthma/Copd		
<i>arformoterol inhalation solution for nebulization 15 mcg/2 ml</i>	Tier 1	ST: Requires prior prescription for Perforomist, Serevent, or Striverdi within the past 120 days; QL (120 ML per 30 days)
BROVANA INHALATION SOLUTION FOR NEBULIZATION 15 MCG/2 ML (arformoterol tartrate)	Tier 3	ST: Requires prior prescription for Perforomist, Serevent, or Striverdi within the past 120 days; QL (120 ML per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>formoterol fumarate inhalation solution for nebulization 20 mcg/2 ml</i>	Tier 1	QL (120 ML per 30 days)
PERFOROMIST INHALATION SOLUTION FOR NEBULIZATION 20 MCG/2 ML (formoterol fumarate)	Tier 3	QL (120 ML per 30 days)
SEREVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/DOSE (salmeterol xinafoate)	Tier 2	QL (60 EA per 30 days)
Asthma/Copd Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting - Drugs For Asthma/Copd		
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation</i>	Tier 1	
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml</i>	Tier 1	
<i>albuterol sulfate inhalation solution for nebulization 2.5 mg/0.5 ml</i>	Tier 1	
<i>levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml, 1.25 mg/3 ml</i>	Tier 1	
<i>levalbuterol tartrate inhalation hfa aerosol inhaler 45 mcg/actuation</i>	Tier 1	
PROAIR RESPICLICK INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION (albuterol sulfate)	Tier 3	ST: Requires prior prescription for generic Albuterol Sulfate 90mcg HFA inhaler within the past 120 days
VENTOLIN HFA INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION (albuterol sulfate)	Tier 3	ST: Requires prior prescription for generic Albuterol Sulfate 90mcg HFA inhaler within the past 120 days
XOPENEX HFA INHALATION HFA AEROSOL INHALER 45 MCG/ACTUATION (levalbuterol tartrate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma/Copd Therapy - Beta Adrenergic Agents - Drugs For Asthma/Copd		
<i>albuterol sulfate oral syrup 2 mg/5 ml</i>	Tier 1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	Tier 1	
<i>albuterol sulfate oral tablet extended release 12 hr 4 mg, 8 mg</i>	Tier 1	
<i>terbutaline oral tablet 2.5 mg, 5 mg</i>	Tier 1	
Asthma/Copd Therapy - Beta Adrenergic-Anticholinergic Combinations - Drugs For Asthma/Copd		
ANORO ELLIPTA INHALATION BLISTER WITH DEVICE 62.5-25 MCG/ACTUATION (umeclidinium bromide/vilanterol trifenate)	Tier 2	QL (60 EA per 30 days)
BEVESPI AEROSPHERE INHALATION HFA AEROSOL INHALER 9-4.8 MCG (glycopyrrolate/formoterol fumarate)	Tier 3	ST: Requires prior prescription for Anoro Ellipta and Stiolto Respimat within the past 365 days; QL (10.7 GM per 30 days)
COMBIVENT RESPIMAT INHALATION MIST 20-100 MCG/ACTUATION (ipratropium bromide/albuterol sulfate)	Tier 2	
DUAKLIR PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400-12 MCG/ACTUATION (aclidinium bromide/formoterol fumarate)	Tier 3	ST: Requires prior prescription for Anoro Ellipta and Stiolto Respimat within the past 365 days; QL (1 EA per 30 days)
<i>ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 ml</i>	Tier 1	
STIOLTO RESPIMAT INHALATION MIST 2.5-2.5 MCG/ACTUATION (tiotropium bromide/olodaterol HCl)	Tier 2	QL (4 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Asthma/Copd Therapy - Beta Adrenergic-Glucocorticoid Combinations - Drugs For Asthma/Copd		
ADVAIR DISKUS INHALATION BLISTER WITH DEVICE 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE (fluticasone propionate/salmeterol xinafoate)	Tier 3	QL (60 EA per 30 days)
ADVAIR HFA INHALATION HFA AEROSOL INHALER 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION (fluticasone propionate/salmeterol xinafoate)	Tier 2	QL (12 GM per 30 days)
AIRDUO RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACTUATION, 232-14 MCG/ACTUATION, 55-14 MCG/ACTUATION (fluticasone propionate/salmeterol xinafoate)	Tier 3	QL (1 EA per 30 days)
AIRSUPRA INHALATION HFA AEROSOL INHALER 90-80 MCG/ACTUATION (albuterol sulfate/budesonide)	Tier 2	QL (32.1 GM per 30 days)
BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 MCG/DOSE (fluticasone furoate/vilanterol trifenate)	Tier 2	QL (60 EA per 30 days)
budesonide/formoterol fumarate (Breyna Inhalation Hfa Aerosol Inhaler 160-4.5 Mcg/Actuation, 80-4.5 Mcg/Actuation)	Tier 1	QL (30.9 GM per 30 days)
<i>budesonide-formoterol inhalation hfa aerosol inhaler 160-4.5 mcg/actuation, 80-4.5 mcg/actuation</i>	Tier 1	QL (30.9 GM per 30 days)
DULERA INHALATION HFA AEROSOL INHALER 100-5 MCG/ACTUATION, 50-5 MCG/ACTUATION (mometasone furoate/formoterol fumarate)	Tier 2	QL (39 GM per 30 days)
DULERA INHALATION HFA AEROSOL INHALER 200-5 MCG/ACTUATION (mometasone furoate/formoterol fumarate)	Tier 2	QL (13 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone propion-salmeterol inhalation aerosol powdr breath activated 113-14 mcg/actuation, 232-14 mcg/actuation, 55-14 mcg/actuation</i>	Tier 1	QL (1 EA per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device 100-50 mcg/dose, 250-50 mcg/dose, 500-50 mcg/dose</i>	Tier 1	QL (60 EA per 30 days)
SYMBICORT INHALATION HFA AEROSOL INHALER 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION (budesonide/formoterol fumarate)	Tier 3	QL (30.9 GM per 30 days)
fluticasone propionate/salmeterol xinafoate (Wixela Inhub Inhalation Blister With Device 100-50 Mcg/Dose, 250-50 Mcg/Dose, 500-50 Mcg/Dose)	Tier 1	QL (60 EA per 30 days)
Asthma/Copd Tx - Beta-Adrenergic-Anticholinergic-Glucocorticoid Comb, - Drugs For Cystic Fibrosis		
BREZTRI AEROSPHERE INHALATION HFA AEROSOL INHALER 160-9-4.8 MCG/ACTUATION (budesonide/glycopyrrolate/formoterol fumarate)	Tier 2	QL (10.7 GM per 30 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 100-62.5-25 MCG (fluticasone furoate/umeclidinium bromide/vilanterol trifenate)	Tier 2	QL (60 EA per 30 days)
TRELEGY ELLIPTA INHALATION BLISTER WITH DEVICE 200-62.5-25 MCG (fluticasone furoate/umeclidinium bromide/vilanterol trifenate)	Tier 2	QL (2 EA per 1 day)
Corticosteroid Implant For Maintaining Sinus Patency - Drugs For The Nose		
SINUVA SINUS IMPLANT 1,350 MCG (mometasone furoate)	Tier 3	PA
Cystic Fibrosis - Inhaled Aminoglycosides - Drugs For Cystic Fibrosis		
BETHKIS INHALATION SOLUTION FOR NEBULIZATION 300 MG/4 ML (tobramycin)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KITABIS PAK INHALATION SOLUTION FOR NEBULIZATION 300 MG/5 ML (tobramycin/nebulizer)	Tier 2	
TOBI INHALATION SOLUTION FOR NEBULIZATION 300 MG/5 ML (tobramycin in 0.225 % sodium chloride)	Tier 2	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE 28 MG (tobramycin)	Tier 2	
<i>tobramycin in 0.225 % nacl inhalation solution for nebulization 300 mg/5 ml</i>	Tier 1	
<i>tobramycin inhalation solution for nebulization 300 mg/4 ml</i>	Tier 3	
<i>tobramycin with nebulizer inhalation solution for nebulization 300 mg/5 ml</i>	Tier 1	
Cystic Fibrosis - Inhaled Monobactams - Drugs For Cystic Fibrosis		
CAYSTON INHALATION SOLUTION FOR NEBULIZATION 75 MG/ML (aztreonam lysine)	Tier 2	
Cystic Fibrosis - Inhaled Osmotic Agents - Drugs For Cystic Fibrosis		
BRONCHITOL INHALATION CAPSULE, W/INHALATION DEVICE 40 MG (mannitol)	Tier 3	ST: Requires prior prescription for inhaled 7% Sodium Chloride solution within the past 120 days; QL (20 EA per 1 day); Age (Min 18 Years)
Cystic Fibrosis-Transmembrane Conductance Regulator (Cftr) Potentiator - Drugs For Cystic Fibrosis		
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG (ivacaftor)	Tier 3	PA
KALYDECO ORAL TABLET 150 MG (ivacaftor)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Cystic Fib-Transmemb Conduct. Reg.(Cftr) Potentiator And Corrector Cmb - Drugs For Cystic Fibrosis		
ALYFTREK ORAL TABLET 10-50-125 MG, 4-20-50 MG (vanzacaftor calcium/tezacaftor/deutivacaftor)	Tier 3	PA
ORKAMBI ORAL GRANULES IN PACKET 100-125 MG, 150-188 MG, 75-94 MG (lumacaftor/ivacaftor)	Tier 3	PA
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (lumacaftor/ivacaftor)	Tier 3	PA
SYMDEKO ORAL TABLETS, SEQUENTIAL 100-150 MG (D)/ 150 MG (N), 50-75 MG (D)/ 75 MG (N) (tezacaftor/ivacaftor)	Tier 3	PA
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL 100-50-75MG (D) /75 MG (N), 80-40-60 MG (D) /59.5 MG (N) (elexacaftor/tezacaftor/ivacaftor)	Tier 3	PA
TRIKAFTA ORAL TABLETS, SEQUENTIAL 100-50-75 MG(D) /150 MG (N), 50-25-37.5 MG (D)/75 MG (N) (elexacaftor/tezacaftor/ivacaftor)	Tier 3	PA
Elastase Inhibitors - Drugs For Asthma/Copd		
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG, 500 MG (alpha-1-proteinase inhibitor)	Tier 3	PA; KP
GLASSIA INTRAVENOUS SOLUTION 20 MG/ML (2 %) (alpha-1-proteinase inhibitor)	Tier 3	PA; KP
PROLASTIN-C INTRAVENOUS SOLUTION 1,000 MG (+/-)/20 ML (alpha-1-proteinase inhibitor)	Tier 3	PA; KP
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG, 4,000 MG, 5,000 MG (alpha-1-proteinase inhibitor)	Tier 3	PA; KP
Lung Surfactants - Drugs For The Lungs		
CUROSURF INTRATRACHEAL SUSPENSION 120 MG/1.5 ML, 240 MG/3 ML (poractant alfa)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
INFASURF INTRATRACHEAL SUSPENSION 35 MG/ML (calfactant)	Tier 3	
SURVANTA INTRATRACHEAL SUSPENSION 25 MG/ML (beractant)	Tier 3	
Mucolytics - Drugs For The Lungs		
<i>acetylcysteine solution 100 mg/ml (10 %), 200 mg/ml (20 %)</i>	Tier 1	
PULMOZYME INHALATION SOLUTION 1 MG/ML (dornase alfa)	Tier 3	PA
Nasal Anesthetics - Allergy		
<i>cocaine nasal solution 4 %</i>	Tier 1	
GOPRELTO NASAL SOLUTION 4 % (cocaine HCl)	Tier 3	
NUMBRINO NASAL SOLUTION 4 % (cocaine HCl)	Tier 1	
Nasal Anticholinergics - Allergy		
<i>ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %), 42 mcg (0.06 %)</i>	Tier 1	
Nasal Antihistamine And Anti-Inflammatory Steroid Combinations - Allergy		
<i>azelastine-fluticasone nasal spray,non-aerosol 137-50 mcg/spray</i>	Tier 1	ST: Requires prior prescription for Flunisolide (nasal formulation) or Fluticasone within the past 120 days; QL (23 GM per 30 days)
DYMISTA NASAL SPRAY, NON-AEROSOL 137-50 MCG/SPRAY (azelastine HCl/fluticasone propionate)	Tier 3	ST: Requires prior prescription for Flunisolide (nasal formulation) or Fluticasone within the past 120 days; QL (23 GM per 30 days)
RYALTRIS NASAL SPRAY, NON-AEROSOL 665-25 MCG/SPRAY (olopatadine HCl/mometasone furoate)	Tier 3	QL (29 GM per 30 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Nasal Antihistamines - Allergy		
<i>azelastine nasal spray,non-aerosol 137 mcg (0.1 %), 205.5 mcg (0.15 %)</i>	Tier 1	
<i>olopatadine nasal spray,non-aerosol 0.6 %</i>	Tier 1	
Nasal Corticosteroids - Allergy		
<i>flunisolide nasal spray,non-aerosol 25 mcg (0.025 %)</i>	Tier 1	QL (25 ML per 30 days)
<i>fluticasone propionate nasal spray,suspension 50 mcg/actuation</i>	Tier 1	
<i>mometasone nasal spray,non-aerosol 50 mcg/actuation</i>	Tier 1	
OMNARIS NASAL SPRAY, NON-AEROSOL 50 MCG (ciclesonide)	Tier 3	ST: Requires prior prescription for Flunisolide or Fluticasone within the past 120 days; QL (5 GM per 12 days)
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION (beclomethasone dipropionate)	Tier 2	ST: Requires prior prescription for nasal Flunisolide or Fluticasone within the past 120 days; QL (6.8 GM per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION (beclomethasone dipropionate)	Tier 2	ST: Requires prior prescription for nasal Flunisolide or Fluticasone within the past 120 days; QL (10.6 GM per 30 days)
TICANASE NASAL KIT, SPRAY SUSPENSION AND SPRAY 50 MCG- 0.9 % (fluticasone propionate/sodium chloride/sodium bicarbonate)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
XHANCE NASAL AEROSOL BREATH ACTIVATED 93 MCG/ACTUATION (fluticasone propionate)	Tier 2	ST: Requires prior prescription for one of the following intranasal corticosteroids: Flunisolide, Fluticasone Propionate, or Mometasone within the past 120 days; QL (32 ML per 30 days)
ZETONNA NASAL HFA AEROSOL INHALER 37 MCG/ACTUATION (ciclesonide)	Tier 3	ST: Requires prior prescription for Flunisolide or Fluticasone within the past 120 days; QL (6.1 GM per 30 days)
Nasal Post-Surgical Agents - Drugs For The Nose		
SINUVA SINUS IMPLANT 1,350 MCG (mometasone furoate)	Tier 3	PA
Nasal Preparations - Nicotinic Receptor Partial Agonist - Drugs For The Nose		
TYRVAYA NASAL SPRAY, METERED, NON-AEROSOL 0.03 MG/SPRAY (varenicline tartrate)	Tier 2	PA
Nasal Wash Combinations - Allergy		
ALKALOL NASAL WASH NASAL SOLUTION (menthol/eucal/thymol/camphor/benz/sod chloride/pot chlorate)	Tier 3	
Non-Opioid Antitussive-1st Gen.Antihistamine-Decongestant Combinations - Drugs For Cough And Cold		
brompheniramine maleate/pseudoephedrine HCl/dextromethorphan (Bromfed Dm Oral Syrup 2-30-10 Mg/5 MI)	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>brompheniramine-pseudoeph-dm oral syrup 2-30-10 mg/5 ml</i>	Tier 1	
Non-Opioid Antitussive-Antihistamine Combinations - Drugs For Cough And Cold		
<i>promethazine-dm oral syrup 6.25-15 mg/5 ml</i>	Tier 3	
Opioid Antitussive-1St Generation Antihistamine Combinations - Drugs For Cough And Cold		
<i>hydrocodone-chlorpheniramine oral suspension,extended rel 12 hr 10-8 mg/5 ml</i>	Tier 1	QL (10 ML per 1 day); Age (Min 18 Years)
<i>promethazine-codeine oral syrup 6.25-10 mg/5 ml</i>	Tier 1	QL (30 ML per 1 day); Age (Min 18 Years)
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HR 8-54.3 MG (chlorpheniramine maleate/codeine phosphate)	Tier 3	ST: Requires prior prescription for Promethazine/Codeine within the past 120 days; QL (2 EA per 1 day); Age (Min 18 Years)
Opioid Antitussive-1St Generation Antihistamine-Decongestant Comb. - Drugs For Cough And Cold		
HISTEX-AC ORAL SYRUP 2.5-10-10 MG/5 ML (triprolidine HCl/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)
MAR-COF BP ORAL LIQUID 2-30-7.5 MG/5 ML (brompheniramine maleate/pseudoephedrine HCl/codeine phosphat)	Tier 3	Age (Min 12 Years)
MAXI-TUSS CD ORAL LIQUID 4-10-10 MG/5 ML (chlorpheniramine maleate/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
POLY-TUSSIN AC ORAL LIQUID 4-10-10 MG/5 ML (brompheniramine maleate/phenylephrine HCl/codeine phosphate)	Tier 3	Age (Min 12 Years)
RYDEX ORAL LIQUID 1.3-10-6.3 MG/5 ML (brompheniramine maleate/pseudoephedrine HCl/codeine phosphat)	Tier 3	Age (Min 12 Years)
Opioid Antitussive-Anticholinergic Combinations - Drugs For Cough And Cold		
HYCODAN (WITH HOMATROPINE) ORAL TABLET 5-1.5 MG (hydrocodone bitartrate/homatropine methylbromide)	Tier 3	QL (6 EA per 1 day); Age (Min 18 Years)
<i>hydrocodone-homatropine oral solution 5-1.5 mg/5 ml</i>	Tier 1	QL (30 ML per 1 day); Age (Min 18 Years)
<i>hydrocodone-homatropine oral tablet 5-1.5 mg</i>	Tier 1	QL (6 EA per 1 day); Age (Min 18 Years)
hydrocodone bitartrate/homatropine methylbromide (Hydromet Oral Solution 5-1.5 Mg/5 ML)	Tier 1	QL (30 ML per 1 day); Age (Min 18 Years)
Opioid Antitussive-Decongestant-Expectorant Combinations - Drugs For Cough And Cold		
CODITUSSIN DAC ORAL LIQUID 30-10-200 MG/5 ML (pseudoephedrine HCl/codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)
GUAIFENESIN DAC ORAL SYRUP 30-10-100 MG/5 ML (pseudoephedrine HCl/codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)
Opioid Antitussive-Expectorant Combinations - Drugs For Cough And Cold		
<i>codeine-guaifenesin oral liquid 10-100 mg/5 ml</i>	Tier 1	Age (Min 12 Years)
CODITUSSIN AC ORAL LIQUID 10-200 MG/5 ML (codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)
G TUSSIN AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GUAIFENESIN AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
MAR-COF CG ORAL LIQUID 7.5-225 MG/5 ML (codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)
MAXI-TUSS AC ORAL LIQUID 10-100 MG/5 ML (codeine phosphate/guaifenesin)	Tier 1	Age (Min 12 Years)
NINJACOF-XG ORAL LIQUID 8-200 MG/5 ML (codeine phosphate/guaifenesin)	Tier 3	Age (Min 12 Years)
Pleural Sclerosing Agents - Drugs For The Lungs		
SCLEROSOL INTRAPLEURAL INTRAPLEURAL AEROSOL POWDER 4 GRAM (talc)	Tier 3	KP
<i>sterile talc intrapleural suspension for reconstitution 5 gram</i>	Tier 1	KP
STERITALC INTRAPLEURAL AEROSOL POWDER 3 GRAM (talc)	Tier 3	KP
STERITALC INTRAPLEURAL SUSPENSION FOR RECONSTITUTION 2 GRAM, 4 GRAM (talc)	Tier 3	KP
Pulmonary Fibrosis Treatment Agents - Antifibrotic Therapy - Drugs For The Lungs		
ESBRIET ORAL CAPSULE 267 MG (pirfenidone)	Tier 3	PA
ESBRIET ORAL TABLET 267 MG, 801 MG (pirfenidone)	Tier 3	PA
<i>pirfenidone oral capsule 267 mg</i>	Tier 3	PA
<i>pirfenidone oral tablet 267 mg, 801 mg</i>	Tier 3	PA
<i>pirfenidone oral tablet 534 mg</i>	Tier 3	PA
Pulmonary Fibrosis Treatment Agents - Multikinase Inhibitors - Drugs For The Lungs		
OFEV ORAL CAPSULE 100 MG, 150 MG (nintedanib esylate)	Tier 3	PA

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaginal Products - Drugs For Women		
Vaginal Antibacterial - Lincosamides - Drugs For Infections		
CLEOCIN VAGINAL CREAM 2 % (clindamycin phosphate)	Tier 3	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (clindamycin phosphate)	Tier 3	ST: At least 2 prior prescriptions for Clindamycin, vaginal Clindamycin cream, oral Metronidazole, vaginal Metronidazole gel, or Tinidazole within the past 365 days; QL (3 EA per 30 days)
<i>clindamycin phosphate vaginal cream 2 %</i>	Tier 1	
CLINDESSE VAGINAL CREAM,EXTENDED RELEASE 2 % (clindamycin phosphate)	Tier 3	ST: Requires prior prescription for generic Clindamycin vaginal cream within the past 120 days
XACIATO VAGINAL GEL 2 % (clindamycin phosphate)	Tier 3	
Vaginal Antifungal - Imidazoles - Drugs For Infections		
GYNAZOLE-1 VAGINAL CREAM 2 % (butoconazole nitrate)	Tier 2	
MICONAZOLE-3 VAGINAL SUPPOSITORY 200 MG (miconazole nitrate)	Tier 1	
Vaginal Antifungal - Triazoles - Drugs For Infections		
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	Tier 1	
<i>terconazole vaginal suppository 80 mg</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives - Drugs For Infections		
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	Tier 1	
NUVESSA VAGINAL GEL 1.3 % (65 MG/5 GRAM) (metronidazole)	Tier 3	
VANAZOLE VAGINAL GEL 0.75 % (37.5MG/5 GRAM) (metronidazole)	Tier 3	
Vaginal Antiseptic Mixtures - Drugs For Infections		
FEM PH VAGINAL GEL 0.9-0.025 % (acetic acid/oxyquinoline sulfate)	Tier 3	
RELAGARD VAGINAL GEL 0.9-0.025 % (acetic acid/oxyquinoline sulfate)	Tier 3	
TRIMO-SAN JELLY VAGINAL GEL 0.025-0.01 % (oxyquinoline sulfate/sodium lauryl sulfate)	Tier 3	
Vaginal Estrogens - Drugs For Women		
estradiol (Estrace Vaginal Cream 0.01 % (0.1 Mg/Gram))	Tier 3	
<i>estradiol vaginal cream 0.01 % (0.1 mg/gram)</i>	Tier 1	
<i>estradiol vaginal tablet 10 mcg</i>	Tier 1	
ESTRING VAGINAL RING 2 MG (7.5 MCG /24 HOUR) (estradiol)	Tier 3	ST: Requires prior prescriptions Premarin cream and one of the following: Estradiol cream or vaginal tablet within the past 365 days; QL (1 EA per 90 days)

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FEMRING VAGINAL RING 0.05 MG/24 HR, 0.1 MG/24 HR (estradiol acetate)	Tier 3	ST: Requires prior prescriptions Premarin cream and one of the following: Estradiol cream or vaginal tablet within the past 365 days; QL (1 EA per 84 days)
PREMARIN VAGINAL CREAM 0.625 MG/GRAM (estrogens, conjugated)	Tier 2	
VAGIFEM VAGINAL TABLET 10 MCG (estradiol)	Tier 3	
estradiol (Yuvaferm Vaginal Tablet 10 Mcg)	Tier 1	
Vaginal Lubricants And Moisturizers - Drugs For Women		
REPLENS EXTERNAL COMFORT VAGINAL GEL (glycerin/mineral oil/polycarbophil)	Tier 3	
Vaginal Products Miscellaneous - Drugs For Women		
AZO BORIC ACID VAGINAL SUPPOSITORY 600 MG (boric acid)	Tier 3	
MONISTAT MAINTAIN VAGINAL SUPPOSITORY 600 MG (boric acid)	Tier 3	
Vaginal Progestins - Drugs For Women		
CRINONE VAGINAL GEL 4 % (progesterone, micronized)	Tier 2	
Vaginal-Cervical Care And Treatment Agents - Drugs For Women		
PROVATE PELVIC ORGAN SUPPORT VAGINAL 61 MM, 67 MM, 73 MM, 79 MM, 85 MM, 91 MM (pessary)	Tier 3	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
Weight Loss/Gain Agents		
Anti-Obesity - Dual GIP And GLP-1 Receptor Agonists		
ZEPBOUND SUBCUTANEOUS PEN INJECTOR 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML (tirzepatide)	Tier 2	PA; KP; QL (2 ML per 28 days)
Treatment Of Hyperphagia In Prader-Willi Syndrome (PWS)		
VYKAT XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 25 MG, 75 MG (diazoxide choline)	Tier 3	PA
Weight Loss/Gain Agents - Drugs For Eating Disorders		
Anti-Obesity - Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists - Drugs For Eating Disorders		
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML (semaglutide)	Tier 2	PA; KP; QL (2 ML per 28 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML (semaglutide)	Tier 2	PA; KP; QL (3 ML per 28 days)
Appetite Stimulants - Cannabinoids - Drugs For Eating Disorders		
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (2 EA per 1 day)
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (dronabinol)	Tier 3	QL (2 EA per 1 day)
SYNDROS ORAL SOLUTION 5 MG/ML (dronabinol)	Tier 3	QL (60 ML per 30 days)
Appetite Stimulants - Progestin Hormone Type - Drugs For Eating Disorders		
<i>megestrol oral suspension 400 mg/10 ml (10 ml)</i>	Tier 1	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	Tier 1	

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs

PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME

PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	Tier 1	ST: Requires prior prescription for Megestrol Acetate within the past 120 days

Tier 1 = Preferred Generic Drugs | Tier 2 = Preferred Brand Name Drugs | Tier 3 = Non-Preferred Generic and Brand Name Drugs
PV = Preventive-Care Benefits required under the Affordable Care Act (ACA) | DME = Other pharmacy items and certain DME
PA = Prior Authorization | ST = Step Therapy | QL = Quantity Limit | Age = Age Edit | KP = Covered under the HMO level of your POS plan through the KP pharmacy

The categorical list of drugs in this Formulary groups drugs into drug categories and class based on the First National Databank (FDB).

This Drug Formulary was updated: 01/01/2026

Index of Drugs

1ST TIER UNIFINE PENTIPS..... 634, 698	ACCU-CHEK GUIDE TEST STRIPS.....556, 699	ACTICOAT FLEX 3 DRESSING.....351
1ST TIER UNIFINE PENTIPS PLUS.....634, 698	ACCU-CHEK SAFE-T-PRO 606, 700	ACTICOAT FLEX 7 DRESSING.....351
2-IN-1 LANCET DEVICE 605, 698	ACCU-CHEK SAFE-T-PRO PLUS..... 606, 700	ACTIFLOVIT.....359
2TEK CONTROL (HIGH- NORMAL).....605, 698	ACCU-CHEK SMARTVIEW CONTRL SOL.....606, 700	ACTI-LANCE LANCETS 606, 700
2TEK GLUCOSE/BLOOD PRESSURE.....599, 605, 699	ACCU-CHEK SMARTVIEW TEST STRIP.....556, 700	ACTIMMUNE.....56
A.I.R.S. NEBULIZER REPLACEMENT.....681, 699	ACCU-CHEK SOFT DEV LANCETS.....606, 700	<i>activated charcoal</i> 477
A-25 (VIT A PALMITATE)....415	ACCU-CHEK SOFTCLIX LANCETS.....606, 700	ACTIVELLA.....442
<i>abacavir</i> 62	ACCUPRIL.....120	ACTIVNUTRIENTS.....374
<i>abacavir-lamivudine</i> 64	ACCURETIC.....119	ACTIVNUTRIENTS (NO IRON).....374
ABC COMPLETE SENIOR WOMEN'S.....374	Accutane.....263	ACTIVNUTRIENTS CHEWABLE.....374
ABENOR.....264	ACCUTREND GLUCOSE CONTROL.....606, 700	ACTIVNUTRIENTS MULTIVITAMIN.....374
ABENOR HP.....264	ACCUTREND GLUCOSE TEST STRIPS.....557, 700	ACTIVNUTRIENTS PERFORMANCE.....374
Abigale.....442	ACD SOLUTION A.....526	ACTIVNUTRIENTS(NO COPPER-IRON).....374
Abigale Lo.....442	ACD-A.....526	ACTONEL.....439
ABILIFY.....190, 207	ACE AEROSOL CLOUD ENHANCER.....681, 700	ACTOPLUS MET.....435
<i>abiraterone</i> 85, 88	<i>acebutolol</i> 141	ACTOS.....460
Abirtega.....86, 88	ACESO AG.....351	ACUICYN.....309
ABLYSINOL.....151	<i>acetaminophen-caff-</i> <i>dihydrocod</i> 20, 21	ACULAR.....857
ABRYSVO (PF).....104	<i>acetaminophen-codeine</i> 20	ACULAR LS.....856
ABSORICA LD.....263	<i>acetazolamide</i> 148	ACUVAIL (PF).....857
ACAI BERRY DIET.....6	<i>acetic acid</i> 513, 870	<i>acyclovir</i> 72, 298
<i>acamprosate</i> 237	<i>acetylcysteine</i> 48, 888	ACZONE.....264
ACANYA.....268	ACIDOPHILUS PROBIOTIC BLEND.....489	ADACEL(TDAP ADOLESN/ADULT)(PF).....110
<i>acarbose</i> 430	ACIDOPHILUS-PECTIN.....468	ADAINZOXIA.....274
ACCOLATE.....879	<i>acidophilus-pectin, citrus</i> 489	<i>adalimumab-adaz</i> 29, 30, 487, 488
ACCRUFER.....365	ACIOXIA.....325	ADALINA.....278
ACCUCAINE KIT.....45, 334	ACIOXIAY.....264	<i>adapalene</i> 276
ACCU-CHEK AVIVA CONTROL SOLN.....605, 699	ACIPHEX.....473	<i>adapalene-benzoyl peroxide</i> 274
ACCU-CHEK AVIVA PLUS TEST STRP.....556, 699	ACIPHEX SPRINKLE.....474	ADASUVE.....188
ACCU-CHEK FASTCLIX LANCET DRUM.....605, 699	<i>acitretin</i> 292	ADBRY.....282
ACCU-CHEK FASTCLIX LANCING DEV.....605, 699	ACTEMRA.....35	ADCIRCA.....155
ACCU-CHEK GUIDE GLUCOSE METER.....605, 699	ACTEMRA ACTPEN.....35	Adderall.....192, 209, 228
ACCU-CHEK GUIDE L1-L2 CTRL SOL.....605, 699	ACTHAR.....426	ADDERALL XR.....192, 209
ACCU-CHEK GUIDE ME GLUCOSE MTR.....605, 699	ACTHAR SELFJECT.....426	<i>adefovir</i> 69
	ACTICOAT 7 DRESSING...351	ADEINZDE.....271
	ACTICOAT DRESSING.....351	ADEK GUMMIES PLUS ZINC.....388
		ADEMPAS.....154
		ADENO-HYDROXO B12....417

ADERMICA.....	271	ADVOCATE PEN NEEDLE	634, 701	AFLURIA 2025-2026 (3YR	UP)(PF).....	114
ADERMICA HP.....	271	ADVOCATE REDI-CODE		AFLURIA 2025-2026 (6MO	UP).....	114
ADJUSTABLE LANCING		PLUS.....	557, 606, 701, 702	AFREZZA.....		453
DEVICE.....	606, 700	ADVOCATE REDI-CODE		AFSTYLA.....		530
ADLARITY.....	243	PLUS CTRL L.....	606, 701	AFTER PILL.....		261
ADMELOG SOLOSTAR U-		ADVOCATE REDI-CODE+		AFTERA.....		261
100 INSULIN.....	456	CTRL HIGH.....	606, 702	AGAMATRIX AMP TEST		
ADMELOG U-100 INSULIN		ADVOCATE SYRINGES		STRIPS.....	558, 703	
LISPRO.....	456	.....	634, 702	AGAMATRIX CONTROL		
ADMIRAZOL.....	267	ADYNOVATE.....	530	SOLN-HIGH.....	606, 703	
ADMIRAZOL HP.....	267	ADZENYS XR-ODT.....	192, 210	AGAMATRIX CONTROL		
ADTHYZA.....	463	AEROBIKA OSCILLATING		SOLN-NORMAL.....	606, 704	
ADULT 50 PLUS EYE		PEP SYSTM.....	682, 702	AGAMATRIX CONTROL		
HEALTH.....	2, 375	AEROCHAMBER		SOLN-NORM-HI.....	607, 704	
ADULT 50 PLUS		MECHANICAL VENT..	682, 702	AGAMATRIX JAZZ TEST		
PROBIOTIC.....	489	AEROCHAMBER MINI	682, 702	STRIPS.....	558, 704	
ADULT ASPIRIN REGIMEN		AEROCHAMBER MV..	682, 702	AGAMATRIX JAZZ		
.....	43, 541	AEROCHAMBER PLUS		WIRELESS 2 MNTR....	607, 704	
ADULT LOW DOSE		FLOW-VU.....	682, 702	AGAMATRIX PRESTO		
ASPIRIN.....	43, 541	AEROCHAMBER PLUS		SYSTEM.....	607, 704	
ADULT MULTIVITAMIN		FLOW-VU,L MSK.....	682, 702	AGAMATRIX PRESTO		
GUMMIES.....	375	AEROCHAMBER PLUS		TEST STRIPS.....	558, 704	
ADULTS 50 PLUS.....	375	FLOW-VU,M MSK.....	682, 702	AGAMATRIX ULTRA-THIN		
ADULTS MULTIVITAMIN....	375	AEROCHAMBER PLUS		LANCET.....	607, 704	
ADVAIR DISKUS.....	884	FLOW-VU,S MSK.....	682, 703	AGAMREE.....	447	
ADVAIR HFA.....	884	AEROCHAMBER PLUS Z		AGRYLIN.....	541	
ADVANCE PLUS		STAT.....	682, 703	AIMOVIG AUTOINJECTOR	219	
INTERMITTENT.....	693, 701	AEROCHAMBER PLUS Z		AIMSCO LATEX CONDOM		
ADVANCED ALLERGY		STAT LG MSK.....	682, 703	.....	657, 704	
COLLECT KIT.....	310	AEROCHAMBER PLUS Z		AIRDUO RESPICLICK.....	884	
ADVANCED ALL-IN-ONE		STAT MD MSK.....	682, 703	AIRS ADULT AEROSOL		
METER.....	606, 701	AEROCHAMBER PLUS Z		MASK.....	682, 704	
ADVANCED GLUC METER		STAT SM MSK.....	682, 703	AIRS DISPOSABLE		
TEST STRIP.....	557, 701	AEROCHAMBER Z-STAT		NEBULIZER.....	661, 704	
ADVANCED GLUCOSE		PLUS-FLW SG.....	682, 703	AIRS PEDIATRIC		
METER.....	606, 701	AEROCHAMBER2GO.....	682, 703	DISPOSABLE MASK		
ADVANCED HERBALS		AEROECLIPSE II		.....	658, 683, 704	
GINGER.....	6	NEBULIZER.....	660, 703	AIRSUPRA.....	884	
ADVANCED LANCING		AEROECLIPSE XL		AIRZONE PEAK FLOW		
DEVICE.....	606, 701	NEBULIZER.....	660, 703	METER.....	680, 705	
ADVANCED PROBIOTIC....	489	AERONEB GO.....	682, 703	AJOVY AUTOINJECTOR....	219	
ADVANCED SKIN CARE....	305	AERONEB GO NEBULIZER		AJOVY SYRINGE.....	219	
ADVANCED TRAVEL		.....	660, 703	AKEEGA.....	85	
LANCETS.....	606, 701	AEROTRACH PLUS....	682, 703	AKLIEF.....	276	
ADVATE.....	530	AEROVENT PLUS.....	682, 703	AKTEN (PF).....	862	
ADVIN COVID-19 AG		AFINITOR.....	95	AKYNZEO (NETUPITANT)..	471	
HOME TEST.....	600, 701	AFINITOR DISPERZ.....	95	Ala-Cort.....	310	
ADVOCATE LANCET..	606, 701	Afirmelle.....	248	ALAMAX CR.....	3	
ADVOCATE LANCING						
DEVICE.....	606, 701					

ALAMAX PROTECT.....	3	ALIVE PREMIUM		<i>alogliptin-pioglitazone</i>	436
Ala-Scalp.....	310	PRENATAL.....	376	ALOMIRA.....	271
<i>albendazole</i>	53	ALIVE WOMEN'S 50 PLUS		ALOMIRA HP.....	271
<i>albuterol sulfate</i>	882, 883	COMPLETE.....	376	ALOMIRA LP.....	271
Alcaine.....	861	ALIVE WOMEN'S 50 PLUS		<i>alosetron</i>	483, 504
<i>alclometasone</i>	310	GUMMY.....	377	ALPHA BETIC.....	377
ALCORTIN A.....	284	ALIVE WOMEN'S ENERGY	377	<i>alpha lipoic acid</i>	3
ALDACTONE.....	121, 148	ALIVE WOMEN'S GUMMY		<i>alpha lipoic acid-biotin</i>	3
ALECENSA.....	87	VITAMIN.....	377	ALPHAGAN P.....	866
<i>alendronate</i>	439	ALIVE WOMEN'S		ALPHANATE.....	530
ALFA-MAX ALFALFA.....	6	MULTIVITAMIN.....	377	ALPHANINE SD.....	528
ALFAMINO JUNIOR.....	393	ALIVE WOMEN'S ULTRA		<i>alprazolam</i>	157, 202
ALFERON N.....	329	POTENCY.....	377	ALPRAZOLAM INTENSOL	
<i>alfuzosin</i>	517	ALIXI.....	267	.....	157, 202
ALHEMO PEN.....	534	ALIXI HP.....	267	ALPROLIX.....	529
ALIGN DUALBIOTIC.....	489	ALKALINE BATTERIES		ALREX.....	853
ALINIA.....	58	.....	607, 705	ALTABAX.....	284
<i>aliskiren</i>	155	ALKALOL NASAL WASH....	890	ALTACAINE.....	862
ALIVE ADULT ULTRA		ALKERAN.....	87	ALTACE.....	120
POTENCY.....	375	ALKINDI SPRINKLE.....	447	ALTAFLUOR BENOX..	860, 861
ALIVE CALCIUM-VITAMIN		ALL FLOW 1000 KIT ...	683, 705	Altavera (28).....	248
D3.....	363	ALL FLOW 1000 PFT		ALTERA NEBULIZER	
ALIVE COMPLETE		FILTER.....	683, 705	HANDSET.....	661, 705
PREMIUM PRENATL.....	375	ALL FLOW 3000 KIT ...	683, 705	ALTERA NEBULIZER	
ALIVE DAILY ENERGY.....	375	ALL FLOW 3000 PFT		SYSTEM.....	661, 705
ALIVE DIABETIC		FILTER.....	683, 705	ALTERNATE SITE LANCET	
MULTIVITAMIN.....	375	ALL FLOW 4000 KIT ...	683, 705	.....	607, 705
ALIVE ENERGY 50 PLUS...	375	ALL FLOW 4000 PFT		ALTERNATE SITE	
ALIVE KIDS CHEWABLE....	397	FILTER.....	683, 705	LANCING DEVICE.....	607, 705
ALIVE KIDS MULTIVITAMIN		ALL FLOW 5000 KIT ...	683, 705	ALTOPREV.....	130
.....	397	ALL FLOW 5000 PFT		ALTRENO.....	276
ALIVE MAX POTENCY.....	375	FILTER.....	683, 705	ALTRIXA.....	388
ALIVE MAX6 POTENCY		ALL FLOW 6000 PFT		ALTRIXA OB.....	411
COMPLETE.....	375	FILTER.....	683, 705	ALTUVIIIO.....	530
ALIVE MEN 50 PLUS		ALLERGIST TRAY 1/2 ML		<i>alum, ammonium (bulk)</i>	239
ULTRA-LUTEIN.....	376	27GX3/8".....	661, 705	ALUNBRIG.....	87, 88
ALIVE MEN'S 50 PLUS		ALLERGIST TRAY		ALURIS.....	274
MULTIVIT.....	376	INTRADERMAL BEV ...	661, 705	ALURIS HP.....	274
ALIVE MEN'S 50 PLUS MV		ALLERGIST TRAY		ALURIS HP PLUS.....	274
(VIT K).....	376	REGULAR BEVEL.....	662, 705	ALURIS LP.....	274
ALIVE MEN'S 50 PLUS		ALLERGY SYRINGE...662, 705		ALURIS LP PLUS.....	274
ULTRA.....	376	ALLEVYN ADHESIVE		ALURIS PLUS.....	274
ALIVE MEN'S ENERGY.....	376	DRESSING.....	352, 705	ALUXOF.....	271
ALIVE MEN'S GUMMY.....	376	ALLEVYN AG ADHESIVE...352		ALUXOF HP.....	271
ALIVE MEN'S MAX3		ALLEVYN LIFE DRESSING		ALVAIZ.....	544
POTENCY.....	376	.....	352, 705	ALVESCO.....	877
ALIVE MEN'S ULTRA		<i>allopurinol</i>	524	<i>alvimopan</i>	50
POTENCY.....	376	<i>almotriptan malate</i>	221	ALVOX.....	277
ALIVE PREMIUM ADULT ...	376	<i>alogliptin</i>	430	ALVOX HP.....	277
		<i>alogliptin-metformin</i>	436	Alyacen 1/35 (28).....	248

Alyacen 7/7/7 (28).....	258	<i>anagrelide</i>	541	AQINJECT PEN NEEDLE	
ALYFTREK.....	887	Analpram-Hc.....	47	.....	634, 706
Alyq.....	155	ANALPRAM-HC.....	47, 327	AQNEURSA.....	834
<i>amantadine hcl</i>	184	ANAPROX DS.....	41	AQUA LANCE LANCING	
AMBIEN.....	234	ANASCORP.....	105	DEVICE.....	607, 706
AMBIEN CR.....	234	ANASPAZ.....	478, 521	AQUASTAT 0.9% SODIUM	
<i>ambrisentan</i>	155	ANASTIA.....	344	CHLORIDE.....	412
<i>amcinonide</i>	310	<i>anastrozole</i>	90	AQUASTAT SFR 0.9%	
AMELUZ.....	338	ANCOBON.....	54	SODIUM CHLOR.....	412
Amethia.....	246	ANDEMBRY		AQUORAL.....	841
Amethyst (28).....	248	AUTOINJECTOR.....	118	ARAKODA.....	57
AMICAR.....	535	ANDROGEL.....	427	ARALAST NP.....	887
AMIELLE VAGINAL		ANGELIQ.....	441	Aranelle (28).....	258
TRAINER.....	658, 706	ANNOVERA.....	260	ARANESP (IN	
<i>amiloride</i>	149	ANODYNE LPT.....	333	POLYSORBATE).....	528
<i>amiloride-</i>		ANORO ELLIPTA.....	883	ARAVA.....	36
<i>hydrochlorothiazide</i>	149	<i>anticoag citrate phos</i>		ARAZLO.....	277
<i>aminocaproic acid</i>	535	<i>dextrose</i>	526	ARBLI.....	124
<i>amiodarone</i>	127	ANTIOXIDANT FORMULA		ARCALYST.....	28
AMITIZA.....	483, 504	(SELENIUM).....	3, 377	ARESTIN.....	843
<i>amitriptyline</i>	180	ANUCORT-HC.....	46	AREXVY (PF).....	104
<i>amitriptyline-</i>		ANUSOL-HC.....	46	<i>arformoterol</i>	881
<i>chlordiazepoxide</i>	179, 202	Anusol-Hc.....	46, 310	<i>arginine (l-arginine)</i>	356
AMLACTIN.....	308	ANZUPGO.....	282	<i>arginine hcl (l-arginine)</i>	356
<i>amlodipine</i>	144	APADAZ.....	21	ARGYLE TRACHEOSTOMY	
<i>amlodipine-atorvastatin</i>	139	Apexicon E.....	310	CARE TRAY.....	658, 706
<i>amlodipine-benazepril</i>	119	APEXOL.....	268	ARICEPT.....	243
<i>amlodipine-olmesartan</i>	122	APEXOL HP.....	268	ARIKAYCE.....	51
<i>amlodipine-valsartan</i>	122	APHORIA.....	275	ARIMIDEX.....	90
<i>amlodipine-valsartan-</i>		APIDRA SOLOSTAR U-100		<i>aripiprazole</i>	190, 191, 207
<i>hcthiazid</i>	122	INSULIN.....	456	ARIXTRA.....	539
<i>ammonium lactate</i>	308	APIDRA U-100 INSULIN....	456	<i>armodafinil</i>	227
Amnesteem.....	263	APLENZIN.....	179	ARMOUR THYROID.....	463
<i>amoxapine</i>	180	APLIGRAF.....	350	ARNUITY ELLIPTA.....	877
<i>amoxicil-clarithromy-</i>		APOGEE IC INTERMIT		AROMASIN.....	90
<i>lansopraz</i>	482	CATHETER.....	693, 706	ARTHROTEC 50.....	37
<i>amoxicillin</i>	51	APOGEE PLUS INTERMITT		ARTHROTEC 75.....	37
<i>amoxicillin-pot clavulanate</i>	52	CATHETER.....	693, 706	ARTICHOKE PREMIUM	
<i>amphetamine</i>	192, 210	APOKYN.....	184	EXTRACT.....	6
<i>amphetamine sulfate</i>		<i>apomorphine</i>	184	ARTILIS.....	268
.....	192, 211, 228	APORIX.....	265, 267	ARTILIS HP.....	268
<i>ampicillin</i>	52	<i>apraclonidine</i>	866	ARTISS.....	343
AM-PM MENOPAUSE		<i>aprepitant</i>	470	Ascomp With Codeine.....	20
FORMULA.....	6	APRETUDE.....	60	ASCOR.....	420
AMPYRA.....	845	Apri.....	248	<i>ascorbate sodium (vitamin c)</i>	
AMVISC.....	863	APRISO.....	485	.....	420
AMVISC PLUS.....	863	APTENSIO XR.....	192	<i>ascorbic acid (vitamin c)</i>	420
AMZEEQ.....	265	APTOM.....	163	<i>ascorbic acid(vitamin</i>	
ANACAINE.....	346	APTIVUS.....	76	<i>c)(bulk)</i>	239, 420
ANAFRANIL.....	180				

<i>ascorbic acid-ascorbate sodium</i>	420	ATACAND HCT.....	122	AUTOLET LITE.....	607, 708
<i>ascorbic acid-zinc oxide</i>	420	<i>atazanavir</i>	77	AUTOPEN 1 TO 21 UNITS.....	635, 708
<i>asenapine maleate</i>	185, 207	ATELVIA.....	439	AUTOPEN 2 TO 42 UNITS.....	635, 708
Ashlyna.....	246	<i>atenolol</i>	140	AUTOSHIELD DUO PEN NEEDLE.....	635, 708
<i>ashwagandha extract</i>	6	<i>atenolol-chlorthalidone</i>	146	AUTOSOFT 30.....	695, 708
<i>ashwagandha root extract</i>	6	ATIVAN.....	157, 202	AUTOSOFT 90.....	695, 708
ASHWAGANDHA ROOT LEAF EXTRACT.....	6	<i>atomoxetine</i>	201	AUTOSOFT XC INFUSION SET 23".....	695, 708
ASMANEX HFA.....	877	ATORVALIQ.....	130	AUTOSOFT XC INFUSION SET 32".....	695, 708
ASMANEX TWISTHALER...877		<i>atorvastatin</i>	130	AUTOSOFT XC INFUSION SET 43".....	695, 708
<i>aspirin</i>	43, 541	<i>atovaquone</i>	58	AUVELITY.....	174
ASPIRIN CHILDRENS..	43, 541	<i>atovaquone-proguanil</i>	56	AUVI-Q.....	146
<i>aspirin-dipyridamole</i>	541	ATRALIN.....	277	AVALIDE.....	123
ASPRUZYO SPRINKLE.....	126	ATRAPRO.....	6	AVAPRO.....	124
ASSURE 4 CONTROL SOLUTION.....	607, 706	ATRAPRO CP.....	305	AVAR.....	268
ASSURE 4 STRIPS.....	559, 706	ATRAPRO DERMAL SPRAY.....	102, 350	AVAR LS.....	268
ASSURE DOSE NORMAL CONTROL.....	607, 706	ATRAPRO HYDROGEL.....	305	AVEIDA.....	340
ASSURE DOSE NORM-HI CONTROL.....	607, 706	ATROPEN.....	151	AVEIDAOXIA.....	340
ASSURE ID DUO PRO SFTY PEN NDL.....	634, 706	<i>atropine</i>	851	AVENOVA.....	309
ASSURE ID PEN NEEDLE.....	634, 706	<i>atropine sulfate (pf)</i>	851	AVERI.....	249
ASSURE ID PRO PEN NEEDLE.....	634, 706	ATROVENT HFA.....	881	Aviane.....	249
ASSURE LANCE.....	607, 706	ATTRUBY.....	427	AVIDORA.....	272
ASSURE LANCE PLUS.....	607, 707	AUBAGIO.....	846	AVIDORA HP.....	272
ASSURE PLATINUM GLUCOSE METER.....	607, 707	Aubra.....	248	Avidoxy.....	79
ASSURE PLATINUM TEST STRIP.....	559, 707	Aubra Eq.....	248	AVIDOXY DK.....	78
ASSURE PRISM CONTROL 1-2 SOLN.....	607, 707	AUGMENTIN.....	52	AVITA.....	277
ASSURE PRISM MULTI METER.....	607, 707	AUGMENTIN ES-600.....	52	AVITENE.....	535
ASSURE PRISM MULTI STRIP.....	559, 707	AUGMENTIN XR.....	52	AVITENE FLOUR.....	535
ASTAGRAF XL.....	546	AUGTYRO.....	97	AVMAPKI-FAKZYNJA.....	85
ASTERO.....	344	AUGUSTIL.....	271	AVO CREAM.....	305
ASTHMA CHECK METER.....	680, 707	AURA PORTANEB.....	661, 707	AVODART.....	518
ASTHMAPACK CHILDREN'S.....	681, 707	<i>auranofin</i>	33	AVONEX.....	843, 844
<i>astragalus root</i>	6	Aurovela 1.5/30 (21).....	248	AWANIS.....	272
ASTRINGYN.....	535	Aurovela 1/20 (21).....	248	Ayuna.....	249
ATACAND.....	124	Aurovela 24 Fe.....	248	AYVAKIT.....	98
		Aurovela Fe 1.5/30 (28).....	248	AZALTA.....	275
		Aurovela Fe 1-20 (28).....	248	AZALTA HP.....	275
		AURUMHEEL.....	465	Azasan.....	33, 548
		AURYXIA.....	365, 515, 516	AZASITE.....	865
		AUSTEDO.....	224, 225, 226	<i>azathioprine</i>	33, 548
		AUSTEDO XR.....	224, 225, 226	<i>azelaic acid</i>	265, 340
		AUSTEDO XR TITRATION KT(WK1-4).....	224, 225, 226	<i>azelastine</i>	852, 889
		AUTOJECT 2 INJECTION DEVICE.....	635, 707	<i>azelastine-fluticasone</i>	888
		AUTO-LANCET MINI...607, 707		AZELEX.....	265, 341
		AUTOLET IMPRESSION LANC DEV.....	607, 708	AZESCO.....	411
		AUTOLET LANCING DEVICE.....	607, 708		

AZILECT.....	183	BAQSIMI.....	426	BD POSIFLUSH NORMAL	
<i>azithromycin</i>	73	BARACLUDE.....	69	SALINE 0.9.....	412
AZO BORIC ACID.....	896	BARIATRIC		BD PRECISIONGLIDE 664, 710	
AZO COMPLETE		MULTIVITAMINS.....	377	BD SAFETYGLIDE	
FEMININE BALANCE.....	489	BARRIGEL.....	693	ALLERGIST TRAY.....	664, 711
AZO CRANBERRY PLUS		BASADROX.....	283	BD SAFETYGLIDE INSULIN	
PROBIOTIC.....	6	BASAGLAR KWIKPEN U-		SYRINGE.....	635, 711
AZO CRANBERRY PLUS		100 INSULIN.....	455	BD SAFETYGLIDE NEEDLE	
VIT C.....	6	BASAGLAR TEMPO		.....	664, 711
AZO DUAL PROTECTION..	489	PEN(U-100)INSLN.....	455	BD SAFETYGLIDE	
AZO MENOPAUSE NIGHT-		BATIZIA.....	283	SHIELDING REG.....	664, 711
MELATONIN.....	216	BAXDELA.....	68	BD SAFETYGLIDE	
AZO VAGINAL HEALTH		BAXONIL.....	341	SYRINGE.....	635, 664, 711
PROBIOTIC.....	489	BAYER ASPIRIN... 43, 541, 542		BD SAFETYGLIDE TB REG	
AZOPT.....	859	BAYER LOW DOSE		BEVEL.....	664, 711
AZOR.....	122	ASPIRIN.....	43, 542	BD SAFETYGLIDE	
AZSTARYS.....	193	B-COMPLEX INJECTION... 358		TUBERCULIN.....	664, 711
AZULFIDINE.....	35, 485	B-COMPLEX PLUS B-12.... 415		BD SAF-T-INTIMA.....	656, 711
AZULFIDINE EN-TABS. 35, 485		<i>b-complex with vitamin c</i> 357		BD SLIP TIP SYRINGE	
Azurette (28).....	246	BD ALLERGIST TRAY REG		.....	664, 665, 712
B ACTIV.....	357	BEVEL.....	662, 708	B-D SLIP TIP SYRINGE	
B COMPLEX 100.....	358	BD ALLERGY SYRINGE		.....	664, 712
<i>b complex-vitamin c-folic</i>		.....	662, 708	BD SPECIALTY USE	
<i>acid</i>	357	BD BLUNT PLASTIC		NEEDLES.....	665, 712
B-100 COMPLEX.....	357	CANNULA.....	662, 708	BD SYRINGE.....	665, 713
B12.....	417	BD BULK SYRINGE SLIP		BD SYRINGE CATH TIP	
B12 ACTIVE.....	417	TIP.....	662, 708, 709	NONSTERILE.....	665, 712
B-50 COMPLEX WITH		BD ECCENTRIC TIP		BD SYRINGE CATHETER	
INOSITOL.....	357	SYRINGE.....	662, 709	TIP.....	665, 712
BABY COUGH.....	5	BD ECLIPSE LUER-LOK		BD SYRINGE LUER-LOK	
BABY COUGH-MUCUS.....	5	.....	635, 662, 709	NONSTERILE.....	665, 712
BACICAP.....	489	BD FILTER NEEDLE-5		BD SYRINGE LUER-LOK	
BACID WITH		MICRON.....	662, 709	STERILE.....	665, 712
LACTOSPORE.....	490	BD INSYTE AUTOGUARD		BD SYRINGE SLIP TIP	
<i>bacitracin</i>	864	.....	656, 709	NONSTERILE.....	665, 712, 713
<i>bacitracin-polymyxin b</i>	864	BD INTEGRA SYRINGE		BD SYRINGE-DUAL	
<i>baclofen</i>	552	.....	662, 663, 709	CANNULA.....	665, 713
BACTRIM.....	53	BD INTERLINK BLUNT		BD TUBERCULIN SLIP-TIP	
BACTRIM DS.....	53	PLASTIC CAN.....	663, 709	.....	666, 713
BAFIERTAM.....	844	BD INTERLINK SYRINGE		BD TUBERCULIN SYRINGE	
BAL-CARE DHA.....	401	.....	663, 709	.....	666, 713
BAL-CARE DHA		BD LUER-LOK BULK		BD VERITOR SARS-COV-2,	
ESSENTIAL.....	401	SYRINGE.....	663, 709	FLU A-B.....	600, 713
BALCOLTRA.....	249	BD LUER-LOK SYRINGE		BD VERITOR SYSTEM	
<i>balsalazide</i>	485	.....	663, 664, 709, 710	SARS-COV-2.....	600, 713
<i>balsam peru-castor oil</i>	354	BD LUER-LOK TIP		BEANAID.....	478
BALVERSA.....	93	CONTROL SYRING....	664, 710	BEANO.....	478
Balziva (28).....	249	BD MICROTAINER		BELBUCA.....	26
BANATROL PLUS.....	468	LANCET.....	608, 710	<i>belladonna alkaloids-opium</i> . 480	
BANZEL.....	171, 172			BELSOMRA.....	235

<i>benazepril</i>	120	BETADINE OPHTHALMIC PREP	866	BIGFOOT UNITY PEN CAP- TRESIBA.....	659, 714
<i>benazepril- hydrochlorothiazide</i>	119	<i>betaine</i>	835	BIJUVA.....	442
BENEFIBER (INULIN-CORN FIBER).....	504	BETALOAN SUIK.....	446	BIKTARVY.....	64
BENEFIBER (WHEAT DEXTRIN).....	505	<i>betamethasone dipropionate</i>	311	BILAC.....	490
BENEFIBER ADVANCED...	490	<i>betamethasone valerate</i>	311	BILTRICIDE.....	53
BENEFIBER CLEAR SF (DEXTRIN).....	505	<i>betamethasone, augmented</i>	311	<i>bimatoprost</i>	867
BENEFIBER DUAL ACTION	490	BETAPACE.....	127, 141	BIMZELX.....	281
BENEFIBER DUAL ACTION-THEANINE.....	490	BETAPACE AF.....	127, 141	BIMZELX AUTOINJECTOR	281
BENEFIBER SUGAR FREE (DEXTRIN).....	505	BETASERON.....	844	BINAXNOW COVID AG	
BENEFIBER SUGAR FREE (INULIN).....	505	<i>betaxolol</i>	140, 861	CARD HOME TST	600, 714
BENEFIX.....	529	<i>bethanechol chloride</i>	523	BINAXNOW COVID-19 AG	
<i>benfotiamine</i>	416	BETHKIS.....	885	CARD.....	600, 714
BENICAR.....	124	BETIMOL.....	861	BINAXNOW COVID-19 AG	
BENICAR HCT.....	123	BETOPTIC S.....	861	SELF TEST.....	600, 714
BENLYSTA.....	37	BEVESPI AEROSPHERE...	883	BINOSTO.....	439
BENTIVITE BX.....	367	BEVITROL.....	471	BIO C 1:1.....	359
BENZAMYCIN.....	268	<i>bexarotene</i>	101, 292	BIOLON.....	863
BENZEPRO.....	273	BEXSERO.....	112	BIOLYTE.....	370
BENZEPRO (MICROSPHERES).....	273	BEYAZ.....	249	BIOMEPRO.....	490
<i>benzhydrocodone- acetaminophen</i>	22	BEYFORTUS.....	105	BIONIME RIGHTEST	
<i>benznidazole</i>	58	<i>bicalutamide</i>	88	GM300 SYSTEM.....	608, 714
BENZODOX 30.....	79	BIDIL.....	156	BIONIME RIGHTEST TEST	
BENZODOX 60.....	79	BIGFOOT UNITY.....	608, 713	STRIPS.....	560, 715
<i>benzoin (bulk)</i>	239, 339	BIGFOOT UNITY PEN CAP- ADMELOG.....	659, 713	BIOPETIT.....	357
<i>benzonatate</i>	876	BIGFOOT UNITY PEN CAP- APIDRA.....	659, 713	BIOSTEP.....	352, 715
<i>benzoyl peroxide</i>	273	BIGFOOT UNITY PEN CAP- ASPART.....	659, 713	BIOSTEP AG.....	352
<i>benztropine</i>	183	BIGFOOT UNITY PEN CAP- BASAGLAR.....	659, 713	BIOTEL CARE BGM-4	
<i>bepotastine besilate</i>	852	BIGFOOT UNITY PEN CAP- FIASP.....	659, 714	METER.....	608, 715
BEPREVE.....	852	BIGFOOT UNITY PEN CAP- HUMALOG.....	659, 714	<i>biotin</i>	420
<i>berberine chloride</i>	77	BIGFOOT UNITY PEN CAP- LANTUS.....	659, 714	BIOTINEX.....	490
BERBERINE ES-5.....	77	BIGFOOT UNITY PEN CAP- LISPRO.....	659, 714	BIOZEN.....	490
BERGACOR.....	6	BIGFOOT UNITY PEN CAP- LYUMJEV.....	659, 714	<i>bismuth subcit k-metronidz- tcn</i>	482
BERGACOR PLUS.....	6	BIGFOOT UNITY PEN CAP- NOVOLOG.....	659, 714	<i>bisoprolol fumarate</i>	140
BERINERT.....	527	BIGFOOT UNITY PEN CAP- TOUJEO.....	659, 714	<i>bisoprolol- hydrochlorothiazide</i>	146
Beser.....	311	BIGFOOT UNITY PEN CAP- TOUJEOMX.....	659, 714	<i>bitter melon extract</i>	6
BESER KIT.....	326			<i>black cohosh</i>	7
BESIVANCE.....	865			<i>black walnut hull</i>	7
BESREMI.....	93			BLANCHE.....	300
BEST FIBER.....	505			BLEPHAMIDE S.O.P.....	849
<i>beta carotene</i>	415			Blisovi 24 Fe.....	249
				Blisovi Fe 1.5/30 (28).....	249
				Blisovi Fe 1/20 (28).....	249
				<i>blood glucose contrl hi,normal</i>	608, 715
				<i>blood glucose control, normal</i>	608, 715

BLOOD GLUCOSE MONITORING.....	608, 715	BREATHERITE VALVED MDI CHAMBER.....	683, 717	<i>bupropion hcl</i>	179
BLOOD GLUCOSE TEST.....	560, 715	BREATHERITE VALVED MDI SPACER.....	683, 717	<i>bupropion hcl (smoking deter)</i>	237
<i>blood-glucose meter</i>	608, 715	BREEZE 2 CONTROL SOLUTION, LOW.....	608, 717	<i>buspirone</i>	158
BLULINK BG SYSTEM REFILL.....	608, 716	BREEZE 2 CONTROL SOLUTION, NML.....	609, 717	<i>butalbital-acetaminop-cod</i>	20
BLULINK DIABETIC TEST BUNDLE.....	608, 716	BREEZE 2 CONTROL SOLUTION,HIGH.....	609, 717	<i>butalbital-acetaminophen</i>	27
BLULINK GLUCOSE MONITOR SYSTEM....	608, 716	BRENZAVVY.....	434	<i>butalbital-acetaminophen-caff</i>	28
BLULINK GLUCOSE TEST STRIP.....	560, 716	BREO ELLIPTA.....	884	<i>butalbital-aspirin-caffeine</i>	42
<i>blunt needle, disposable</i>	666, 716	BREXAFEMME.....	54, 55	<i>butorphanol</i>	26
BONEUP.....	361	Breyna.....	884	BUTRANS.....	27
BONEUP (CALCIUM ASCORBATE).....	361	BREZTRI AEROSPHERE... ..	885	BUTTERFLY TOUCH LANCET.....	609, 717
BONJESTA.....	469	Briellyn.....	249	<i>butylated hydroxytoluene</i>	240
BONSITY.....	438	BRILINTA.....	541	BYDUREON BCISE.....	431
BOOST GLUCOSE CONTROL.....	393	<i>brimonidine</i>	341, 866	BYLVAY.....	545
BOOSTNOW IMMUNE SUPPORT.....	377	<i>brimonidine-dorzolamide</i>	849	BYSTOLIC.....	140
BOOSTRIX TDAP.....	110	<i>brimonidine-dorzolamide (pf)</i>	849	<i>cabergoline</i>	462
BORON COMPLEX.....	373	<i>brimonidine-dorzol-</i>		CABLIVI.....	525
<i>bosentan</i>	155	<i>brimonidine-dorzol-</i>		CABOMETYX.....	96
BOSULIF.....	98	<i>bimatoprost</i>	847	CABTREO.....	272
<i>boswellia serrata extract</i>	7	<i>brimonidine-timolol</i>	859	<i>ca-d3-mag ox-zinc-cop-mang-bor</i>	361
BOWEL SUPPORT-IRRITABLE BOWEL.....	7	BRINSUPRI.....	871	<i>ca-d3-mag-zinc-cop-mang-bor</i>	361
BOYS TRAINING PANTS 4T-5T.....	633, 716	<i>brinzolamide</i>	859	CADEAU DHA.....	401
BP 10-1.....	268	BRIVIACT.....	170	CADIRA COMPLIANT BLOOD STAT.....	695
BP MANAGER.....	7	Bromfed Dm.....	890	CADUET.....	139
BPCO.....	354	<i>bromfenac</i>	857	<i>caffeine</i>	213
BPO.....	274	<i>bromocriptine</i>	183	<i>caffeine citrate</i>	213
BRAFTOVI.....	91	<i>brompheniramine-pseudoeph-dm</i>	891	<i>calc carb-mag ox-d3-zinc gluc</i>	361
BREATHERITE MDI SPACER.....	683, 716	BROMSITE.....	857	<i>calc-d3-magnes-b6-zn-cu-mangan</i>	361
BREATHERITE SPACER-MASK, NEO.....	683, 716	BRONCHIAL SOOTHE.....	7	<i>calcipotriene</i>	293
BREATHERITE SPACER-MASK,ADULT.....	683, 716	BRONCHITOL.....	886	<i>calcipotriene-betamethasone</i>	279
BREATHERITE SPACER-MASK,CHILD.....	683, 716	BROVANA.....	881	<i>calcitonin (salmon)</i>	441
BREATHERITE SPACER-MASK,INFANT.....	683, 717	BRUKINSA.....	91, 98	<i>calcitriol</i>	294, 421, 834
BREATHERITE SPACER-MASK,S.CHLD.....	683, 717	BRYHALI.....	293, 311	<i>calcium acetate</i>	361
		BUCAPSOL.....	158	<i>calcium acetate(phosphat bind)</i>	514, 515
		<i>budesonide</i>	486, 877	<i>calcium carb, citrate, malate</i>	361
		<i>budesonide-formoterol</i>	884	<i>calcium carb-d3-mag ox-zinc ox</i>	362
		BUFFERED C POWDER....	420	<i>calcium carb-mag ox-zinc sulf</i>	362
		BULLSEYE MINI SAFETY LANCETS.....	609, 717	<i>calcium carbonate</i>	361
		<i>bumetanide</i>	149		
		BUPHENYL.....	836		
		<i>bupivacaine in nacl(pf)</i>	45		
		<i>buprenorphine</i>	26		
		<i>buprenorphine hcl</i>	26, 236		
		<i>buprenorphine-naloxone</i>	236		

<i>calcium carbonate-vitamin d3</i>	363, 364	<i>carbamazepine</i>	163, 205	CAREPOINT LUER SLIP	
<i>calcium citrate</i>	361	CARBATROL.....	163, 205	SYRING-NDL.....	666, 718
<i>calcium citrate-vitamin d3</i>	364	<i>carbidopa</i>	183	CAREPOINT PRECISION	
<i>calcium no.38-d3-mag-boron</i>		<i>carbidopa-levodopa</i>	181	LUER LOCK.....	666, 718
.....	362	<i>carbidopa-levodopa-</i>		CAREPOINT PRECISION	
<i>calcium pantothenate</i>	419	<i>entacapone</i>	181	NEEDLE.....	666, 718
<i>calcium phos-d3-</i>		<i>carbinoxamine maleate</i>		CAREPOINT PRECISION	
<i>magnesium-zinc</i>	362	.....	872, 873, 874	SAFETY.....	666, 718
<i>calcium phosphate-vitamin</i>		Carbzah.....	872, 874	CAREPOINT SAFETY LL	
<i>d3</i>	364	CARDIOPLEGIA DEL NIDO		SYR-NEEDLE.....	666, 718
<i>calcium-d3-zinc-copper-</i>		FORMULA.....	868	CARESENS CONTROL A	
<i>mangan</i>	362	CARDIOPLEGIA DEL NIDO-		AND B.....	609, 718
<i>calcium-vitamin d3-vitamin k</i>	362	ISOLYT S.....	869	CARESENS LANCETS	
CALMAID.....	7	CARDIOPLEGIA HIGH		.....	609, 718
CALQUENCE		POTASSIUM.....	869	CARESENS N.....	609, 718
(ACALABRUTINIB MAL). 91, 98		CARDIOPLEGIA IND 4:1		CARESENS N FELIZ BT	
CALTRATE 600 PLUS D.....	364	PLASMALYT.....	869	GLUC METER.....	609, 718
CALTRATE GUMMY BITES	364	CARDIOPLEGIA IND 8:1		CARESENS N FELIZ	
CALTRATE-D3 PLUS		NON-ENRCH.....	869	GLUCOSE METER.....	609, 718
MINERALS.....	362	CARDIOPLEGIA		CARESENS N PLUS BT	
Camila.....	257	INDUCTION 4:1.....	869	.....	609, 718
CAMRESE.....	247	CARDIOPLEGIA		CARESENS N TEST	
CAMRESE LO.....	247	MAINTENANCE 4:1.....	869	STRIPS.....	561, 718
CAMZYOS.....	145	CARDIOPLEGIA		CARESENS N VOICE.....	609, 718
CANASA.....	485	REPERFUSATE 4:1.....	869	CARESTART COVID-19 AG	
<i>candesartan</i>	124	CARDIOPLEGIA WARM		HOME TST.....	601, 719
<i>candesartan-</i>		INDUCT 4:1.....	869	CARETOUCH CONTROL	
<i>hydrochlorothiazid</i>	123	<i>cardioplegic no.17(induct</i>		SOLN L2-L3.....	609, 719
CANDICIDAL.....	7	<i>4:1)</i>	869	CARETOUCH GLUCOSE	
<i>cantharidin in acetone</i>	331	<i>cardioplegic no.19 (maint</i>		MONITORING.....	609, 719
CANTHARIS		<i>4:1)</i>	869	CARETOUCH INSULIN	
COMPOSITUM.....	466	<i>cardioplegic soln</i>	869	SYRINGE.....	635, 636, 719
<i>capecitabine</i>	90	<i>cardioplegic solution no.25..</i>	870	CARETOUCH LANCING	
CAPEX.....	311	CARDIZEM.....	143	DEVICE.....	609, 719
CAPHOSOL.....	841	CARDIZEM CD.....	143	CARETOUCH LUER LOCK	
CAPLYTA.....	187	CARDIZEM LA.....	143	SYRINGE.....	666, 667, 719
CAPRELSA.....	98	CARDURA.....	152	CARETOUCH LUER LOCK	
CAPSFENAC PAK.....	336	CARDURA XL.....	152	SYR-NEEDLE.....	667, 719
CAPSINAC.....	336	CAREFINE PEN NEEDLE		CARETOUCH LUER SLIP	
CAPSUBLEND-H.....	240	.....	635, 717	SYRINGE.....	667, 719, 720
CAPSULE #3		CAREONE LANCING		CARETOUCH PEN	
(HYPROMELLOSE).....	241	DEVICE.....	609, 717	NEEDLE.....	636, 720
<i>captopril</i>	120	CAREONE ULTRA THIN		CARETOUCH SAFETY	
<i>captopril-hydrochlorothiazide</i>		LANCET.....	609, 717	LANCETS.....	609, 720
.....	119	CAREPOINT LUER LOCK		CARETOUCH TEST STRIP	
CAPVAXIVE.....	111	SYRINGE.....	666, 717	.....	561, 720
CARAC.....	291	CAREPOINT LUER LOCK		CARETOUCH TWIST	
CARAFATE.....	511	SYR-NEEDLE.....	666, 717	LANCET.....	609, 720
CARBAGLU.....	837	CAREPOINT LUER SLIP		<i>carglumic acid</i>	837
		SYRINGE.....	666, 718	<i>carisoprodol</i>	552

<i>carisoprodol-aspirin</i>	551	CENTRUM MINIS ADULTS		CERTAVITE-ANTIOXIDANT	
<i>carisoprodol-aspirin-codeine</i>	554	50 PLUS.....	378	.....	388
CARNITEX.....	355	CENTRUM MINIS MEN 50		CERVIDIL.....	425
CARNITOR.....	835	PLUS.....	378	CETACAINE.....	333
CARNITOR (SUGAR-FREE)		CENTRUM MINIS WOMEN		CETAPHIL GENTLE SKIN	
.....	835	50 PLUS.....	378	CLEANSER.....	343
CAROSPIR.....	121, 148	CENTRUM MULTI MENTAL		<i>cetirizine</i>	875
CARRASYN HYDROGEL		FOCUS.....	378	CETRAXAL.....	870
WOUND DRESS.....	352, 720	CENTRUM MULTI PLUS		<i>cetorelix</i>	461
<i>carteolol</i>	861	BEAUTY.....	378	CETROTIDE.....	461
Cartia Xt.....	143	CENTRUM MULTI PLUS		<i>cevimeline</i>	842
<i>carvedilol</i>	121	OMEGA-3.....	378	<i>chamomile flower</i>	7
<i>carvedilol phosphate</i>	121	CENTRUM		Charlotte 24 Fe.....	249
<i>cascara sagrada</i>	510	MULTIGUMMIES MEN.....	378	<i>chaste tree fruit</i>	7
CASODEX.....	88	CENTRUM		Chateal Eq (28).....	249
CATAPRES-TTS-1.....	147	MULTIGUMMIES WOMEN.....	378	CHEMET.....	50
CATAPRES-TTS-2.....	147	CENTRUM POSTNATAL....	379	CHEMSTRIP BG LOG	
CATAPRES-TTS-3.....	147	CENTRUM PRENATAL.....	379	BOOK.....	609, 720
CAYA CONTOURED...603, 720		CENTRUM SILVER.....	379	CHENODAL.....	473, 544
CAYSTON.....	886	CENTRUM WOMEN.....	388	CHEST RUB (WITH PINE	
Caziant (28).....	258	CENTRUM WOMEN		OIL).....	347
<i>cefaclor</i>	67	IMMUNE MINIS.....	379	CHILD PROBIOTIC	
<i>cefadroxil</i>	66	CENTURY.....	388	DIGEST-IMMUNE.....	490
CEFALY.....	659, 720	CENTURY ADULT		CHILDREN'S ASPIRIN..43, 542	
<i>cefdinir</i>	67	FORMULA.....	379	CHILDRENS CHEWABLE	
<i>cefixime</i>	67	CENTURY MATURE.....	379	PROBIOTIC.....	490
<i>cefpodoxime</i>	67	<i>cephalexin</i>	66	CHILDREN'S DAILY	
<i>cefprozil</i>	67	CEQUA.....	856	PROBIOTIC.....	490
<i>cefuroxime axetil</i>	67	CEQUR SIMPLICITY...691, 720		CHILDREN'S FIBER	
CELACYN.....	305, 689	CEQUR SIMPLICITY		GUMMY BEAR.....	505
CELEBREX.....	38	INSERTER.....	609, 720	CHILDREN'S MELATONIN..216	
<i>celecoxib</i>	38	CERACADE.....	305	CHILDREN'S	
CELEXA.....	174	CERAMAX.....	306	MULTIVITAMIN.....	397, 398
CELLCEPT.....	34, 547	<i>ceramides 1,3,6-ii</i>	304	CHILDREN'S	
CELLPAD.....	689, 720	CERASPORT ENDURANCE		MULTIVITAMIN GUMMY....	398
<i>cellulose (bulk)</i>	242	.....	370	CHILDREN'S PROBIOTIC..	491
CELONTIN.....	171	CERASPORT EX1.....	370	CHILDREN'S SLEEP	
CEM-UREA.....	331	CERASPORT PLUS.....	370	(MELATONIN).....	216
CENTANY.....	283	CERAVE.....	304	CHLOHUX.....	325
CENTANY AT.....	283	CERAVE AM.....	343	CHLOOXIA.....	325
CENTRUM.....	379, 388	CERAVE DAILY		<i>chlordiazepoxide hcl</i>	157, 202
CENTRUM ADULT 50 PLUS		MOISTURIZING.....	304	<i>chlordiazepoxide-clidinium</i>	
.....	377	CERAVE FOAMING FACIAL		.....	202, 480, 481
CENTRUM ADULTS.....	378	.....	304	<i>chlorhexidine gluconate</i>	840
CENTRUM CHEWABLES...378		CERAVE PM.....	304	<i>chloroquine phosphate</i>	57
CENTRUM KIDS		CERAVE SA.....	304	<i>chlorpromazine</i>	188, 189
MULTIGUMMY.....	397	CERAVE SA (WITH		<i>chlorthalidone</i>	150
CENTRUM MENOPAUSE		NIACINAMIDE).....	304	<i>chlorzoxazone</i>	552
MULTIVITAMIN.....	378	CERDELGA.....	835	CHOICE DM CLARUS	
		CERTAVITE SENIOR.....	379	NORM CONTROL.....	610, 721

CHOICEDM CLARUS 561, 610, 721	<i>citalopram</i> 174	CLEVER CHOICE GLUCOSE MONITOR. 610, 722
CHOLBAM.....471	CITRANATAL (DUAL-IRON) 401	CLEVER CHOICE LEVEL 1 CONTROL.....610, 722
CHOLECAL DF..... 414	CITRANATAL 90 DHA (ALGAL OIL).....401	CLEVER CHOICE LEVEL 2 CONTROL.....610, 722
<i>cholecalciferol (vitamin d3)</i> 421, 422	CITRANATAL ASSURE..... 401	CLEVER CHOICE LEVEL 3 CONTROL.....610, 722
<i>cholestyramine (with sugar)</i> .128	CITRANATAL BLOOM..... 367	CLEVER CHOICE MICRO 610, 722
Cholestyramine Light..... 128	CITRANATAL DHA (ALGAL OIL).....401	CLEVER CHOICE MICRO TEST STRIP.....562, 722
<i>choline bitartrate</i> 136	CITRANATAL HARMONY (IRON FUM)..... 401	CLEVER CHOICE NEB KIT- ADULT.....684, 722
<i>choline,magnesium salicylate</i> 43	CITRANATAL MEDLEY..... 379	CLEVER CHOICE NEB KIT- CHILD.....684, 722
<i>chorionic gonadotropin, human</i> 452	CITRATABS..... 518	CLEVER CHOICE NEBULIZER..... 684, 722
CHOSEN LANCET..... 610, 721	CITRULLINE 1000.....356	CLEVER CHOICE PEAK FLOW METER.....681, 722
CHOSEN LANCING DEVICE..... 610, 721	CLAIRVEE.....491	CLEVER CHOICE PRO 562, 610, 722, 723
CHOSEN SAFETY LANCET 610, 721	Claravis.....263	CLEVER CHOICE TALK GLUCOSE SYS.....610, 723
<i>chromium nicotinate</i> 373	CLARINEX.....875, 876	CLEVER CHOICE TALK TEST..... 562, 723
<i>chromium picolinate</i> 373	CLARINEX-D 12 HOUR..... 872	CLEVER CHOICE TEST STRIPS.....563, 723
CIALIS..... 355, 518	<i>clarithromycin</i> 73	CLEVER CHOICE VOICE PLUS TEST..... 563, 724
CIBINQO..... 282	CLEANSING EYELID MOIST PADS..... 309	CLEVER CHOICE WHISPER AIRE PED..684, 724
CICASIL.....690, 721	CLEANSING EYELID WIPES EXT STR.....309	CLICKFINE PEN NEEDLE 636, 724
CICATRACE PAD..... 690, 721	CLEANSING WASH....268, 341	CLIMARA.....443
Ciclodan.....287	CLEAR FIBER.....505	CLIMARA PRO.....442
CICLODAN KIT..... 287	<i>clemastine</i> 872, 874	Clindacin.....265
<i>ciclopirox</i> 287	Clemasz.....873, 874	Clindacin Etz.....265
<i>ciclopirox-ure-camph-menth- euc</i> 287	Clemsza.....873, 874	CLINDACIN ETZ..... 267
<i>cilostazol</i> 541	CLENPIQ.....511	Clindacin P..... 265
CILOXAN.....865	CLEOCIN.....894	CLINDACIN PAC.....267
CIMDUO..... 61	CLEOCIN HCL..... 73	CLINDAGEL..... 266
<i>cimetidine</i> 473	Cleocin Pediatric.....73	<i>clindamycin hcl</i> 73
<i>cimetidine hcl</i> 473	CLEOCIN T..... 265	<i>clindamycin palmitate hcl</i> 73
CIMZIA..... 29, 30, 488	CLEVER CHEK BLOOD GLUCOSE..... 610, 721	Clindamycin Pediatric..... 73
CIMZIA POWDER FOR RECONST..... 29, 30, 488	CLEVER CHEK BLOOD GLUCOSE SYST.....610, 721	<i>clindamycin phosphate</i> 266, 894
CIMZIA STARTER KIT 29, 30, 488	CLEVER CHEK LANCETS 610, 721	<i>clindamycin-benzoyl peroxide</i> 269
<i>cinacalcet</i> 440	CLEVER CHOICE BLOOD GLUC SYS..... 610, 721	<i>clindamycin-tretinoin</i> 272
<i>cinnamon bark</i> 7	CLEVER CHOICE CHAMBER-LRG MASK 683, 721	CLINDESSE..... 894
<i>cinnamon bark extract</i> 7	CLEVER CHOICE CHAMBER-MED MASK 684, 721	
CINRYZE.....527	CLEVER CHOICE CHAMBER-SM MASK.684, 721	
CIPRO..... 68		
CIPRO HC.....870		
<i>ciprofloxacin</i> 68		
<i>ciprofloxacin hcl</i> 68, 865, 870		
<i>ciprofloxacin- dexamethasone</i> 870		
<i>ciprofloxacin-fluocinolone</i> 870		

CLINITEST COVID-19		
HOME TEST	601, 724	
CLINPRO 5000	838	
<i>clobazam</i>	159, 202	
<i>clobetasol</i>	294, 311, 312, 853	
<i>clobetasol-emollient</i>	312	
CLOBEX	312	
CLOBEZIN	290	
<i>clocortolone pivalate</i>	312	
Clodan	313	
CLODAN KIT	328	
Clomid	446	
<i>clomiphene citrate</i>	446	
<i>clomipramine</i>	180	
<i>clonazepam</i> .	157, 159, 202, 203	
<i>clonidine</i>	147	
<i>clonidine (pf)</i>	12	
<i>clonidine hcl</i>	147, 191	
<i>clopidogrel</i>	542	
<i>clorazepate dipotassium</i>	157, 203	
CLOROTEKAL (PF)	45	
<i>clotrimazole</i>	288, 840	
<i>clotrimazole-betamethasone</i>	290	
<i>clozapine</i>	187	
CLOZARIL	187	
C-NATE DHA	401	
COAGADEX	532	
COAGUCHEK LANCETS	610, 724	
COAGUCHEK XS	555, 724	
<i>coal tar</i>	333	
COARTEM	57	
COBALEFOL	423	
COBENFY	156	
COBENFY STARTER PACK	156	
<i>cocaine</i>	888	
COCOA BUTTER FORMULA - VIT E	306	
<i>codeine sulfate</i>	12	
<i>codeine-butalbital-asa-caff</i>	20	
<i>codeine-guaifenesin</i>	892	
CODITUSSIN AC	892	
CODITUSSIN DAC	892	
COLAZAL	485	
<i>colchicine</i>	523, 524	
COLCRYS	524	
<i>colesevelam</i>	128	
COLESTID	128, 129	
<i>colestipol</i>	129	
COLLATYL	352	
COLOR LANCETS	610, 724	
COMBIGAN	859	
COMBIPATCH	442	
COMBIVENT RESPIMAT	883	
COMBOGESIC	37	
COMETRIQ	96	
COMFORT EZ INSULIN SYRINGE	636, 724	
COMFORT EZ LANCETS	610, 724	
COMFORT EZ PEN NEEDLES	636, 725	
COMFORT EZ PRO SAFETY PEN NDL	636, 725	
COMFORT TOUCH PEN NEEDLE	637, 725	
COMFORT TOUCH PLUS SAFETY LANC	610, 725	
COMFORT TOUCH ULT THIN LANCETS	611, 725	
COMFORTSEAL LARGE MASK	684, 725	
COMFORTSEAL MEDIUM MASK	684, 725	
COMFORTSEAL SMALL MASK	684, 725	
COMIRNATY 2025-2026(5- 11Y)(PF)	113	
COMIRNATY 2025-26 (12Y UP)(PF)	113	
COMPACT SPACE CHAMBER	684, 725	
COMPACT SPACE CHAMBER-LRG MASK	684, 725	
COMPACT SPACE CHAMBER-MED MASK	684, 725	
COMPACT SPACE CHAMBER-SM MASK .	684, 725	
COMP-AIR NEBULIZER COMPRESSOR	684, 726	
Compazine	189, 469	
COMPLERA	65	
COMPLETE BALANCE MENOPAUSE RLF	216	
COMPLETE LIVER CLEANSE	357	
COMPLETE MV ADULT 50 PLUS	379	
COMPLETE NATAL DHA	401	
COMPLETENATE	402	
Compro	469	
CONCEPTION	600, 726	
CONCERTA	193	
CONDYLOX	331	
CONJUPRI	144	
CONSENSI	143	
Constulose	507	
CONTOUR CONTROL SOLUTION, HIGH	611, 726	
CONTOUR CONTROL SOLUTION, LOW	611, 726	
CONTOUR CONTROL SOLUTION, NML	611, 726	
CONTOUR METER	611, 726	
CONTOUR NEXT EZ METER	611, 726	
CONTOUR NEXT GEN METER	611, 726	
CONTOUR NEXT GLUCOSE METER	611, 726	
CONTOUR NEXT LEV 1 CONTROL SOL	611, 726	
CONTOUR NEXT LEV 2 CONTROL SOL	611, 726	
CONTOUR NEXT LINK	611, 726	
CONTOUR NEXT LINK 2.4	611, 726	
CONTOUR NEXT METER	611, 726	
CONTOUR NEXT ONE METER	611, 726	
CONTOUR NEXT TEST STRIPS	563, 727	
CONTOUR PLUS BLUE METER	611, 727	
CONTOUR PLUS TEST STRIP	563, 727	
CONTOUR TEST STRIPS	563, 727	
COPAXONE	845	
COPIKTRA	96, 97	
<i>copper gluconate</i>	373	
COQMAX OMEGA	136	
CORDRAN	313, 314	

CORDRAN TAPE LARGE	CRINONE..... 446, 896	CULTURELLE PROBIOTIC-
ROLL..... 313	<i>cromolyn</i> 95, 862, 879	MULTIVIT 379
CORDX COVID-19 AG	Crotan..... 349	CULTURELLE PROBIOTIC-
HOME TEST 601, 727	CRYODOSE TA MEDIUM	PREBIOTIC..... 493
CORDX TYFAST FLU-	STREAM SPR..... 334	CULTURELLE
COVID-19 TEST 601, 727	CRYODOSE TA MIST	SLIMBIOTICS..... 493
COREG..... 121	SPRAY..... 334	CULTURELLE WOMEN'S 4-
COREG CR..... 121	CRYOSERV..... 240	IN-1 493
CORIFACT..... 532	Cryselle (28)..... 249	CULTURELLE WOMEN'S
CORLANOR..... 151	CTEXLI..... 473, 545	WELLNESS..... 493
CORTANE-B..... 871	CULTURELLE..... 493	CUPRIMINE..... 35, 49
CORTEF..... 447	CULTURELLE ABDOMINAL	CURAFIL GEL WOUND
CORTENEMA..... 486	SUPP-CMFT..... 491	 352, 727
CORTIFOAM..... 486	CULTURELLE ADVANCED	CURCUPLEX-95..... 8
CORTISOLV 7	REGULARITY..... 491	CURITY AMD..... 604, 727
<i>cortisone</i> 447	CULTURELLE BABY	CURITY AMD (WITH
CORTISPORIN-TC..... 870	COLIC-SOOTHING..... 491	POLYHEXAMETH)..... 352, 727
CORTROPHIN GEL..... 426	CULTURELLE BABY	CURITY DRAINAGE BAG
COSENTYX..... 281	DIGESTIVE CALM..... 491	 633, 727
COSENTYX (2 SYRINGES) 281	CULTURELLE BABY	CURITY IODOFORM
COSENTYX PEN..... 281	HEALTH DEVELOP..... 491	PACKING STRIP..... 604, 728
COSENTYX PEN (2 PENS) 281	CULTURELLE BLOATING	CUROSURF 887
COSENTYX UNOREADY	GAS..... 491	CUTAQUIG..... 107
PEN..... 281	CULTURELLE DIGESTIVE	CUTEMOL EMOLLIENT..... 306
COSOPT 859	HEALTH..... 491	CUTTER ALL FAMILY..... 330
COSOPT (PF)..... 859	CULTURELLE IMMUNE	CUTTER BACKWOODS
COTELLIC..... 95	DEFENSE..... 492	DRY 330
COTEMPLA XR-ODT..... 193	CULTURELLE KIDS 4 IN 1	CUTTER SKINSATIONS..... 330
COVARYX..... 441	IMMUNE..... 492	CUVITRU..... 107
COVARYX H.S..... 441	CULTURELLE KIDS	CUVPOSA..... 843
COVID-19 AT-HOME TEST	GROW-THRIVE..... 492	CUVRIOR..... 49
..... 601, 727	CULTURELLE KIDS	<i>cyanocobalamin (vitamin b-</i>
<i>covid19 test adm.by</i>	GUMMY..... 492	<i>12)</i> 417, 418
<i>pharmacist</i> 601, 727	CULTURELLE KIDS	<i>cyanocobalamin-</i>
COXANTO..... 41	IMMUNE DEFENSE..... 492	<i>cobamamide</i> 418
COZAAR..... 124	CULTURELLE KIDS	<i>cyanocobalamin-</i>
CRALONIN..... 466	PROBIO-FIBER..... 492	<i>methylcobalamin</i> 415, 418
<i>cranberry conc-ascorbic acid</i> ... 7	CULTURELLE KIDS	CYCLINEX-2..... 396
<i>cranberry extract</i> 7	PROBIOT-FIBER..... 492	<i>cyclobenzaprine</i> 552
<i>cranberry fruit</i> 7	CULTURELLE KIDS	Cyclogyl..... 851
<i>cranberry fruit concentrate</i> 7	PROBIOTIC-MV..... 398	CYCLOMYDRIL..... 848
CRANBERRY URINARY	CULTURELLE KIDS	CYCLOPAK..... 554
TRACT HEALTH..... 7	PROBIOTICS..... 492	<i>cyclopentolate</i> 851
CRANBERRY-	CULTURELLE KIDS PRO-	<i>cycloopen-tropic-phenyleph-</i>
PROBIOTC(BLEND)-VITC.. 491	MV-LUTEIN..... 398	<i>watr</i> 848
CRENESSITY..... 425	CULTURELLE MEN'S	<i>cyclopent-tropic-phen-ketr-</i>
CREON..... 472	DAILY HEALTH..... 492	<i>wat</i> 848
CRESEMBA..... 55	CULTURELLE	<i>cyclophosphamide</i> 34, 87
CRESTOR..... 130	METABOLISM-WT MGMT .. 492	<i>cyclop-trop-propa-phen-ket-</i>
CREXONT..... 181, 182		<i>wat</i> 848

<i>cycloserine</i>	65	<i>dasatinib</i>	98	DEPAKOTE SPRINKLES	
CYCLOSET.....	431	Dasetta 1/35 (28).....	250	.....	160, 205
<i>cyclosporine</i>	34, 546, 856	Dasetta 7/7/7 (28).....	258	DEPEN TITRATABS.....	36, 49
CYCLOSPORINE IN		DAURISMO.....	93	DEPLIN FC.....	423
KLARITY.....	856	DAVIMET WITH FLUORIDE		DEPO-ESTRADIOL.....	443
<i>cyclosporine modified</i>	34, 546	.....	399	DEPO-PROVERA.....	245
CYCLOTENS REFILL.....	552	DAVIMET WITH IRON.....	380	DEPO-SUBQ PROVERA	
CYCLOTENS STARTER.....	553	DAVIMET-M.....	389	104.....	245
CYMBALTA.....	176, 214	DAVOL IRRIGATION		Depo-Testosterone.....	427
<i>cyproheptadine</i>	873, 874	SYRINGE.....	667, 728	DERMACINRX	
Cyred.....	250	DAVOL PISTON		CLORHEXACIN.....	354
Cyred Eq.....	249	IRRIGATION.....	667, 728	DERMACINRX DAVIMET...	389
CYSTADANE.....	836	DAWNZERA.....	118	DERMACINRX DEXATRAN	380
CYSTADROPS.....	860	DAYAVITE.....	380	DERMACINRX DOTREMIN	414
CYSTAGON.....	512	DAYBUE.....	242	DERMACINRX FOLDITAM.	414
CYSTARAN.....	860	DAYPRO.....	41	DERMACINRX FOLIFLEX..	380
CYTOMEL.....	464	Daysee.....	247	DERMACINRX FOLITIN-Z..	380
CYTOTEC.....	477	DAYTRANA.....	193	DERMACINRX	
D3-2000.....	422	DAYVIGO.....	235	FOLIXAPURE.....	414
<i>dabigatran etexilate</i>	543	DAZAVEIDAOXIA.....	341	DERMACINRX FOLIXATE..	414
DAFILOR.....	287	DAZINIA.....	284	DERMACINRX FOLTAMIN.	414
DAILY FIBER.....	505	DAZOMON.....	341	DERMACINRX FOLTREXYL	
DAILY FIBER (PSYLLIUM-		DDAVP.....	429	.....	414
ASPART).....	505	DEBACTEROL.....	840	DERMACINRX LACTEROL	493
DAILY FIBER (PSYLLIUM-		Deblitane.....	257	DERMACINRX LEXITRAL..	336
SUCROSE).....	505	DECARA K.....	421	Dermacinrx Lidocan.....	344
DAILY GUMMIES.....	380	<i>deferasirox</i>	49	DERMACINRX LIDOGEL....	344
DAILY MULTIVITAMIN-		<i>deferiprone</i>	49	DERMACINRX LIDOREX....	344
MINERALS.....	388	<i>deferoxamine</i>	49	DERMACINRX MULTITAM.	380
DAILY PROBIOTIC (4		<i>deflazacort</i>	447	DERMACINRX	
STRAINS).....	493	DEFLUX.....	698	MULTIVITAMIN.....	389
DAILY PROBIOTIC		DELESTROGEN.....	443	DERMACINRX PHN PAK....	346
(B.INFANTIS).....	493	DELIBON.....	290	DERMACINRX PRENATRIX	
DAILY PROBIOTIC (S.		DELSTRIGO.....	65	.....	402
BOULARDII).....	493	DELUO.....	103, 350	DERMACINRX	
DAILY-VITE (WITH FOLIC		<i>demeclocycline</i>	79	PRENATRYL.....	402
ACID).....	389	DEMEROL.....	13	DERMACINRX PRETRATE	402
DAIRY RELIEF.....	472	DEMEROL (PF).....	13	DERMACINRX PROBINATE	
<i>dalfampridine</i>	845	DEMSEER.....	153	.....	493
DALIRESP.....	880	DENTA 5000 PLUS.....	838	DERMACINRX PROBISOL.	493
<i>danazol</i>	450	DENTA 5000 PLUS		DERMACINRX PROBITRAN	
<i>dandelion root</i>	8	SENSITIVE.....	838	.....	493
DANTRIUM.....	554	DENTAGEL.....	838	DERMACINRX PROBITROL	
<i>dantrolene</i>	554	DENVITA.....	286	.....	494
DANZITEN.....	98	DEOXIA.....	266, 267	DERMACINRX PROMEROL	
<i>dapsone</i>	56, 266	DEOXIADEMTAR.....	272	.....	494
DARAPRIM.....	57	DEOXIATAR.....	272	DERMACINRX RIBOTIN-E.	380
<i>darifenacin</i>	521	DEOXIAVAR.....	272	DERMACINRX SURGICAL	
DARTISLA.....	479	DEPAKOTE.....	160, 205	PHARMAPAK.....	354
<i>darunavir</i>	76	DEPAKOTE ER... 160, 205, 219			

DERMACINRX	DEVILBISS PULMOMATE	DIAPERS, UNISEX SIZE 5
THERAZOLE PAK.....290	COMPRESSOR.....684, 728	633, 729
DERMACINRX VENEXA.....380	DEVILBISS TRAVELER	DIAPERS, UNISEX SIZE 6
DERMACINRX VENEXA FE	COMPRESSOR.....685, 728	633, 729
.....380	Dexabliss.....447	DIASAXIATAR.....272
DERMACINRX VENTRIXYL380	<i>dexamethasone</i> 447	DIASDIMAXIA.....267, 268
DERMACINRX VENTRIXYL	DEXAMETHASONE	DIASOXIA.....268
FE.....380	INTENSOL.....447	DIATROL.....381
DERMACINRX VITRAMYN.381	<i>dexamethasone sodium</i>	DIATRUE CONTROL SOLN
DERMACINRX VITRANOL.381	<i>phosphate</i> 853	NORMAL.....612, 729
DERMACINRX VITRANOL	<i>dexchlorpheniramine</i>	DIATRUE CONTROL
FE.....381	<i>maleate</i> 872, 874	SOLUTION HIGH.....612, 729
DERMACINRX VITREXATE381	DEXCOM G6 RECEIVER	DIATRUE CONTROL
DERMACINRX VITREXATE	611, 728	SOLUTION LOW.....612, 729
FE.....381	DEXCOM G6 SENSOR	DIATRUE PLUS BLOOD
DERMACINRX ZINTREXYL-	611, 728	GLUCOSE MET.....612, 729
C.....381	DEXCOM G6	DIATRUE PLUS TEST
DERMACINRX ZRM PAK...346	TRANSMITTER.....612, 728	STRIP.....564, 729
DERMALID.....344	DEXCOM G7 RECEIVER	<i>diazepam</i> 157, 159, 203
DERMA-SMOOTH/FS	612, 728	Diazepam Intensol.....157, 203
BODY OIL.....314	DEXCOM G7 SENSOR	<i>diazoxide</i> 426
DERMA-SMOOTH/FS	612, 728	DIBENZYLINE.....152
SCALP OIL.....314	DEXEDRINE SPANSULE	<i>dichlorphenamide</i> 148, 549
DERMASO PLUS.....306	193, 194, 211, 228	DICLEGIS.....469
DERMAWERX SURGICAL	DEXERYL.....306	<i>diclofenac epolamine</i> 337
PLUS PAK.....354	DEXILANT.....474	<i>diclofenac potassium</i>
DERMAZENE.....290	<i>dexlansoprazole</i> 474	40, 42, 220
DERMELLE.....339	<i>dexmethylphenidate</i> 194	<i>diclofenac sodium</i>
DERMOTIC OIL.....871	DEXONTO.....447	40, 291, 337, 857
DERM-SILK.....690, 728	DEXTENZA.....853	<i>diclofenac submicronized</i> 40
DERMULCERA.....354	<i>dextroamphetamine sulfate</i>	<i>diclofenac-misoprostol</i> 37
DERPIXA.....339	194, 211, 212, 228, 229	DICLOFEX DC.....336
DESCOVY.....61	<i>dextroamphetamine-</i>	DICLOFONO.....338
DESFERAL.....49	<i>amphetamine</i> 195, 210, 229	DICLOGEN.....336
<i>desflurane</i> 44	DHEA.....1	DICLOPR.....336
<i>desipramine</i> 180	DHIVY.....182	DICLOSAICIN.....336
<i>desloratadine</i> 875, 876	DIABETIC MULTIVITAMIN..381	DICLOTAL.....336
<i>desmopressin</i> 429	DIACOMIT.....172, 173	DICLOTREX.....336
<i>desog-e.estradiol/e.estradiol</i> 247	DIADIMAXIA.....267	DICLOVIX.....335
<i>desonide</i> 314	DIAOXIA.....267	<i>dicloxacillin</i> 76
DESOWEN.....314	DIAPERS, UNISEX SIZE 1	<i>dicyclomine</i> 480
<i>desoximetasone</i> 314, 315	633, 729	DIFFERIN.....277
DESOXYN.....193, 211	DIAPERS, UNISEX SIZE 2	DIFICID.....73
<i>desvenlafaxine</i> 176	633, 729	<i>diflorasone</i> 315, 316
<i>desvenlafaxine succinate</i> 176	DIAPERS, UNISEX SIZE 3	DIFLUCAN.....55
DEVILBISS DISPOSABLE	633, 729	<i>diflunisal</i> 43
NEBULIZER.....661, 728	DIAPERS, UNISEX SIZE 4	<i>difluprednate</i> 853
DEVILBISS PULMO-AIDE	633, 729	DIFMETIOXRIME.....286
COMPRESSR.....684, 728		DIGEST ADV PROBIO
		PLUS GAS.....494

DIGEST PROBIOTIC (S.BOULARDII).....	494	DIVIGEL.....	443	DRITHOCREME HP.....	294
DIGESTIVE ADVANTAGE IMMUNE.....	494	DIVINIX.....	326	DRIXECE.....	269
DIGESTIVE ADVANTAGE INTENS BOW.....	494	DM2.....	459	DRIZALMA SPRINKLE 176, 214	
DIGESTIVE ADVANTAGE KID PROBIO.....	494	DMT SUIK.....	447	<i>dronabinol</i>	209, 469, 897
DIGESTIVE ADVANTAGE LACTOS SUP.....	494	Dodex.....	418	DROPLET GENTEEL	
DIGESTIVE ADVANTAGE PROBIOTIC.....	494	<i>dofetilide</i>	128	LANCING DEVICE.....	612, 730
DIGESTIVE PROBIOTIC.....	494	DOJOLVI.....	391	DROPLET INSULIN	
DIGESTIVE SUPPORT.....	8	Dolishale.....	250	SYR(HALF UNIT).....	637, 730
Digitek.....	147	DOLOBID.....	43	DROPLET INSULIN	
<i>digoxin</i>	147, 148	DOLOTRANZ.....	333	SYRINGE.....	637, 730
<i>dihydroergotamine</i>	220	DOMELA.....	326	DROPLET LANCETS..	612, 730
Dilantin.....	162	<i>donepezil</i>	243	DROPLET LANCING	
Dilantin Extended.....	162	DONNATAL.....	481	DEVICE.....	612, 731
Dilantin Infatabs.....	162	DOPTelet (10 TAB PACK).....	544	DROPLET MICRON PEN	
DILANTIN-125.....	162	DOPTelet (15 TAB PACK).....	544	NEEDLE.....	637, 731
DILAUDID.....	13	DOPTelet (30 TAB PACK).....	544	DROPLET PEN NEEDLE	
DILAUDID (PF).....	13	DORAL.....	203, 233	.....	638, 731
<i>diltiazem hcl</i>	143, 144	DORYX.....	79	DROPSAFE ACTI-LANCE	
DILT-XR.....	144	DORYX MPC.....	79	.....	612, 731
DILUTING MEDIUM FOR NOVOLOG.....	359	<i>dorzolamide</i>	860	DROPSAFE INSULIN	
DIMENTHO.....	336	<i>dorzolamide (pf)</i>	859	SYRINGE.....	638, 731
<i>dimethyl fumarate</i>	845	<i>dorzolamide-timolol</i>	859	DROPSAFE PEN NEEDLE	
DIMOXIA.....	278	<i>dorzolamide-timolol (pf)</i>	859	.....	638, 731
DIOCHLOY.....	325	DOSOKAP.....	421	DROPSAFE SICURA	
DIONARIS.....	290	Dotti.....	443	SAFETY NEEDLE.....	667, 731
DIOOXIA.....	294	DOVATO.....	60	<i>drospirenone-e.estradiol-</i>	
DIOVAN.....	124	DOVER BULB SYRINGE		<i>lm.fa</i>	250
DIOVAN HCT.....	123	.....	667, 729	<i>drospirenone-ethinyl</i>	
DIOVASC.....	359	DOVER COATED LATEX		<i>estradiol</i>	250
DIPENTUM.....	485	FOLEY.....	693, 730	DROXIA.....	543
Diphen.....	873, 874	DOVER LATEX FOLEY		<i>droxidopa</i>	147
<i>diphenoxylate-atropine</i>	467	CATHETER.....	693, 730	DRY SKIN THERAPY(WITH	
DIPROLENE		DOVER RED RUBBER		LANOLIN).....	306
(AUGMENTED).....	316	ROBINSON CATH.....	693, 730	DRY SKIN THERAPY(W-	
<i>dipyridamole</i>	542	DOVER UNIVERSAL..	693, 730	PETROLATUM).....	306
DISALCID.....	43	<i>doxazosin</i>	152	DRYSOL.....	292
DISKETs.....	13	<i>doxepin</i>	180, 235, 347	DRYSOL DAB-O-MATIC.....	292
<i>disopyramide phosphate</i>	126	<i>doxercalciferol</i>	834	DSUVIA.....	13
<i>disulfiram</i>	237	<i>doxycycline hyclate</i>		DUAKLIR PRESSAIR.....	883
DITHOL.....	336	.....	79, 80, 81, 843	DUAVEE.....	441
DIURIL.....	150	<i>doxycycline monohydrate</i>		DUETACT.....	435
<i>divalproex</i>	160, 205, 219	.....	81, 340	DULERA.....	884
DIVENDO.....	290	<i>doxylamine-pyridoxine (vit</i>		<i>duloxetine</i>	176, 215
		<i>b6)</i>	469	DULOXICAINE....	177, 215, 231
		D-PENAMINE.....	36, 49	DUOBRII.....	279
		DRAMAMINE GINGER.....	8	DUODOTE.....	48
		DRAMAMINE NON-		DUOPA.....	182
		DROWSY.....	8	DUPIXENT PEN.....	282, 878
		DRAXACE.....	269	DUPIXENT SYRINGE..	283, 878
		DRAXACEY.....	269	DURACLON (PF).....	12

DUREX AVANTI BARE REAL FEEL..... 657, 731	EASY GLIDE PEN NEEDLE 639, 733	EASY TOUCH FLURINGE 669, 737
DUREX EXTRA SENSITIVE CONDOM..... 657, 731	EASY MINI EJECT LANCING DEVICE..... 612, 733	EASY TOUCH FLURINGE FLIPLOCK..... 668, 737
DUREX TROPICAL CONDOM..... 657, 731	EASY NEB COMPRESSOR NEBULIZER..... 685, 733	EASY TOUCH FLURINGE SHEATHLOCK..... 669, 737
DUREZOL..... 853	EASY PLUS II BLOOD GLUCOSE MET..... 612, 733	EASY TOUCH GLUCOSE MONITOR..... 613, 737
DURLAZA..... 43, 542	EASY PLUS II HIGH CONTROL..... 612, 733	EASY TOUCH HIGH-LOW CONTROL..... 613, 737
DUROLANE..... 550	EASY PLUS II LOW CONTROL..... 612, 733	EASY TOUCH HYPODERMIC NEEDLE 669, 737
<i>dutasteride</i> 518	EASY PLUS II TEST... 564, 734	EASY TOUCH INSULIN SAFETY SYR..... 639, 737
<i>dutasteride-tamsulosin</i> 512	EASY STEP..... 564, 734	EASY TOUCH INSULIN SYRINGE.... 639, 640, 737, 738
DUVYZAT..... 548	EASY STEP BLOOD GLUCOSE METER..... 612, 734	EASY TOUCH LANCETS 613, 738
DYANAVEL XR..... 195, 210	EASY STEP HIGH CONTROL SOLN..... 613, 734	EASY TOUCH LANCING DEVICE..... 613, 738
DYCLOPRO..... 346	EASY STEP LOW CONTROL SOLUTION..... 613, 734	EASY TOUCH LUER LOCK INSULIN..... 640, 738
DYMISTA..... 888	EASY TALK BLOOD GLUCOSE METER..... 613, 734	EASY TOUCH LUER LOCK SYRINGE..... 669, 738
DYNAFOAM AG..... 352	EASY TALK GLUCOSE TEST..... 565, 735	EASY TOUCH PEN NEEDLE..... 640, 739
DYNAGINATE AG..... 352	EASY TALK HIGH CONTROL..... 613, 735	EASY TOUCH SAFETY LANCETS..... 613, 739
DYNOMA..... 326	EASY TALK LOW CONTROL..... 613, 735	EASY TOUCH SAFETY PEN NEEDLE..... 640, 739
DYRENIUM..... 149	EASY TALK PLUS II HIGH CONTROL..... 613, 735	EASY TOUCH SHEATHLOCK INSULIN 640, 739
E.E.S. 400..... 73	EASY TALK PLUS II LOW CONTROL..... 613, 735	EASY TOUCH SHEATHLOCK SYRG-NDL 669, 739
EAA UCD..... 396	EASY TALK PLUS II TEST STRIP..... 565, 735	EASY TOUCH SHEATHLOCK SYRINGE 670, 739
EAR POPPER INFLATION DEVICE..... 695, 731	EASY TOUCH 640, 670, 738, 739, 740	EASY TOUCH TEST STRIP 566, 740
EASIVENT HOLDING CHAMBER..... 685, 732	EASY TOUCH BLU CTRL SOLN-L1,L3..... 613, 735	EASY TOUCH TUBERCULIN FLIPLOCK 670, 740
EASIVENT MASK LARGE 685, 732	EASY TOUCH BLULINK GLUC SYST..... 613, 735	EASY TOUCH TUBERCULIN SHEATHLK 670, 740
EASIVENT MASK MEDIUM 685, 732	EASY TOUCH BLULINK TEST STRIP..... 565, 736	EASY TOUCH TWIST LANCETS..... 614, 740
EASIVENT MASK SMALL 685, 732	EASY TOUCH FLIPLOCK INSULIN..... 639, 736	
EASY COMFORT INSULIN SYRINGE..... 638, 732	EASY TOUCH FLIPLOCK NEEDLE..... 668, 736	
EASY COMFORT LANCETS..... 612, 732	EASY TOUCH FLIPLOCK SYRINGE..... 668, 736, 737	
EASY COMFORT PEN NEEDLES..... 638, 732		
EASY COMFORT SAFETY PEN NEEDLE..... 639, 732		
EASY FIBER..... 505		
EASY FIBER (WHEAT DEXTRIN)..... 505		
EASY GLIDE CATHETER TIP SYRING..... 667, 732		
EASY GLIDE INSULIN SYRINGE..... 639, 732, 733		
EASY GLIDE LUER LOCK SYRINGE..... 667, 668, 733		
EASY GLIDE LUER SLIP TB SYRING..... 668, 733		

EASY TOUCH UNI-SLIP 640, 670, 740	<i>econazole nitrate</i> 288	ELEMENT TEST STRIPS 568, 744
EASY TRAK BLOOD GLUCOSE METER..... 614, 740	ECONTRA EZ..... 261	ELEPSIA XR.....170
EASY TRAK GLUCOSE TEST..... 566, 741	ECONTRA ONE-STEP.....261	ELESTRIN.....444
EASY TRAK HIGH CONTROL..... 614, 741	ECOTRIN..... 43, 542	<i>eletriptan</i> 221
EASY TRAK II BLOOD GLUCOSE MTR..... 614, 741	ECOZA..... 288	ELIDEL..... 299
EASY TRAK II CTRL SOLN- NORMAL..... 614, 741	EDARBI..... 124	ELIGARD.....94
EASY TRAK II TEST STRIP 566, 741	EDARBYCLOR.....123	ELIGARD (4 MONTH)..... 94
EASY TRAK LOW CONTROL..... 614, 741	EDECIN..... 149	ELIMITE.....349
EASY TWIST AND CAP LANCETS..... 614, 741	EDLUAR..... 234	Elinest.....250
EASY-C IMMUNE HEALTH 420	ED-SPAZ..... 478, 522	ELIQUIS..... 527
EASYGLUCO METER.614, 741	EDURANT 61	ELIQUIS DVT-PE TREAT 30D START 527
EASYGLUCO MONITORING SYSTEM 614, 741	EDURANT PED 61	ELITE-OB 381
EASYGLUCO TEST 567, 742	EEMT 441	Elixophyllin.....880
EASYMAX..... 567, 742	EEMT HS.....441	ELLA.....261
EASYMAX 15 LEVEL 2 614, 742	<i>efavirenz</i> 61	ELLIOTTS B (PF)..... 364
EASYMAX 15 TEST STRIPS.....567, 742	<i>efavirenz-emtricitabin- tenofov</i> 65	ELLUME COVID-19 HOME TEST 601, 744
EASYMAX NG.....614, 742	<i>efavirenz-lamivu-tenofov disop</i> 65	ELLZIA PAK..... 326
EASYMAX NORMAL CONTROL..... 614, 742	EFFER-K..... 372	ELMIRON..... 513
EASYMAX T1..... 614, 742	EFFEXOR XR.....177	ELOCTATE.....530
EASYMAX V SPEAKING GLUCOSE SYS.....614, 743	EFFIENT 542	<i>eltrombopag olamine</i> 544
EASYPPOINT NEEDLE.670, 743	EFUDEX..... 291	Eluryng..... 260
EASY-TOUCH BLOOD GLUCOSE METER..... 614, 743	EGRIFTA SV 450	ELYXYB.....221
EBASE CONTROLLER 685, 743	EGRIFTA WR..... 451	ELYZIA..... 299
EBGLYSS PEN..... 282	EKTERLY 153	ELYZIA (WITH HYALURONATE)..... 299
EBGLYSS SYRINGE.....282	ELDERTONIC..... 360	EMBRACE BLOOD GLUCOSE SYSTEM 568, 615, 744
ECEOXIA.....266	ELECARE JR..... 393	EMBRACE EVO BLOOD GLUCOSE KIT..... 615, 744
<i>echinacea</i> 8	<i>electrolytes-dextrose</i> 370	EMBRACE EVO GLUCOSE MONITOR.....615, 745
<i>echinacea purp aerial part ext</i> 8	ELEMAR.....333	EMBRACE EVO LEVEL 1 615, 745
ECLIPSE NEEDLE..... 670, 743	ELEMENT COMPACT GLUCOSE METER..... 614, 743	EMBRACE EVO TEST STRIPS.....569, 745
ECLIPSE SYRINGE.... 670, 743	ELEMENT COMPACT HIGH CONTROL.....614, 743	EMBRACE GLUCOSE CONTROL HIGH.....615, 745
EC-NAPROSYN..... 41	ELEMENT COMPACT NORMAL CONTROL...615, 743	EMBRACE GLUCOSE CONTROL LOW.....615, 745
EC-NAPROXEN..... 41	ELEMENT COMPACT TEST STRIPS.....568, 743	EMBRACE LANCETS.615, 745
	ELEMENT COMPACT V GLUCOSE MTR..... 615, 743	EMBRACE LANCING DEVICE..... 615, 745
	ELEMENT HIGH CONTROL 615, 744	EMBRACE PEN NEEDLE 640, 745
	ELEMENT LOW CONTROL 615, 744	EMBRACE PRO.....615, 745
	ELEMENT NORMAL CONTROL..... 615, 744	
	ELEMENT PLUS BLOOD GLUCOSE KIT..... 615, 744	

EMBRACE PRO GLUCOSE METER.....	615, 745	EMULSION SB.....	306	EOHILIA.....	448
EMBRACE PRO TEST STRIPS.....	569, 746	EMVERM.....	53	EPANED.....	120
EMBRACE SAFETY LANCET.....	615, 746	Emzahh.....	257	EPCLUSA.....	71
EMBRACE TALK BLOOD GLUCOSE SYS.....	616, 746	<i>enalapril maleate</i>	120	EPICERAM.....	306
EMBRACE TALK CONTROL-HIGH (L2)..	616, 746	<i>enalapril-hydrochlorothiazide</i>	119	EPICYN.....	350
EMBRACE TALK CONTROL-LOW (L1)..	616, 746	ENBRACE HR.....	389	EPIDIOLEX.....	160
EMBRACE TALK GLUCOSE MONITOR.	616, 746	ENBREL.....	28, 30, 31	EPIDUO.....	275
EMBRACE TALK TEST STRIPS.....	569, 746	ENBREL MINI.....	28, 30	EPIDUO FORTE.....	275
EMBRACE WAVE GLUCOSE TEST STRP	570, 747	ENBREL SURECLICK....	28, 31	EPIFIX AMNIOTIC MEMBRANE.....	347
EMBRACE WAVE PLUS GLUCOSE MTR.....	616, 747	ENDARI.....	356, 392, 543	EPIFOAM.....	327
EMEND.....	470, 471	ENDO AVITENE.....	535	<i>epinastine</i>	852
EMERGEN-C.....	414	Endocet.....	23, 24	<i>epinephrine</i>	146, 877
EMERGEN-C APPLE CIDER VINEGAR.....	8, 413	ENDOMETRIN.....	446	EIPEN.....	146
EMERGEN-C ASHWAGANDHA.....	413	ENFIT IRRIGAT SYRINGE- CONTAINR.....	604, 747	EIPEN 2-PAK.....	146
EMERGEN-C ELDERBERRY.....	413	ENFIT MEDICAL STRAW	659, 747	EIPEN JR.....	146
EMERGEN-C ENERGY PLUS.....	413	ENFIT MEDICINE BOTTLE ADAPTER.....	659, 747	EIPEN JR 2-PAK.....	146
EMERGEN-C IMMUNE PLUS.....	413	ENGERIX-B (PF).....	106	Epitol.....	163, 205
EMERGEN-C KIDZ DAILY IMMUNE.....	398	Enilloring.....	260	EPIVIR.....	62
EMERGEN-C KIDZ IMMUNE PLUS.....	398	<i>enoxaparin</i>	539	<i>eplerenone</i>	121, 148
EMERGEN-C TURMERIC GINGER.....	414	ENOXILUV.....	540	EPOGEN.....	528
EMFLAZA.....	448	Enpresse.....	258	EPRONTIA.....	165
EMGALITY PEN.....	219	ENSACOVE.....	88	<i>eprosartan</i>	125
EMGALITY SYRINGE.	156, 219	Enskyce.....	250	EPSOLAY.....	341
EMPAVELI.....	525, 543	ENSPRYNG.....	547	EQUETRO.....	163, 205
EMROSI.....	82, 340	ENSTILAR.....	279	<i>ergocalciferol (vitamin d2)</i> ...	422
EMSAM.....	173	ENSURE CLEAR THERAPEUTIC.....	393	<i>ergoloid</i>	245
<i>emtricitabine</i>	62	ENSURE RAPID HYDRATION.....	370	ERGOMAR.....	220
<i>emtricitabine-tenofovir (tdf)</i>	61, 62	ENSURE SURGERY.....	393	<i>ergotamine-caffeine</i>	220
<i>emtricitabine-tenofovir</i>	65	ENSURE SURGERY PERIOP BUNDLE.....	393	ERIVEDGE.....	93
EMTRIVA.....	62	<i>entacapone</i>	183	ERLEADA.....	88
		ENTADFI.....	512	<i>erlotinib</i>	86
		<i>entecavir</i>	69	ERMEZA.....	464
		<i>enteral connector, enfit</i> 604, 747		Errin.....	257
		ENTERAL GRAVITY BAG SET-ENFIT.....	604, 747	ERTACZO.....	288
		ENTRESTO.....	124	Ery Pads.....	266
		ENTRESTO SPRINKLE.....	124	ERYGEL.....	266
		ENTTY.....	306	ERYPED 400.....	73
		ENTYVIO PEN.....	487	Ery-Tab.....	74
		Enulose.....	471	ERYTHROCIN (AS STEARATE).....	74
		ENVARUSUS XR.....	546	<i>erythromycin</i>	74, 865
		ENVIVE.....	494	<i>erythromycin ethylsuccinate</i> ..	74
		ENZNONUTY.....	334	<i>erythromycin with ethanol</i>	266
				<i>erythromycin-benzoyl peroxide</i>	269
				ESBRIET.....	893
				<i>escitalopram oxalate</i>	174
				Esgic.....	28
				<i>eslicarbazepine</i>	163

<i>esomeprazole magnesium</i> .. 474	EVENCARE MINI	E-Z JECT LANCETS... 617, 750
ESPEROCT.....530	GLUCOSE TEST STR.571, 748	E-Z JECT THIN LANCETS
Estartylla.....250	EVENCARE MINI	617, 750
<i>estazolam</i> 203, 233	MONITOR SYSTEM....616, 748	EZ SMART CONTROL 617, 750
Estrace..... 895	EVENCARE PROVUEW	EZ SMART LANCETS.617, 750
<i>estradiol</i> 444, 445, 895	TEST STRIP.....571, 748	EZ SMART PLUS SYSTEM
<i>estradiol valerate</i> 445	EVENCARE TEST.....571, 749	617, 750
<i>estradiol-norethindrone acet</i> 442	<i>evening primrose oil</i> 8	EZ SMART PLUS TEST
ESTRATEST F.S.....441	<i>everolimus (antineoplastic)</i> 95	572, 751
ESTRING.....895	<i>everolimus</i>	EZ SMART SYSTEM...617, 751
ESTROGEL.....445	<i>(immunosuppressive)</i> 547	EZ SMART TEST..... 572, 751
<i>estrogens-</i>	EVERSENSE 365 SENSOR	EZALLOR SPRINKLE..... 131
<i>methyltestosterone</i> 441	616, 749	<i>ezetimibe</i> 135
ESTROVEN CMPLT	EVERSENSE 365	<i>ezetimibe-rosuvastatin</i> 139
MENOPAUSE RLF.....8	TRANSMITTER..... 616, 749	<i>ezetimibe-simvastatin</i> 139
ESTROVEN SLIMBIOTICS.494	EVICEL.....537	FABHALTA.....525
<i>eszopiclone</i> 234	EVISTA.....462	Falmina (28)..... 250
<i>ethacrynic acid</i> 149	EVOCLIN.....266	<i>famciclovir</i> 72
<i>ethambutol</i> 66	EVOLUTION BLOOD	<i>famotidine</i> 473
<i>ethosuximide</i> 171	GLUCOSE METER.... 616, 749	FANAPT..... 186
ETHOXIA.....277	EVOLUTION NORMAL	FANAPT TITRATION PACK
<i>ethyl acetate</i> 240	CONTROL..... 616, 749	A..... 186
<i>ethyl alcohol</i> 151	EVOLUTION TEST STRIPS	FANAPT TITRATION PACK
<i>ethyl chloride</i> 335	572, 749	B..... 186
<i>ethynodiol diac-eth estradiol</i> 250	EVOTAZ..... 63, 77	FANAPT TITRATION PACK
<i>etodolac</i> 42	EVOXAC.....842	C..... 186
<i>etonogestrel-ethinyl estradiol</i>	EVRYSDI.....554, 555	FANTASY CONDOM...657, 751
.....260	EXCEL SYRINGE.....670, 749	FARESTON..... 100
<i>etoposide</i> 92	EXEL HYPODERMIC	FARXIGA.....434
<i>etravirine</i> 61	NEEDLES.....670, 749	FASENRA PEN..... 879
<i>eua patient assessment</i>	EXEL INSULIN..... 640, 750	FASTEP COVID-19 AG
.....660, 747	EXEL SYRINGE..... 671, 750	HOME TEST.....601, 751
EUCERIN ADVANCED	EXELDERM.....288	FC2 FEMALE CONDOM
REPAIR..... 306	EXELON PATCH.....243	604, 751
EUCERIN INTENSIVE	<i>exemestane</i> 90	<i>febuxostat</i> 524
REPAIR..... 306	<i>exenatide</i> 432	FEIBA NF..... 526
EUCRISA.....283	EXFORGE..... 122	Feirza.....250
EUFLEXXA.....550	EXFORGE HCT.....122	<i>felbamate</i> 160
EURAX.....349	EXJADE.....49	FELBATOL..... 160
EUTHYROX.....464	EXODERM..... 286	FELDENE..... 39
EVAMIST.....445	EXTENDED RESERVOIR	<i>felodipine</i> 144
Evekeo.....195, 212, 229	641, 750	FEM DOPHILUS.....495
EVENCARE.....616, 748, 749	EYE..... 466	FEM PH.....895
EVENCARE G2...570, 616, 747	EYE HEALTH AREDS-2.....3	FEMALE CATHETER..694, 751
EVENCARE G3 CONTROL	EYE HEALTH PLUS	FEMARA.....90
.....616, 748	LUTEIN.....3, 381	FEMCAP.....599, 751
EVENCARE G3 GLUCOSE	EYE MULTIVITAMIN..... 3, 381	FEMLYV..... 250
METER..... 616, 748	EYELID WIPES (WITH	FEMRING..... 896
EVENCARE G3 TEST.570, 748	CHAMOMILE).....309	<i>fenofibrate</i> 129
	EYSUVIS.....853	<i>fenofibrate micronized</i> 129

<i>fenofibrate nanocrystallized</i>	129	FIBER		FLINTSTONES WITH	
<i>fenofibric acid</i>	129	SUPPLEMENT(WHEATDEX		EXTRA IRON.....	398
<i>fenofibric acid (choline)</i>	129	TRIN).....	506	FLOLIPID.....	131
FENOGLIDE.....	129	FIBER THERAPY		FLOMAX.....	517
<i>fenoprofen</i>	41	(PSYLLIUM-SUCRO).....	506	FLORAFOL FE PEDIATRIC	399
FENOPRON.....	41	FIBERWELL.....	506	FLORAFOL PEDIATRIC.....	399
FENOVAR.....	336	FIBRICOR.....	130	FLORAFOL PEDIATRIC	
FENOVIA.....	286	<i>fidaxomicin</i>	74	MULTIVITAMI.....	399
<i>fentanyl</i>	13	FIDILA.....	286	FLORAJEN WOMEN.....	495
<i>fentanyl (pf)-bupivacaine-</i>		FILOMA.....	287	FLORAMAX.....	495
<i>nacl</i>	21	FILSPARI.....	118	FLORASAVE.....	495
<i>fentanyl citrate</i>	13	FILSUVEZ.....	354	FLORASTART.....	495
<i>fentanyl citrate (pf)</i>	13, 44	FINACEA.....	266, 341	FLORASTOR ADVANCED..	495
<i>fentanyl citrate (pf)-0.9%nacl</i>	13	<i>finasteride</i>	517	FLORASTOR DIGEST-	
<i>fentanyl-ropivacaine-nacl</i>		FINAZOL.....	381	METABOLIC.....	495
<i>(pf)</i>	21	FINGERSTIX LANCETS		FLORASTOR WOMAN'S	
<i>fenugreek seed</i>	8	.....	617, 751	PROBIOTIC.....	495
FERGON.....	365	<i>finngolimod</i>	846	FLORASTORBABY.....	495
FERIVA 21-7.....	367	FINTEPLA.....	173	FLORASTORKIDS.....	495
FERIVA FA (WITH		Finzala.....	250	FLORASTORSELECT GUT	
SUMALATE).....	367	Fioricet.....	28	BOOST.....	495
FERRETTS IPS.....	365	FIORICET WITH CODEINE..	20	FLORASTORSELECT	
<i>ferric citrate</i>	365, 515, 516	FIRAZYR.....	143	IMMUNITY BOOST.....	495
<i>ferric glycinate</i>	365	FIRDAPSE.....	550	FLORATUMMYS QUICK	
FERRIPROX.....	49	FIRMAGON KIT W		DISSOLVE.....	496
FERRIPROX (2 TIMES A		DILUENT SYRINGE.....	94	FLOWFLEX COVID-19 AG	
DAY).....	49	FIRVANQ.....	69	HOME TEST.....	601, 752
<i>ferrous fumarate</i>	365	FISH OIL.....	136	FLOWFLEX PLUS COVID-	
<i>ferrous gluconate</i>	366	Flac Otic Oil.....	871	19 AND FLU.....	601, 752
<i>ferrous sulfate</i>	366	FLAREX.....	854	FLUAD 2025-2026 (65 YR	
FERVINA.....	286	FLASHARREST.....	8	UP)(PF).....	114
<i>fesoterodine</i>	523	<i>flavoxate</i>	523	FLUARIX 2025-2026 (PF)...	115
FETZIMA.....	177	<i>flaxseed oil</i>	8	FLUBLOK 2025-2026 (PF)..	115
FE-VITE.....	366	<i>flecainide</i>	127	FLUCELVAX 2025-2026.....	115
Fexmid.....	553	FLECTOR.....	338	FLUCELVAX 2025-2026	
FIASP FLEXTOUCH U-100		FLEQSUVY.....	553	(PF).....	115
INSULIN.....	457	FLEXICHAMBER.....	685, 751	<i>fluconazole</i>	55
FIASP PENFILL U-100		FLEXICHAMBER-LG CHILD		<i>flucytosine</i>	54
INSULIN.....	457	MASK.....	685, 751	<i>fludrocortisone</i>	461
FIASP PUMPCART.....	457	FLEXICHAMBER-SM		FLULAVAL 2025-2026 (PF)	115
FIASP U-100 INSULIN.....	457	ADULT MASK.....	685, 751	FLUMIST 2025-2026... 108, 115	
FIBER (DEXTRIN).....	505	FLEXICHAMBER-SM		FLUMIST HOME 2025-2026	
FIBER (PSYLLIUM HUSK-		CHILD MASK.....	685, 752	.....	108, 115
SUGAR).....	505	FLEXI-SEAL SIGNAL FMS		<i>flunisolide</i>	889
FIBER (WITH		.....	633, 752	<i>fluocinolone</i>	316
ASPARTAME).....	506	FLINTSTONES COMPLETE		<i>fluocinolone acetonide oil</i>	871
FIBER GUMMIES.....	506	(FE SULF).....	398	<i>fluocinolone and shower cap</i>	
FIBER GUMMIES (WITH B-		FLINTSTONES IMMUNITY		.....	316
COMPLEX).....	506	SUPPORT.....	398	<i>fluocinonide</i>	316
				Fluocinonide-E.....	316

<i>fluocinonide-emollient</i>	316	FOLLISTIM AQ.....	446	FORA V12 BLOOD	
FLUOPAR.....	326	FOLVITA COMPLEX.....	415	GLUCOSE SYSTEM... 617, 756	
<i>fluorescein-benoxinate</i> 860, 861		<i>fondaparinux</i>	539	FORACARE GD20.....	576, 756
<i>fluorescein-proparacaine</i>	860	FORA 6 CONNECT		FORACARE GD20	
<i>fluoride (sodium)</i>	838, 839	GLUCOSE STRIP.....	573, 752	GLUCOSE METER.....	618, 756
FLUORIDEX DAILY		FORA 6CONN-GTEL-TN'G		FORACARE GD40 TEST	
DEFENSE.....	839	ADV STRIP.....	573, 752	STRIPS.....	577, 756
FLUORIDEX SENSITIVITY		FORA D40D GLUCOSE-BP		FORACARE GD40B	
RELIEF.....	839	MONITOR.....	599, 617, 752	GLUCOSE METER.....	618, 756
FLUORIMAX 5000.....	839	FORA D40G GLUCOSE-BP		FORACARE GDH HIGH	
FLUORIMAX 5000		MONITOR.....	599, 617, 752	CONTROL.....	618, 757
SENSITIVE.....	839	FORA D40-G31 TEST		FORACARE GDH LOW	
<i>fluorometholone</i>	854	STRIPS.....	573, 753	CONTROL.....	618, 757
<i>fluorouracil</i>	291	FORA G20.....	574, 617, 753	FORACARE GDH NORMAL	
FLUOVIX.....	317	FORA G30A.....	617, 753	CONTROL.....	618, 757
FLUOVIX PLUS.....	316	FORA GD50 BLOOD		FORACARE LANCETS	
<i>fluoxetine</i>	174, 175	GLUCOSE SYSTEM... 617, 753		.....	618, 757
FLUOXIA.....	326	FORA GD50 TEST STRIPS		FORANE.....	44
<i>fluphenazine hcl</i>	189	.....	574, 753	<i>formoterol fumarate</i>	882
<i>flurandrenolide</i>	317	FORA GTEL GLUCOSE		FORTEO.....	438
<i>flurazepam</i>	203, 233	TEST STRIP.....	574, 754	FORTIFY OPT ADV (L.	
<i>flurbiprofen</i>	41	FORA GTEL MULTI-		SALIVARUS).....	496
<i>flurbiprofen sodium</i>	858	FUNCTN MONITOR....	598, 754	FORTIFY OPTIMA	
<i>fluticasone propionate</i>		FORA HIGH CONTROL		PROBIOTIC.....	496
.....	317, 877, 878, 889	.....	617, 754	FORTIFY OPTIMA WOMEN	
<i>fluticasone propion-</i>		FORA LANCING DEVICE		ADVANCED.....	496
<i>salmeterol</i>	885	.....	617, 754	FORTIFY OPTIMA WOMEN	
<i>fluvastatin</i>	131, 132	FORA LOW CONTROL		PROBIOTIC.....	496
<i>fluvoxamine</i>	175	.....	617, 754	FORTIFY PROBIOTIC.....	496
FLUZONE 2025-2026.....	116	FORA NORMAL CONTROL		FORTIFY PROBIOTIC 50	
FLUZONE 2025-2026 (PF)..	115	.....	617, 754	PLUS.....	496
FLUZONE HIGH-DOSE		FORA PREMIUM V10		FORTIFY WOMEN	
2025-26 (PF).....	116	GLUCOSE METER.....	617, 754	PROBIO(L.SALIV.).....	496
FML FORTE.....	854	FORA TEST N'GO VOICE		FORTIFY WOMEN	
FML LIQUIFILM.....	854	METER.....	617, 754	PROBIOTIC.....	497
FOCALIN.....	195	FORA TEST STRIP.....	575, 754	FOSAMAX.....	439
FOCALIN XR.....	195	FORA TN'G ADV MOBILE		FOSAMAX PLUS D.....	438
FOLAGENT DHA.....	382	MULTI MTR.....	598, 754	<i>fosamprenavir</i>	77
FOLAMAX.....	382	FORA TN'G ADVAN PRO		<i>fosfomycin tromethamine</i>	
FOLAMED DHA.....	382	TEST STRIP.....	575, 755	.....	54, 520
FOLAPRIME.....	382	FORA TN'G ADVANCE		<i>fosinopril</i>	120
FOLCYTEINE.....	424	PRO MONITOR.....	599, 755	<i>fosinopril-</i>	
FOLET ONE.....	389, 402	FORA TN'G VOICE METER		<i>hydrochlorothiazide</i>	119
FOLETRA.....	423	.....	617, 755	FOSRENOL.....	515
<i>folic acid</i>	423	FORA TN'G VOICE TEST		FOTIVDA.....	98
<i>folic acid-vitamin b6-vit b12</i>	415	STRIPS.....	575, 755	FRAGMIN.....	540
FOLIC D3.....	415	FORA V10.....	576, 755	FRAICHE 5000.....	839
FOLICORE B COMPLEX....	415	FORA V10-V12-D10-D20		FRAICHE 5000 PREVI.....	839
FOLIKA-BC.....	357	STRIPS.....	576, 756	FRAICHE 5000 SENSITIVE	839
FOLIVANE-OB.....	382				

FREESTYLE CONTROL	<i>frovatriptan</i> 221	GE333 BLOOD GLUCOSE
.....618, 757	FRUITIVITS.....393	SYSTEM.....619, 760
FREESTYLE FLASH	FRUZAQLA.....98	GE333 BLOOD GLUCOSE
SYSTEM.....618, 757	FULPHILA.....533	TEST STRIP.....579, 760
FREESTYLE FREEDOM	Fulvicin P/G.....56	<i>gefitinib</i> 86
.....618, 757	FURADANTIN.....54, 519	<i>gelatin</i> 8
FREESTYLE FREEDOM	FUROSCIX.....149	GELCLAIR.....841
LITE.....618, 757	<i>furosemide</i> 149	GELFILM.....535, 863
FREESTYLE INSULINX	FUZEON.....59	GEL-FLOW.....536
.....577, 618, 757	Fyavolv.....442	GEL-FLOW NT.....535
FREESTYLE INSULINX	FYCOMPA.....158	GELFOAM.....536
TEST STRIPS.....577, 757	FYLNETRA.....533	GELFOAM COMPRESSED
FREESTYLE LANCETS	Fyremadel.....461	SIZE 100.....536
.....618, 757	G TUSSIN AC.....892	GELFOAM JMI POWDER...536
FREESTYLE LIBRE 14 DAY	<i>gabapentin</i> 161, 231	GELFOAM JMI SPONGE...536
READER.....618, 757	GABARONE.....161	GELFOAM SPONGE SIZE
FREESTYLE LIBRE 14 DAY	GABLOFEN.....553	100.....536
SENSOR.....618, 757	GALAFOLD.....837	GELFOAM SPONGE SIZE
FREESTYLE LIBRE 2 PLUS	<i>galantamine</i> 243	12-7MM.....536
SENSOR.....618, 758	Galbriela.....250	GELFOAM SPONGE SIZE
FREESTYLE LIBRE 2	Gallifrey.....462	200.....536
READER.....618, 758	GALZIN.....48	GELFOAM SPONGE SIZE
FREESTYLE LIBRE 2	<i>gamma-aminobutyric acid</i> 8	50.....536
SENSOR.....619, 758	GAMMAGARD LIQUID.....107	GELMIX.....241
FREESTYLE LIBRE 3 PLUS	GAMMAKED.....107	GEL-ONE.....550
SENSOR.....619, 758	GAMUNEX-C.....107	GELSYN-3.....550
FREESTYLE LIBRE 3	<i>ganirelix</i> 461	<i>gemfibrozil</i> 130
READER.....619, 758	GARDASIL 9 (PF).....114	Gemmily.....250
FREESTYLE LIBRE 3	<i>garlic</i> 8	GEMTESA.....514
SENSOR.....619, 758	<i>garlic extract</i> 8	GENABIO COVID-19 RAPID
FREESTYLE LITE METER	GARLICIN CARDIO.....8	AT-HOME.....601, 760
.....619, 758	GARLIX.....8	GENADEK.....398
FREESTYLE LITE STRIPS	GAS RELIEF-PREVENTION	GENADEK STEP 1.....382
.....577, 758	478	GENADEK STEP 2.....382
FREESTYLE PRECISION	GASTRACID.....472	GENADUR.....348
.....641, 759	GASTROCROM.....95	GENADUR (WITH
FREESTYLE PRECISION	<i>gatifloxacin</i> 865	LEXINAL).....348
NEO METER.....619, 758	GATTEX 30-VIAL.....511	Generlac.....471
FREESTYLE PRECISION	GATTEX ONE-VIAL.....511	Gengraf.....34, 546
NEO STRIPS.....578, 759	GAVILYTE-C.....508	GENNAMD.....9
FREESTYLE SIDEKICK II	Gavilyte-G.....508	GENOTROPIN.....451
.....619, 759	Gavilyte-N.....508	GENOTROPIN MINIQUEEK 451
FREESTYLE SYSTEM KIT	GAVRETO.....100	<i>gentamicin</i> 283, 864
.....619, 759	GDRIVE.....619, 759	GENTLE IRON.....367
FREESTYLE TEST.....578, 759	GE100 BLOOD GLUCOSE	GENTLE SKIN CLEANSER 343
FREESTYLE UNISTIK 2	SYSTEM.....619, 759	GENTLE SKIN
.....619, 759	GE100 BLOOD GLUCOSE	CLEANSER(WITH SLS).....343
FRIVO.....286	TEST STRIP.....578, 760	GENVISC 850.....551
FROTEK.....338	GE100 CONTROL	GENVOYA.....64
FROVA.....221	SOLUTION NORMAL..619, 760	GEODON.....186, 207

GERI-MUCIL (ASPARTAME).....	506	GLUCOCARD EXPRESSION	580, 620, 761, 762	<i>glucosamine-d3-hyaluronic acid</i>	2
GERI-MUCIL (SUGAR).....	506	GLUCOCARD SHINE..	620, 762	<i>glucosamine-msm-chondr- d3-bosw</i>	2
GI PROTECT.....	396	GLUCOCARD SHINE		<i>glucosam-msm-chond- hrb149-hyal</i>	2
GILENYA.....	846	CONNEX METER.....	620, 762	<i>glucose</i>	426
GILOTRIF.....	86	GLUCOCARD SHINE		GLUCOSE CONTROL	620, 764
GIMOTI.....	478	EXPRESS METER.....	620, 762	GLUCOSE KETONE	
<i>ginger (zingiber officinalis)</i>	9	GLUCOCARD SHINE		CONTROL SOLN.....	620, 764
<i>ginger root-ginger root ext</i>	9	METER.....	620, 762	GLUCOTROL XL.....	435
<i>ginkgo biloba leaf extract</i>	9	GLUCOCARD SHINE		<i>glutamine</i>	356, 511
GINKGO BILOBA PLUS (BACOPA).....	9	METER KIT.....	620, 762	<i>glutamine (sickle cell)</i>	356, 392, 543
GIRLS TRAINING PANTS 4T-5T.....	634, 760	GLUCOCARD SHINE TEST STRIPS.....	580, 762	<i>glutaraldehyde</i>	104
GLASSIA.....	887	GLUCOCARD SHINE XL		GLUTAREX-2.....	391, 394
<i>glatiramer</i>	845	METER.....	620, 762	<i>glutathione (bulk)</i>	3, 239
Glatopa.....	845	GLUCOCARD VITAL..	620, 762	<i>glyburide</i>	435
GLEEEVEC.....	98	GLUCOCARD VITAL		<i>glyburide micronized</i>	435
GLEOSTINE.....	87	SENSOR.....	580, 763	<i>glyburide-metformin</i>	434
GLIADEL WAFER.....	87	GLUCOCARD VITAL TEST STRIPS.....	581, 763	<i>glycerin</i>	308
<i>glimepiride</i>	434	GLUCOCOM AUTOLINK	620, 763	GLYCINE UROLOGIC.....	513
<i>glipizide</i>	434	GLUCOCOM BLOOD		<i>glycine urologic solution</i>	513
<i>glipizide-metformin</i>	434	GLUCOSE.....	620, 763	<i>glycopyrrolate</i>	480, 843
GLOPERBA.....	524	GLUCOCOM CONTROL		<i>glycopyrrolate (pf)</i>	479
GLUCAGON (HCL) EMERGENCY KIT.....	426	HIGH.....	620, 763	Glydo.....	344
Glucagon Emergency Kit (Human).....	426	GLUCOCOM CONTROL		GLYRX-PF.....	480
<i>gluc-chon-msm-col-hy-bos- c-min</i>	1	NORMAL.....	620, 763	GLYTACTIN BETTERMILK 5-5.....	395
GLUCERNA 1.5 CAL.....	393	GLUCOCOM GLUCOSE	581, 763	GLYXAMBI.....	433
GLUCERNA HUNGER SMART.....	393	GLUCOCOM LANCETS	620, 764	GM100.....	581, 621, 764
GLUCERNA SNACK BAR...	394	GLUCOSA IMMUNE BOOSTER.....	9	GOCOVRI.....	184
GLUCO NAVII GLUCOSE MONITOR.....	619, 760	<i>glucosam su dip-chondroit-c- mn</i>	1	GOJJI BLOOD GLUCOSE TEST STRIP.....	582, 764
GLUCO NAVII TEST STRIP	579, 761	<i>glucosam-chondr-msm-c- manganes</i>	1	GOJJI GLUCOSE CNTRL SOL-NORMAL.....	621, 764
GLUCOCARD 01 HI- NORMAL CONTROL...	619, 761	<i>glucosam-chondr-vit c-mn- boron</i>	1	GOJJI LANCETS.....	621, 764
GLUCOCARD 01 METER	619, 761	<i>glucosamine 2kcl-msm- chondroit</i>	1	GOJJI LANCING DEVICE	621, 764
GLUCOCARD 01 NORMAL CONTROL.....	620, 761	<i>glucosamine sulfate</i>	1	GOJJI MULTI-FUNCTIONAL METER.....	599, 764
GLUCOCARD 01 SENSOR PLUS.....	579, 761	GLUCOSAMINE-CHONDR- D3 (C-MANG).....	1	GOLD BOND THERAPEUTIC FOOT.....	306
		<i>glucosamine-chondroitin</i>	1	<i>goldenseal root</i>	9
		<i>glucosamine-d3-boswellia serr</i>	2	GOLYTELY.....	508
				GOMEKLI.....	95
				GONAL-F.....	446
				GONAL-F RFF.....	446
				GONAL-F RFF REDI-JECT.	446
				GONITRO.....	125

GOPRELTO.....	888	<i>halcinonide</i>	317, 318	HEMOFIL M SUPER HIGH.	531
GOTOKNOW COVID-19 AG		HALCION.....	203, 233	HEP FLUSH-10 (PF).....	538
HOME TEST.....	601, 765	<i>halobetasol propionate</i>	294, 318	<i>heparin (porcine)</i>	538
GRAFIX CORE.....	347	Haloette.....	260	<i>heparin (porcine) in 0.9%</i>	
GRAFIX PRIME.....	348	HALOG.....	318, 319	<i>nacl</i>	538
GRAFIX XC.....	348	<i>haloperidol</i>	188	<i>heparin (porcine) in 5 % dex</i>	538
GRALISE.....	231, 232	<i>haloperidol lactate</i>	188	<i>heparin lock flush (porcine).</i>	538
<i>granisetron hcl</i>	470	HALUCORT.....	306	HEPARIN	
GRANIX.....	533	HAPRODERM.....	307	LOCKFLUSH(PORCINE)(PF	
<i>grape seed extract</i>	9	HARLIKU.....	836	).....	538
GRASTEK.....	104	HARMONY GLUCOSE		<i>heparin, porcine (pf)....</i>	538, 539
GREEN TEA-600.....	9	TEST STRIP.....	582, 765	HEPLISAV-B (PF).....	106
<i>griseofulvin microsize</i>	56	HARVONI.....	71	HEPSERA.....	69
<i>griseofulvin ultramicrosize</i>	56	HAVRIX (PF).....	106	HEPZATO (50 MM	
<i>guaiacol</i>	239	HAXCHLO.....	290	CATHETER).....	87
GUAIFENESIN AC.....	893	HAXCHLODREX.....	290	HEPZATO (62 MM	
GUAIFENESIN DAC.....	892	HAXDRAX.....	287	CATHETER).....	87
<i>guanfacine</i>	147, 191	HCU GEL POWDER.....	392	HER STYLE.....	261, 262
GUARDIAN 4 GLUCOSE		HCU MAXAMUM.....	392	HERBAL COLON	
SENSOR.....	621, 765	HEALON GV PRO.....	863	CLEANSER.....	5
GUARDIAN 4		HEALON PRO.....	863	HERNEXEOS.....	92
TRANSMITTER.....	621, 765	HEALON5 PRO.....	863	HETLIOZ.....	218
GUARDIAN CONNECT		HEALTHPRO GLUCOSE		HETLIOZ LQ.....	218
TRANSMITTER.....	621, 765	MONITOR.....	621, 765	HEXIOUNYL.....	286
GUARDIAN LINK 3		HEALTHPRO HIGH-LOW		HI-D ADEK GUMMIES	
TRANSMITTER.....	621, 765	CONTROL.....	621, 765	PLUS ZINC.....	389
GUARDIAN SENSOR 3		HEALTHPRO TEST STRIPS		HI-D DROP.....	398
.....	621, 765	.....	582, 765	HIGH POTENCY MULTIVIT	
GUMMY DINOS.....	398	HEALTHWISE INSULIN		(W-IRON).....	389
GVOKE.....	427	SYRINGE.....	641, 766	HIGH POTENCY	
GVOKE HYOPEN 1-PACK		HEALTHWISE PEN		MULTIVITAMIN.....	389
.....	426	NEEDLE.....	641, 766	HISTEX-AC.....	891
GVOKE HYOPEN 2-PACK		HEALTHY EYES LUTEIN-		HIXDEFRIMA.....	287
.....	426	ZEAXANTHIN.....	3	HIZENTRA.....	107
GVOKE PFS 1-PACK		HEALTHY EYES		HOMATROPAIRE.....	852
SYRINGE.....	426	SUPERVISION2.....	3	HOME NEBULIZER PLUS	
GVOKE PFS 2-PACK		Heather.....	257	SIDESTREAM.....	685, 766
SYRINGE.....	427	HEMADY.....	448	HOMINEX-2.....	392
GYNAZOLE-1.....	894	HEMANGEOL.....	142	HORIZANT.....	226
HAEGARDA.....	527	HEMATEX.....	366	HORMONE PROTECT.....	9
Hailey.....	251	HEMATOGEN.....	367	HORNY GOAT WEED	
Hailey 24 Fe.....	251	HEMATOGEN FORTE.....	367	PLUS.....	9
Hailey Fe 1.5/30 (28).....	251	HEMATRON-AF.....	367	HOVYN.....	299
Hailey Fe 1/20 (28).....	251	HEMAX.....	367	HPR.....	307
HAIR, SKIN AND NAILS		HEMICLOR.....	150	HPR PLUS.....	307
(BIOTIN).....	420	HEMLIBRA.....	534	HPR PLUS HYDROGEL.....	305
HAIR, SKIN AND NAILS		HEMMOREX-HC.....	46	HPR PLUS-MB HYDROGEL	
(HERBS).....	382	HEMOFIL M HIGH.....	531	.....	305
HAIR,SKIN AND NAILS(FA-		HEMOFIL M LOW.....	531	HUMALOG JUNIOR	
BIOTIN).....	382	HEMOFIL M MID.....	531	KWIKPEN U-100.....	457

HUMALOG KWIKPEN		HYDRATION MULTIPLIER		HYGIENIC CLEANSING	
INSULIN.....	457	IMMUNE.....	371	LOTION.....	307
HUMALOG MIX 50-50		HYDREA.....	90	HYLAZINC.....	423
KWIKPEN.....	454	HYDRO 35.....	331	HYMOVIS.....	551
HUMALOG MIX 75-25		HYDRO 40.....	331	HYMPAVZI PEN.....	534
KWIKPEN.....	454	<i>hydrochlorothiazide</i>	150	<i>hyoscyamine sulfate</i>	478, 522
HUMALOG MIX 75-25(U-		<i>hydrocodone bitartrate</i>	14	HYOSYNE.....	478, 479, 522
100)INSULN.....	454	<i>hydrocodone-</i>		HYPER-SAL.....	241
HUMALOG TEMPO PEN(U-		<i>acetaminophen</i>	22, 23	HYPOCYN ANTIPRURITIC	
100)INSULN.....	457	<i>hydrocodone-</i>		.....	103, 350
HUMALOG U-100 INSULIN	457	<i>chlorpheniramine</i>	891	HYPOCYN DERMAL... 103,	351
HUMATE-P.....	531	<i>hydrocodone-homatropine</i> ...	892	HYPOLANCE AST	
HUMATROPE.....	451	<i>hydrocodone-ibuprofen</i>	22, 23	LANCING.....	621, 766
HUMIRA.....	29, 31, 488	<i>hydrocortisone</i>		<i>hypromellose</i>	242
HUMIRA PEN.....	29, 31, 488	.....	46, 320, 448, 486	HYQVIA.....	108
HUMIRA(CF).....	29, 31, 488	<i>hydrocortisone acetate</i> ..	46, 319	HYSINGLA ER.....	14
HUMIRA(CF) PEN... 29,	31, 488	<i>hydrocortisone butyrate</i>		HYZAAR.....	123
HUMIRA(CF) PEN		.....	319, 320	<i>ibandronate</i>	439
CROHNS-UC-HS....	29, 31, 488	HYDROCORTISONE		IBRANCE.....	92
HUMIRA(CF) PEN PSOR-		LOTION COMPLETE.....	328	IBSRELA.....	483
UV-ADOL HS.....	29, 31, 488	<i>hydrocortisone sod</i>		IBTROZI.....	98
HUMULIN 70/30 U-100		<i>succinate</i>	448	Ibu.....	41
INSULIN.....	452	<i>hydrocortisone valerate</i>	320	IBUPAK.....	41
HUMULIN 70/30 U-100		<i>hydrocortisone-acetic acid</i> ...	871	<i>ibuprofen</i>	41
KWIKPEN.....	452	<i>hydrocortisone-iodoquinol-</i>		<i>ibuprofen-famotidine</i>	37
HUMULIN N NPH INSULIN		<i>aloe2</i>	284	<i>icatibant</i>	143
KWIKPEN.....	453	<i>hydrocortisone-iodoquinol</i> ...	290	Iclevia.....	251
HUMULIN N NPH U-100		<i>hydrocortisone-iodoquinol-</i>		ICLOFENAC CP.....	337
INSULIN.....	453	<i>aloe</i>	284	ICLUSIG.....	96
HUMULIN R REGULAR U-		<i>hydrocortisone-pramoxine</i>		<i>icosapent ethyl</i>	134
100 INSULN.....	453	.....	47, 321, 327	ID NOW COVID-19 TEST	
HUMULIN R U-500 (CONC)		<i>hydrogen peroxide (bulk)</i>		KIT.....	601, 766
INSULIN.....	453	.....	104, 240	IDARAN.....	341
HUMULIN R U-500 (CONC)		Hydromet.....	892	IDEAL BOWEL SUPPORT..	497
KWIKPEN.....	453	<i>hydromorphone</i>	14	IDELVION.....	529
HURRI-FREEZE.....	334	<i>hydromorphone (pf)</i>	14	IDHIFA.....	96
HYALGAN.....	551	<i>hydromorphone (pf)-0.9 %</i>		IDYYXIATAR.....	275
HYCANTIN.....	101	<i>nacl</i>	14	IGALMI.....	235
HYCLODEX.....	103, 350	<i>hydroquinone</i>	300	IGG 2000 CWP.....	396
HYCODAN (WITH		<i>hydroxocobalamin</i>	418	IGG PURE.....	396
HOMATROPINE).....	892	<i>hydroxychloroquine</i>	32, 57	IHEALTH CONTROL SOLN	
<i>hydralazine</i>	148	<i>hydroxyethyl</i>		LEVEL 2.....	621, 766
HYDRALYTE.....	370	<i>methacrylate, bulk</i>	240	IHEALTH COVID-19 AG	
HYDRALYTE PLUS.....	370	HYDROXYM.....	321	HOME TEST.....	601, 766
HYDRATING		<i>hydroxypropyl cellulose</i>	242	IHEALTH GLUCO PLUS	
ELECTROLYTE.....	370	<i>hydroxyurea</i>	90	METER.....	621, 766
HYDRATING		<i>hydroxyzine hcl</i>	157	IHEALTH GLUCOSE TEST	
ELECTROLYTE SF.....	371	<i>hydroxyzine pamoate</i>	157	STRIP.....	583, 766
HYDRATION MULTIPLI		HYFTOR.....	335	IHEEZO (PF).....	862
SUGAR FREE.....	371				

ILET INFUSION KIT-INSET 23"..... 695, 767	INDICAID COVID-19 AG HOME TEST.....601, 767	INPEN (FOR HUMALOG) GREY..... 641, 768
ILET INFUSION KIT-INSET 32"..... 695, 767	<i>indomethacin</i> 42	INPEN (FOR HUMALOG) PINK..... 641, 768
ILET INFUSION-CONTACT DTCH 23"..... 696, 767	INFANT-TODDLER MULTIVIT..... 397	INPEN (NOVOLOG OR FIASP) BLUE.....642, 768
ILET INSULIN PUMP.. 692, 767	INFANT-TODDLER MULTIVITAMIN..... 397	INPEN (NOVOLOG OR FIASP) GREY.....642, 769
ILET STARTER KIT CONTACT..... 691, 767	INFANT-TODDLER MULTIVIT-IRON..... 398	INPEN (NOVOLOG OR FIASP) PINK.....642, 769
ILET STARTER KIT-INSET 691, 767	INFASURF.....888	INQOVI..... 102
ILEVRO..... 858	INFINITY CONTROL SOLUTION HIGH..... 621, 767	INREBIC..... 94
ILEXOR..... 326	INFINITY CONTROL SOLUTION LOW..... 621, 767	INSPIRACHAMBER... 686, 769
ILIDERM..... 334	INFINITY CONTROL SOLUTION NORM..... 621, 767	INSPIRACHAMBER WITH MASK-LARGE..... 686, 769
<i>imatinib</i> 98	INFINITY METER KIT. 622, 767	INSPIRACHAMBER WITH MASK-MED..... 686, 769
IMBRUVICA.....91, 98	INFINITY STARTER KIT 622, 767	INSPIRACHAMBER WITH MASK-SMALL..... 686, 769
IMIOXIA.....286	INFINITY TEST STRIPS 583, 768	INSPIRATION ELITE FILTER..... 686, 769
<i>imipramine hcl</i> 180	INFLAMMACIN.....38	INSPIRA..... 121, 148
<i>imipramine pamoate</i> 180	INFLAMMA-K..... 337	INSTA-GLUCOSE (WITH DEXTRIN).....427
<i>imiquimod</i> 329	INFLATHERM(DICLOFENA C-MENTHOL)..... 38	INSUFLON..... 691, 769
IMITREX.....221	INGREZZA..... 225, 226	INSUL-CAP..... 622, 769
IMITREX STATDOSE PEN. 221	INGREZZA INITIATION PK(TARDIV)..... 225, 226	INSUL-EZE.....622, 769
IMITREX STATDOSE REFILL..... 221	INGREZZA SPRINKLE 225, 227	<i>insulin asp prt-insulin aspart</i> 454
IMKELDI..... 98	INJECT EASE LANCETS 622, 768	<i>insulin aspart u-100</i> 457, 458
IMMUNERX.....382	INLYTA..... 98	<i>insulin glargine-yfgn</i> 455
IMPACT ADVANCED RECOVERY..... 394	INNOPRAN XL..... 142	<i>insulin lispro</i> 458
IMPAVIDO..... 58	INNOSPIRE DELUXE. 685, 768	<i>insulin lispro protamin-lispro</i> 454
IMPOYZ.....295, 321	INNOSPIRE ELEGANCE 685, 768	<i>insulin syrlndl u100 half</i> <i>mark</i> 642, 769
IMURAN..... 34, 548	INNOSPIRE ESSENCE 685, 768	INSULIN SYRINGE.... 642, 769
INBRIJA.....183	INNOSPIRE GO NEBULIZER..... 661, 768	<i>insulin syringe-needle u-100</i> 642, 770
Incassia..... 257	INNOSPIRE MINI..... 685, 768	<i>insulin u-500 syringe-needle</i> 642, 770
IN-CHECK NASAL WITH MASK..... 681, 767	INNOSPIRE REPLACEMENT FILTER 685, 768	INSUPEN PEN NEEDLE 642, 770
IN-CHECK ORAL FLOW METER.....681, 767	<i>inositol</i> 359	INSYTE IV CATHETER 656, 770
INCONTROL LANCING DEVICE..... 621, 767	<i>inositol-choline bitartrate</i> 136	INTEGRA SYRINGE... 671, 770
INCONTROL PEN NEEDLE 641, 767	INPEFA.....425	INTELENCE..... 61
INCONTROL SUPER THIN LANCETS..... 621, 767	INPEN (FOR HUMALOG) BLUE..... 641, 768	INTELISWAB COVID-19 HOME TEST.....601, 770
INCONTROL ULTRA THIN LANCETS..... 621, 767		INTENSE DRY SKIN THERAPY.....307
INCRELEX.....460		
INCRUSE ELLIPTA..... 880		
<i>indapamide</i> 150		
INDERAL LA.....142		
INDERAL XL.....142		

INTERLINK LEVER LOCK	ISORDIL TITRADOSE.....125	JENTADUETO XR.....437
CANNULA..... 680, 770	<i>isosorbide dinitrate</i> 125	Jinteli..... 442
INTERLINK SYRINGE AND	<i>isosorbide mononitrate</i> 125	JIVI..... 531
CANNULA..... 671, 770	<i>isosorbide-hydralazine</i> 156	JOENJA.....836
Introvale.....251	<i>isotretinoin</i> 263	JOINT COMFORT AND
INTUNIV ER..... 191	<i>isradipine</i> 144	MOVEMENT.....9
INVACARE LANCETS.622, 770	ISTALOL.....861	JOINT HEALTH-BONE
INVEGA..... 186, 187	ISTURISA.....425	STRENGTH.....362
INVELTYS..... 854	IS-ZC 50..... 373	JOLESSA..... 251
INVOKAMET..... 433	ITHOXIA..... 277	JORNAY PM..... 195
INVOKAMET XR..... 433	ITOVEBI..... 96	JOURNAVX..... 12
INVOKANA..... 434	<i>itraconazole</i> 55	Joyeaux..... 251
INZDEAXIATAR..... 272	<i>ivabradine</i> 151	JUBLIA..... 290
INZDEAXIAVAR..... 272	I-VALEX-2.....391	Juleber.....251
INZDEOXIA..... 269	IVENIX ADMIN SET 2INLET	JULUCA.....60
INZIRQO.....150	2YSITE..... 656, 771	Junel 1.5/30 (21).....251
IODOFLEX..... 103	IVENIX ADMIN SET 2INLET	Junel 1/20 (21).....251
IODOSORB..... 103	Y-SITE..... 656, 771	Junel Fe 1.5/30 (28)..... 251
IOPIDINE.....866	IVENIX LVP EPIDURAL	Junel Fe 1/20 (28)..... 252
IPOL..... 116	SET NRFIT..... 555, 771	Junel Fe 24.....252
I-PORT..... 680, 770	<i>ivermectin</i> 53, 341	JUST 4 KIDZ MULTIVIT-
I-PORT ADVANCE 6 MM	IWILFIN..... 85	PROBIOTIC.....399
INJEC PORT..... 680, 770	IXINITY..... 529	JUST RIGHT 5000..... 839
I-PORT ADVANCE 9 MM	IYUZEH (PF)..... 867	JUVAZIN.....338
INJEC PORT..... 680, 770	JADENU..... 50	JUVEN (WITH COLLAGEN)396
<i>ipratropium bromide</i> 881, 888	JADENU SPRINKLE..... 50	JUXTAPID..... 140
<i>ipratropium-albuterol</i> 883	Jaimiess.....247	JYLAMVO.....32, 89
IQIRVO.....545	JAKAFI..... 94	JYNARQUE..... 517
<i>irbesartan</i> 125	JALYN..... 512	K1-1000.....424
<i>irbesartan-</i>	Jantoven.....526	K2-D3 MAX.....421
<i>hydrochlorothiazide</i> 123	JANUMET.....436	Kaitlib Fe.....252
IRESSA..... 86	JANUMET XR.....436	KALETRA..... 63
IRON (FERROUS	JANUVIA..... 430	Kalliga.....252
SULFATE)..... 366	JARDIANCE..... 434	KALYDECO.....886
<i>iron bisglycinate chelate</i> 366	JARRO-DOPHILUS	KANGAROO 924 SAFETY
IRON FOLATE PLUS..... 368	ALLERGEN FREE.....497	SCREW..... 604, 771
<i>iron,carbonyl-vitamin c</i> 368	JARRO-DOPHILUS BABY.. 497	KANGAROO EPUMP SET
IRRIGATION SYRINGE	JARRO-DOPHILUS EPS.....497	604, 771
.....671, 771	JARRO-DOPHILUS PLUS	KANGAROO GRAVITY SET
ISENTRESS..... 60	FOS..... 497	604, 771
ISENTRESS HD.....60	JARRO-DOPHILUS	KAPSPARGO SPRINKLE... 140
Isibloom..... 251	WOMEN..... 497	KARBINAL ER.....873, 874
I-SIGHT..... 3	Jasmiel (28)..... 251	Kariva (28)..... 247
<i>isoflurane</i> 44	JATENZO..... 428	KATARAXAP..... 301
ISOLEUCINE 1000.....356, 392	Javygtor..... 837	KATARVIA..... 301
ISOLEUCINE AMINO ACID	JAYPIRCA.....91, 98	KATARYA.....301
SUPPLMNT..... 356, 392	Jaythari..... 448	KATARYAXN..... 301
<i>isoniazid</i> 66	JELMYTO..... 101	KATERZIA..... 145
<i>isopropyl alcohol</i> 240	Jencycla.....257	KAXM..... 300
ISORDIL..... 125	JENTADUETO.....436	KAZANO.....437

KAZURI.....	329	KIMONO LUBRICATED		KOTARAXAP.....	302
KEFUNOVA.....	335	CONDOMS.....	657, 771	KOVALTRY.....	531
KEIDO.....	301	KIMONO MICROTHIN		K-PHOS NO 2.....	518
Kelnor 1/35 (28).....	252	AQUA LUBE CON.....	657, 772	K-PHOS ORIGINAL.....	518
Kelnor 1/50 (28).....	252	KIMONO MICROTHIN		KPN.....	402
KELOTOP.....	690, 771	CONDOMS.....	657, 772	KRAZATI.....	94
KENALOG.....	321, 448	KIMONO MICROTHIN		<i>krill-om-3-dha-epa-phospho-</i>	
KENALOG-80.....	448	LARGE CONDOMS.....	657, 772	<i>ast.....</i>	136
KENDALL DISINFECTANT		KIMONO TEXTURED		KRINTAFEL.....	57
CAP.....	680, 771	CONDOMS.....	657, 772	Kristalose.....	507
KENGUARD FOLEY		KIMONO THIN		Kurvelo (28).....	252
CATHETER.....	694, 771	LUBRICATED CONDOMS		KUTAR.....	302
KEPPRA.....	170	.....	657, 772	KUTARVIA.....	302
KEPPRA XR.....	170	KINDERLYTE HERBAL		KUTARYAXM.....	302
KERAGEL.....	352, 771	IMMUNITY.....	371	KUTARYAXMPA.....	302
KERAGELT.....	352, 771	KINDERMED INFANTS		KUTEA.....	300
KERALYT.....	331	COUGH PLUS.....	5	KUVAN.....	837
KERAMATRIX.....	348	KINDERMED INFANTS		KUVARYA.....	302
KERASTAT.....	309	NIGHT COUGH.....	5	KUVARYE.....	302
KERAXA.....	337	KINERET.....	34	KUXM.....	300
KERENDIA.....	121	Kionex (With Sorbitol).....	360	KYLEENA.....	246
KERIDA.....	329	Kiprofen.....	41	KYNARA.....	329
KERLIX AMD.....	352, 353, 771	KIRSTY.....	458	KYZATREX.....	428
KESIMPTA PEN.....	843	KIRSTY PEN.....	458	<i>l norgest/e.estradiol-e.estrad</i>	
KETARYA.....	301	KISQALI.....	92	.....	247, 258
<i>ketoconazole.....</i>	55, 288	KITABIS PAK.....	886	<i>l. acidophilus-b. coagulans..</i>	497
Ketodan.....	288	KLARITY (CHONDROITIN)		L.E.T. (LIDO-EPINEPH-	
KETODAN KIT.....	288	(PF).....	847	TETRA).....	344
KETONE CARE.....	694, 771	KLARON.....	266	L.E.T.(LIDO-EPINEPH BIT-	
KETONE URINE TEST.....	694, 771	Klayesta.....	285	TETRA).....	344
KETONEX-2.....	392	KLISYRI (250 MG).....	291	<i>labetalol.....</i>	121
<i>ketoprofen.....</i>	41	KLISYRI (350 MG).....	291	<i>lacosamide.....</i>	161
<i>ketorolac.....</i>	38, 39, 858	KLONOPIN.....	157, 159, 203	<i>lactase.....</i>	472
KETOSTIX.....	694, 771	Klor-Con.....	372	<i>lactated ringers.....</i>	360
KEVARAXAP.....	301	Klor-Con 10.....	372	LACTEOL DIARRHEASE....	497
KEVARTIA.....	301	KLOR-CON 8.....	372	LACTEOL DIARRHEASE	
KEVARYA.....	301	Klor-Con M10.....	372	KIDS.....	497
KEVEYIS.....	549	Klor-Con M15.....	372	<i>lactobacillus acidophilus.....</i>	497
KEVZARA.....	35	Klor-Con M20.....	372	<i>lactobacillus acidoph-l.bulgar</i>	
KEXM.....	300	KLOR-CON/EF.....	372	.....	498
KEYA.....	301	KLOXXADO.....	50	LACTOVIVE.....	498
KEYFOLIC.....	382	KOATE.....	531	<i>lactulose.....</i>	471, 507, 508
KHINDIVI.....	448	KOGENATE FS.....	531	LAGEVRIO (EUA).....	78
KIDS BONES-MUSCLES....	362	KONSYL SUGAR-FREE....	506	LAMICTAL.....	168
KIDS BRAIN BUILDER.....	416	KONVOMEF.....	477	LAMICTAL ODT.....	168, 206
KIDS MELATONIN.....	216	KOREAN GINSENG.....	9	LAMICTAL ODT STARTER	
KIDS MULTI ZERO.....	399	KORLYM.....	432	(BLUE).....	168, 206
KIDS SLEEP CALM.....	217	KOSELUGO.....	95	LAMICTAL ODT STARTER	
KIDS SLEEP IMMUNE		KOSHER PRENATAL PLUS		(GREEN).....	168, 206
HEALTH.....	217	IRON.....	402		

LAMICTAL ODT STARTER (ORANGE).....	168, 206	LC PLUS NEBULIZER-PED MASK.....	661, 772	LEVSIN.....	479, 522
LAMICTAL STARTER (BLUE) KIT.....	168, 206	LC-655.....	368	LEVSIN/SL.....	479, 522
LAMICTAL STARTER (GREEN) KIT.....	168, 206	L-CARNITINE.....	356	LEVULAN.....	338
LAMICTAL STARTER (ORANGE) KIT.....	169, 206	L-CARNITINE (TARTRATE).....	355	LEXAPRO.....	175
LAMICTAL XR.....	169	<i>l-cystine</i>	356	Lexette.....	295, 321
LAMICTAL XR STARTER (BLUE).....	169	LDO PLUS.....	344	LIALDA.....	485
LAMICTAL XR STARTER (GREEN).....	169	<i>lecithin, soy</i>	136	LIBERVANT.....	159, 203
LAMICTAL XR STARTER (ORANGE).....	169	LEENA 28.....	258	LIBRAX (WITH CLIDINIUM)	203, 480, 481
LAMIOFLUR.....	466	LEFLUNICLO.....	36, 338	LICART.....	338
<i>lamivudine</i>	62, 69	<i>leflunomide</i>	36	LICE-BEDBUG-MITE BEDDING.....	349
<i>lamivudine-zidovudine</i>	64	<i>lenalidomide</i>	101	<i>licorice root (g.glabra)</i>	9
<i>lamotrigine</i>	169, 206	LENVIMA.....	99	LIDO BDK.....	695
LAMPIT.....	58	LEQEMBI IQLIK.....	242	<i>lidocaine</i>	345
<i>lancets</i>	622, 772	LEQSEVI.....	262	<i>lidocaine hcl</i> ...45, 344, 345, 841	
LANCETS, SUPER THIN	622, 772	Lessina.....	252	<i>lidocaine hcl-hydrocortison ac</i>	47, 327
LANCETS, THIN.....	622, 772	LETAIRIS.....	155	Lidocaine Viscous.....	841
LANCETS, ULTRA THIN	622, 772	<i>letrozole</i>	90	<i>lidocaine-hydrocortisone- aloe</i>	47
<i>lancing device</i>	622, 772	<i>leucovorin calcium</i>	102	<i>lidocaine-prilocaine</i>	334
LANCING DEVICE WITH LANCETS.....	622, 772	LEUKERAN.....	87	<i>lidocaine-racepinep- tetracaine</i>	345
<i>lancing device with lancets</i>	622, 772	LEUKINE.....	534	<i>lidocaine-tetracaine</i>	345
LANCING SYSTEM.....	622, 772	<i>leuprolide</i>	94	Lidocan Iii.....	345
LANOLIN (HPA).....	309	<i>levabuterol hcl</i>	882	Lidocan Iv.....	345
LANOXIN.....	148	<i>levabuterol tartrate</i>	882	Lidocan V.....	345
<i>lansoprazole</i>	474, 475	<i>levamlodipine</i>	145	LIDODERM.....	345
<i>lanthanum</i>	516	LEVBID.....	479, 522	LIDOMARK 1-5.....	45
LANZO LANCING DEVICE	622, 772	<i>levetiracetam</i>	170	LIDOMARK 2-5.....	45
<i>lapatinib</i>	85	LEVICYN ANTIPRURITIC	347, 354	LIDOPIN.....	345
Larin 1.5/30 (21).....	252	LEVICYN ANTIPRURITIC SG.....	307	LIDOPURE PATCH.....	345
Larin 1/20 (21).....	252	LEVICYN DERMAL.....	351	LIDORX.....	345
Larin 24 Fe.....	252	<i>levobunolol</i>	861	LIDTOPIC.....	345
Larin Fe 1.5/30 (28).....	252	<i>levocarnitine</i>	356, 835	LIDTOPIC MAX.....	345
Larin Fe 1/20 (28).....	252	<i>levocarnitine (with sugar)</i>	835	LIKMEZ.....	58
LASIX.....	149	<i>levocarnitine tartrate</i>	356	LILETTA.....	246
<i>latanoprost</i>	867	<i>levocetirizine</i>	875, 876	<i>linezolid</i>	76
LATUDA.....	186	<i>levofloxacin</i>	68, 865	LINZESS.....	471, 483
LAYOLIS FE.....	252	Levonest (28).....	258	Liomny.....	464
LAZCLUZE.....	86	<i>levonorgest-eth.estradiol- iron</i>	253	LIORESAL.....	553
LC PLUS.....	661, 772	<i>levonorgestrel</i>	261, 262	<i>liothyronine</i>	464
		<i>levonorgestrel-ethinyl estrad</i>	253	LIPITOR.....	132
		<i>levonorg-eth estrad triphasic</i>	258	LIPOCHOL PLUS.....	136
		Levora-28.....	253	LIPOFEN.....	130
		<i>levorphanol tartrate</i>	14, 15	LIPO-FLAVONOID.....	359
		LEVO-T.....	464	LIQREV.....	155
		<i>levothyroxine</i>	464	LIQUICAL PLUS.....	362
		LEVOXYL.....	465	LIQUID C.....	420

LIQUID MULTIVITAMIN.....	383	LOMOTIL.....	468	LUPKYNIS.....	546
<i>liraglutide</i>	432	LONSURF.....	90	<i>lurasidone</i>	186
<i>lisdexanfetamine</i>	196	<i>loperamide</i>	467	Lurbipr.....	41
<i>lisinopril</i>	120	LOPID.....	130	Lurbiro.....	41
<i>lisinopril-hydrochlorothiazide</i>		<i>lopinavir-ritonavir</i>	63	<i>lutein</i>	4
.....	119	LOPRESSOR.....	141	LUTEIN PLUS WITH	
LITE TOUCH-MEDIUM		LOPROX (AS OLAMINE)....	287	ZEAXANTHIN.....	4, 383
MASK.....	686, 772	LOPROX KIT.....	287, 288	<i>lutein-zeaxanthin</i>	4
LITEAIRE MDI CHAMBER		<i>lorazepam</i>	157, 203	<i>lutein-zeaxanthin-bilberry ext</i> ...	4
.....	686, 772	Lorazepam Intensol....	157, 203	Lutera (28).....	253
LITETOUCH-LARGE MASK		LORBRENA.....	88	LUXAMEND.....	307
.....	686, 772	LOREEV XR.....	158, 203, 204	LUXIQ.....	322
LITETOUCH-SMALL MASK		LORMATE.....	417	LUZU.....	289
.....	686, 772	Loryna (28).....	253	LYBALVI.....	190, 191, 207
LITFULO.....	262	<i>losartan</i>	125	Lyleq.....	257
<i>lithium carbonate</i>	209	<i>losartan-hydrochlorothiazide</i>	123	Lyllana.....	445
<i>lithium citrate</i>	209	LOTEMAX.....	854	LYNPARZA.....	97
LITHOBID.....	209	LOTEMAX SM.....	855	LYRICA.....	161, 214
LITHOLYTE.....	518	LOTENSIN.....	120	LYRICA CR.....	213, 230, 232
LITHOSTAT.....	518	LOTENSIN HCT.....	120	<i>lysine hcl</i>	356
LITTLE ANIMALS.....	397	<i>loteprednol etabonate</i>	855	LYSODREN.....	88
LIVALO.....	132	Lotrel.....	119	LYTGOBI.....	93
LIVDELZI.....	545	LOTREL.....	119	LYUMJEV KWIKPEN U-100	
LIVER PROTECT.....	4	LOTREXONE.....	12	INSULIN.....	458
LIVITA FOR ADULT.....	383	LOTRONEX.....	483, 504	LYUMJEV KWIKPEN U-200	
LIVITA FOR CHILDREN.....	399	LOUNZDOMDIOXIATAR....	273	INSULIN.....	458
LIVMARLI.....	545	LOUTREX.....	297, 307	LYUMJEV TEMPO PEN(U-	
LIVTENCITY.....	68	<i>lovastatin</i>	132	100)INSULN.....	458
L-MESITRAN SOFT.....	353	Lovaza.....	134	LYUMJEV U-100 INSULIN..	458
LMR PLUS.....	334	LOVENOX.....	540	LYVISPAH.....	553
LO LOESTRIN FE.....	247	Low-Ogestrel (28).....	253	Lyza.....	257
LOCOID.....	322	<i>loxapine succinate</i>	188	<i>maca</i>	9
LOCOID LIPOCREAM.....	321	LOYON.....	307	MACROBID.....	54, 519
Lodine.....	42	Lo-Zumandimine (28).....	253	<i>mafenide acetate</i>	298
LODOCO.....	12	<i>lubiprostone</i>	483, 504	<i>mag citrate-potassium citrate</i>	
LODOSYN.....	183	LUCEMYRA.....	236	.....	372
Loestrin 1.5/30 (21).....	253	LUCIRA CHECK-IT COVID		MAGE.....	498
Loestrin 1/20 (21).....	253	HOME TST.....	602, 773	MAGELLAN INSULIN	
Loestrin Fe 1.5/30 (28-Day)	253	LUER LOCK SYRINGE		SAFETY SYRNG.....	643, 773
Loestrin Fe 1/20 (28-Day)....	253	.....	671, 773	MAGELLAN SAFETY	
Lofena.....	40	LUER SLIP TIP SYRINGE		SYRINGE.....	671, 773
<i>lofexidine</i>	236	TRAY.....	671, 773	MAGELLAN SYRINGE	
LOFRIC.....	694, 773	LUER-LOK TIP.....	671, 773	.....	643, 671, 773
LOFRIC ORIGO.....	694, 773	LUGOLS.....	103, 364	MAGIC3 INTERMITTENT	
LOFRIC PRIMO NELATON		<i>luliconazole</i>	289	CATHETER.....	694, 774
CATHETER.....	694, 773	LUMAKRAS.....	94	<i>magnesium chloride</i>	368
LOFRIC SENSE NELATON		LUMIGAN.....	867	<i>magnesium citrate</i>	368
CATHETER.....	694, 773	LUMRYZ.....	227	<i>magnesium citrate,mag</i>	
Lojaimiess.....	247	LUMRYZ STARTER PACK..	227	<i>oxide</i>	369
LOKELMA.....	360	LUNESTA.....	234		

<i>magnesium citrate-lemon</i>	MAXICOMFORT SAFETY	MEDROL (PAK).....448
<i>balm</i> 369	PEN NEEDLE.....643, 774	MEDROLOAN II SUIK.....448
MAGNESIUM COMPLEX.....369	MAXIDEX.....855	MEDROLOAN SUIK.....448
<i>magnesium gluconate</i> 369	MAXITROL.....850	<i>medroxyprogesterone</i> ..246, 462
<i>magnesium glycinate</i> 369	MAXI-TUSS AC.....893	MEDTRONIC EXT
MAGNESIUM OPTIMIZER..369	MAXI-TUSS CD.....891	INFUSION SET 23".....696, 775
<i>magnesium oxide</i> 369, 467	MAYZENT.....846	MEDTRONIC EXT
MALARONE.....57	MAYZENT STARTER(FOR	INFUSION SET 32".....696, 775
MALARONE PEDIATRIC.....57	1MG MAINT).....846	<i>mefenamic acid</i> 38
<i>malathion</i> 349	MAYZENT STARTER(FOR	<i>mefloquine</i> 57
<i>maraviroc</i> 59	2MG MAINT).....846	MEGARED ADV TOTAL
MAR-COF BP.....891	MB HYDROGEL.....305	BODY REFRESH.....136
MAR-COF CG.....893	MB HYDROGEL	MEGARED ADVANCED 4-
MARINOL.....209, 469, 897	(CYCLOMETHICONE).....305	IN-1.....137
Marlissa (28).....253	MC 300 NEBULIZER W-	MEGARED ADVANCED
MARNATAL-F.....402	MOUTHPIECE.....661, 774	TOTAL BODY.....137
MARPLAN.....173	MC 300 NEBULIZER-	MEGARED OMEGA-3
MARVONA SUIK (PF).....45	UNVRSL TUBING.....661, 774	KRILL OIL.....137
MATERVIA.....411	MCT OIL.....392	<i>megestrol</i> 97, 897, 898
MATULANE.....87	MCT PRO-CAL.....394	MEKAM.....303
Matzim La.....144	<i>meclizine</i> 468	MEKAM HP.....302
MAVENCLAD (10 TABLET	<i>meclofenamate</i> 38	MEKINIST.....95
PACK).....845	<i>mecobalamin (vitamin b12)</i> . 418	MEKTOVI.....95
MAVENCLAD (4 TABLET	MECORIX.....302	<i>melatonin</i> 5, 216
PACK).....845	MECORIX HP.....302	MELATONINMAX.....216
MAVENCLAD (5 TABLET	MECORIX PLUS.....302	<i>melatonin-pyridoxine (vit b6)</i>
PACK).....845	MEDCAPS MENOPAUSE.....9	9, 217
MAVENCLAD (6 TABLET	MEDIHONEY (CAL	<i>melatonin-pyridoxine hcl (b6)</i>
PACK).....845	ALGINATE-HONEY)....353, 774	9, 217
MAVENCLAD (7 TABLET	MEDIHONEY (HONEY).....353	<i>melatonin-theanine</i> 217
PACK).....845	MEDISENSE.....622, 774	Meleya.....257
MAVENCLAD (8 TABLET	MEDISENSE CONTROLS	MELIDU.....303
PACK).....845	1-HI 1-LO.....622, 774	MELONDIS.....303
MAVENCLAD (9 TABLET	MEDISENSE GLUCOSE	MELONDIS PLUS.....303
PACK).....846	KETONE.....622, 774	<i>meloxicam</i> 39
MAVILO.....302	MEDISENSE MID	<i>meloxicam submicronized</i> 40
MAVILO HP.....302	CONTROL.....622, 774	<i>memantine</i> 244
MAVILO LP.....302	MEDISENSE THIN	<i>memantine-donepezil</i> 244
MAVYRET.....70	LANCETS.....622, 774	MEN 50 PLUS
MAX SLEEP JUNIOR.....216	<i>medium chain triglycerides</i> ..392	MULTIVITAMIN.....383
MAXALT.....222	MEDLANCE PLUS	MENEST.....445
MAXALT-MLT.....222	LANCETS.....622, 775	MENOFEM.....10
MAXFE (FOLATE).....368	MEDLANCE PLUS	MENOPUR.....446
MAXICOMFORT II PEN	SPECIAL BLADE.....622, 775	MENOSTAR.....445
NEEDLE.....643, 774	MEDORFA.....301	MENQUADFI (PF).....111
MAXICOMFORT INSULIN	MEDORFA HP.....301	MEN'S 50 PLUS
SYRINGE.....643, 774	MEDORFA HP PLUS.....300	MULTIVITAMIN.....383
MAXI-COMFORT INSULIN	MEDORFA LP.....301	MEN'S DAILY GUMMIES....383
SYRINGE.....643, 774	MEDORFA PLUS.....302	MEN'S DAILY
	MEDROL.....448	MULTIVITAMIN.....383

MEN'S MULTIVITAMIN.....	383	<i>methoxsalen</i>	292	MICRODOT BLOOD	
MEN'S MULTIVITAMIN		<i>methscopolamine</i>	479	GLUCOSE SYSTEM	
GUMMIES.....	383	<i>methsuximide</i>	171	.....	584, 623, 775
MENTHO-CAINE.....	334	METHYL PROTECT.....	416	MICRODOT HIGH-LOW	
MENVEO A-C-Y-W-135-DIP		<i>methyl salicylate</i>	347	CONTROL.....	623, 776
(PF).....	111	<i>methyldopa</i>	147	MICRODOT NORMAL	
<i>meperidine</i>	15	<i>methyldopa-</i>		CONTROL.....	623, 776
<i>meperidine (pf)</i>	15	<i>hydrochlorothiazide</i>	147	MICRODOT XTRA BLOOD	
<i>meprobamate</i>	158	<i>methylene blue (bulk-solid)</i> ..	240	GLUCOSE.....	584, 776
MEPRON.....	58	<i>methylergonovine</i>	461	Microgestin 1.5/30 (21).....	254
<i>mercaptapurine</i>	89	METHYLIN.....	196, 228	Microgestin 1/20 (21).....	254
MERILOG.....	459	<i>methylphenidate</i>	197	Microgestin Fe 1.5/30 (28)...	254
MERILOG SOLOSTAR.....	459	<i>methylphenidate hcl</i>		Microgestin Fe 1/20 (28).....	254
Merzee.....	253	.....	196, 197, 228	MICROLET 2 LANCING	
<i>mesalamine</i>	485	<i>methylprednisolone</i>	448	DEVICE.....	623, 776
<i>mesalamine with cleansing</i>		<i>methyltestosterone</i>	428	MICROLET LANCET...623, 776	
<i>wipe</i>	485	<i>methyltetrahydrofolate</i>		MICROLET NEXT LANCING	
<i>mesna</i>	102	<i>glucos</i>	423	DEVICE.....	623, 776
MESNEX.....	102	<i>metoclopramide hcl</i>	478	MICROLIFE PEAK FLOW	
MESTINON.....	550	<i>metolazone</i>	150	METER.....	681, 776
MESTINON TIMESPAN.....	550	<i>metoprolol succinate</i>	141	MICRONEX.....	389
METADATE CD.....	196	<i>metoprolol ta-</i>		<i>microplegic solution no.1</i>	868
Metadate Er.....	196	<i>hydrochlorothiaz</i>	146	MICROSPACER.....	686, 776
METAMUCIL (INULIN-		<i>metoprolol tartrate</i>	141	MICURADERM.....	297, 307
CORN FIBER).....	506	METROCREAM.....	341	<i>midazolam</i>	44, 204, 234
METANX FC.....	416	METROGEL.....	342	<i>midazolam (pf)</i>	44, 204
<i>metaxalone</i>	553	METROLOTION.....	342	<i>midodrine</i>	147
METDRAY.....	330	<i>metronidazole</i>	58, 342, 895	MIEBO (PF).....	847
METER-CHECK.....	623, 775	<i>metyrosine</i>	153	MIFEPREX.....	425
<i>metformin</i>	459, 460	<i>mexiletine</i>	127	<i>mifepristone</i>	425, 432
<i>methadone</i>	15	MIACALCIN.....	441	MIGERGOT.....	220
Methadone Intensol.....	15	Mibelas 24 Fe.....	254	<i>miglitol</i>	430
METHADOSE.....	15	MICARDIS.....	125	<i>miglustat</i>	835
Methadose.....	15	MICARDIS HCT.....	123	MIGRANAL.....	220
<i>methamphetamine</i>	196, 212	<i>miconazole nitrate-zinc ox-</i>		MIGRANOW.....	222
<i>methazolamide</i>	148	<i>pet</i>	289	Mili.....	254
<i>methenamine hippurate</i> ..	74, 519	MICONAZOLE-3.....	894	<i>milk thistle</i>	10
<i>methenamine mandelate</i>		MICORT-HC.....	46, 322	<i>milk thistle sd ext-blessed th</i> ..	10
.....	74, 519	MICRO BLOOD GLUCOSE		<i>milk thistle seed extract</i>	10
<i>methen-sod phos-meth blue-</i>		.....	583, 775	MIMORA.....	303
<i>hyos</i>	75, 521	MICRO THIN LANCETS		Mimvey.....	442
<i>me-thfolate glucos-</i>		.....	623, 775	MINCORA.....	416
<i>mecobalamin</i>	417	MICROAIR MESH		MIND AND MEMORY.....	10
<i>methimazole</i>	437	NEBULIZER.....	661, 775	MINERIN CREME.....	307
METHIONINE.....	356, 393	MICROCHAMBER.....	686, 775	MINI LANCING DEVICE	
METHITEST.....	428	MICROCYN.....	103, 351	.....	623, 776
<i>methocarbamol</i>	553			MINI MULTIVITAMINS-	
METHOCEL E 4 M.....	242			IRON.....	389
<i>methotrexate sodium</i>	32, 89				
<i>methotrexate sodium (pf)</i> ..	32, 89				

MINI PLUS NEBULIZER		MIRODERM		MONOJECT 35CC	
.....661, 776		FENESTRATED PLUS.....348		SYRINGE CATH TIP ...671, 778	
MINI PRENATAL.....402		MIRODRY WOUND		MONOJECT 3CC SYR	
MINI ULTRA-THIN II....643, 776		MATRIX.....349		25GX1".....671, 778	
MINI WRIGHT PEAK FLOW		MIROTRACT.....349		MONOJECT ALLERGY	
METER.....681, 776		<i>mirtazapine</i> 173		TRAY.....672, 778	
MINIMED 630G INSULIN		MIRVASO.....342		MONOJECT ALLERGY	
PUMP.....692, 776		<i>misoprostol</i> 477		TRAY DETACH.....672, 778	
MINIMED 770G INSULIN		MITIGARE.....524		MONOJECT BLOOD	
PUMP.....693, 776		<i>mitomycin (pf) in water</i> 852		COLLECTION.....555, 778	
MINIMED 780G INSULIN		MITOPRIME.....4		MONOJECT CONTROL	
PUMP.....693, 777		MITOSOL.....852		SYRINGE LUER.....672, 778	
MINIMED MIO ADVANCE		MIUDELLA.....246		MONOJECT DISPOSABLE	
INF SET23".....696, 777		MI-VITE RX.....424		SYRINGE.....672, 778	
MINIMED MIO ADVANCE		MKO (MIDAZOLAM-		MONOJECT ECCENTRIC	
INF SET43".....696, 777		KETAMINE-ONDAN).....44		NON-STERILE.....672, 778	
MINIMED QUICK SET 18"		MMA-PA GEL.....395		MONOJECT HYPODERMIC	
.....696, 777		M-M-R II (PF).....108, 116, 117		NEEDLES.....672, 779	
MINIMED QUICK SET 23"		M-NATAL PLUS.....402		MONOJECT INSULIN	
.....696, 777		MNEXSPIKE 2025-2026		SAFETY SYRING.....644, 779	
MINIMED QUICK SET 32"		(PF).....113		MONOJECT INSULIN	
.....696, 777		MOBILE LANCETS.....623, 777		SYRINGE.....644, 779	
MINIMED QUICK SET 43"		<i>modafinil</i> 227		MONOJECT LUER	
.....696, 777		MODD1 PATIENT		ADAPTER.....680, 779	
MINIMED QUICK-SERTER		WELCOME KIT.....691, 778		MONOJECT LUER-LOCK	
(MMT-395).....623, 777		MODD1 SUPPLY KIT..697, 778		TIP.....672, 779	
MINIMED SILHOUETTE 18"		MODERNA COVID 24-		MONOJECT MAGELLAN	
.....696, 777		25(6M-11Y)PF.....113		SYRINGE.....672, 780	
MINIMED SILHOUETTE 23"		MODEYSO.....84		MONOJECT PHARMACY	
.....696, 777		<i>moexipril</i> 120		TRAY LUER.....672, 673, 780	
MINIMED SILHOUETTE 32"		MOISTURIZING CREAM....307		MONOJECT PHARMACY	
.....696, 777		MOISTURIZING NORMAL-		TRAY REG TIP.....673, 780	
MINIMED SILHOUETTE 43"		DRY SKIN.....304		MONOJECT PREFILL	
.....696, 777		MOITURIZING LOTION.....307		ADVANCED NS.....413	
MINIMED SURE T 18".696, 777		MOKURA.....303		MONOJECT REG TIP NON-	
MINIMED SURE T 23".696, 777		MOKURA LP.....303		STERILE.....673, 780	
MINIMED SURE T 32".697, 777		MOKURA MOD.....303		MONOJECT REGULAR	
MINIVELLE.....445		MOKURA PLUS.....303		LUER.....673, 780, 781	
<i>minocycline</i> 36, 82, 263, 264		MOLEXI.....303		MONOJECT SAFETY LUER	
<i>minoxidil</i> 148		<i>molindone</i> 188		LOCK TIP.....673, 781	
MINREX.....370		<i>mometasone</i> 322, 889		MONOJECT SAFETY	
Minzoya.....254		Mondoxylene NI.....82		SYRINGES.....673, 674, 781	
MIPLYFFA.....834		MONISTAT MAINTAIN.....896		MONOJECT SMARTIP	
MIRAPEX ER.....184		MONO-FLO DRAINAGE		CANNULA.....674, 781	
MIRCERA.....528		BAG.....633, 778		MONOJECT SYRINGE	
MIRENA.....246		MONOJECT 0.9% SODIUM		644, 674, 675, 782	
MIRO3D.....348		CHLORIDE.....413		MONOJECT SYRINGE	
MIRO3D FIBERS.....348		MONOJECT 140CC		LUER LOK.....674, 781	
MIRODERM		PISTON SYRINGE.....671, 778		MONOJECT SYRINGE	
FENESTRATED.....349				REGULAR LUER.....674, 781	

MONOJECT SYRINGE		MYFORTIC.....547
TOOMEY TYPE.....675, 782	MULTI PRO.....383	MYGLUCOHEALTH
MONOJECT TB.....675, 782	MULTIA DAILY	584, 623, 783
MONOJECT TB LUER LOK	MULTIVITAMIN.....383	MYGLUCOHEALTH
.....675, 782	MULTI-LANCET DEVICE 2	CONTROL SOLUTION623, 783
MONOJECT TB REGULAR	623, 783	MYGLUCOHEALTH
LUER TIP.....675, 782	MULTITOL-M.....383	LANCETS.....623, 783
MONOJECT TB SAFETY	<i>multivit with min-folic acid</i>	MYHIBBIN.....547
SYRINGE.....675, 782	383, 384	MYLERAN.....86
MONOJECT TUBERCULIN	<i>multivit,calc,min-fa-k1-lycop</i> 384	MYLK.....362
SYRINGE.....675, 783	<i>multivitamin</i> 389	MYNATAL.....402
MONOJECT ULTRA	MULTIVITAMIN GUMMIES.384	MYNATAL ADVANCE.....402
COMFORT INSULIN... 644, 783	MULTI-VITAMIN WITH	MYNATAL PLUS.....402
MONOLET LANCETS.623, 783	FLUORIDE.....399, 400	MYNATAL-Z.....403
MONOLET THIN LANCETS	MULTIVITAMIN WOMEN 50	MYNATE 90 PLUS.....403
.....623, 783	PLUS.....384	MYRBETRIQ.....514
Mono-Linyah.....254	MULTIVITAMIN-ZINC-	MYROSINASE.....10
MONOVISC.....551	STRESS.....357	MYSOLINE.....159
MONSEL'S.....536	MULTI-VIT-FLOR.....400	MYTESI.....467
<i>montelukast</i> 879	MULTIVIT-FLUORIDE	MYTHIUS.....303
MONUROL.....54, 520	(METAFOLIN).....400	MYVORI.....303
Morgidox.....83	<i>multivit-min-ferrous fumarate</i>	MYXREDLIN.....454
MORGIDOX 1X 50.....82	384	N.O.MAX ER.....356
MORGIDOX 1X100.....83	<i>multivit-min-ferrous</i>	<i>nabumetone</i> 39
MORGIDOX 2X100.....83	<i>gluconate</i> 384	<i>nadolol</i> 142
<i>moringa oleifera</i> 10	<i>mupirocin</i> 283	<i>naftifine</i> 285
<i>morphine</i> 15, 16	<i>mupirocin calcium</i> 283	NAFTIN.....285
<i>morphine (pf)</i> 15	MURI-LUBE.....240	<i>nalbuphine</i> 27
<i>morphine concentrate</i> 15	MUSCUSOLICE.....335	Nalocet.....23, 25
<i>morphine in 0.9 % sodium</i>	MVW COMPLETE FORM	<i>naloxone</i> 50
<i>chlor</i> 15	PROBIOT MINI.....498	NALTREX.....12
MOTEGRITY.....477	MVW COMPLETE FORMUL	<i>naltrexone</i> 237
MOTOFEN.....468	PROBIOTIC.....498	NAMENDA TITRATION PAK
MOTPOLY XR.....161	MVW MODULATOR	244
MOUNJARO.....431	FORMUL MULTIVIT.....384	NAMENDA XR.....244
MOVANTIK.....50	MVW MODULATR FORM	NAMZARIC.....245
MOVE FREE PLUS MSM-	MINI MULTIVT.....384	NANO 2ND GEN PEN
VIT D3.....2	MVW MODULATR	NEEDLE.....644, 783
MOVIPREP.....508	FORMLTN PEDIATRIC.....399	NANO PEN NEEDLE..644, 783
MOXATAG.....52	MY CHOICE.....261, 262	NANOVN ADULT.....384
MOXICAINE.....345	MY WAY.....261, 262	NANRAN.....283
<i>moxifloxacin</i> 68, 865	MYALEPT.....460	NAPROSYN.....41
<i>moxifloxacin-bromfenac</i> 851	MYCAPSSA.....462	NAPROXIN.....38
MRESVIA (PF).....104	<i>mycophenolate mofetil</i> ...34, 547	<i>naproxen</i> 41, 42
MS CONTIN.....16	<i>mycophenolate sodium</i> 547	<i>naproxen sodium</i> 42
MSUD GEL POWDER.....393	MYDAYIS.....197, 210	<i>naproxen-esomeprazole</i> 38
MUCOSITISRX.....841	MYDCOMBI.....848	<i>naratriptan</i> 222
MUGARD.....842	Mydriacyl.....852	NARCAN.....50
MULPLETA.....544	MYDRIATIC4(TROP-PROP-	NARDIL.....173
MULTAQ.....128	PE-KTRLC).....862	NATACYN.....865, 866
	MYFEMBREE.....461	

NATAL PNV.....	411	NESTABS DHA.....	403	NILANDRON.....	88
NATAZIA.....	258	NESTABS ONE.....	389	<i>nilotinib hcl</i>	99
<i>nateglinide</i>	432	Neuac.....	269	<i>nilutamide</i>	88
NATESTO.....	428	NEUAC KIT.....	269	<i>nimodipine</i>	144
NATROBA.....	349	NEULASTA.....	533	NINJACOF-XG.....	893
NAYZILAM.....	159, 204	NEULASTA ONPRO.....	533	NINLARO.....	97
<i>nebivolol</i>	141	NEUPOGEN.....	533	<i>nisoldipine</i>	145
<i>nebulizer and compressor</i>	686, 783	NEUPRO.....	185	<i>nitazoxanide</i>	58
NEBUPENT.....	74	NEURAPTINE.....	335	<i>nitisinone</i>	836
NEBUSAL.....	241	NEURIVA ORIGINAL.....	10	Nitro-Bid.....	125
Necon 0.5/35 (28).....	254	NEURONTIN.....	161	NITRO-DUR.....	125, 126
<i>nefazodone</i>	176	NEUTEK 2TEK TEST STRIPS.....	585, 784	<i>nitrofurantoin</i>	54, 520
NEFFY.....	146	NEVANAC.....	858	<i>nitrofurantoin macrocrystal</i>	54, 520
NEMLUVIO.....	262	<i>nevirapine</i>	61	<i>nitrofurantoin monohyd/m-</i> <i>cryst</i>	54, 520
NENDRUX.....	330	NEW DAY.....	261, 262	<i>nitroglycerin</i>	46, 126
NEOCATE JUNIOR WITH PREBIOTICS.....	394	NEW SKIN BOTANICALS...	338	NITROLINGUAL.....	126
<i>neomycin</i>	51	NEW SKIN KIDS.....	339	NITROMIST.....	126
<i>neomycin-bacitracin-poly-hc</i>	850	NEW SKIN SENSITIVE.....	339	NITROSTAT.....	126
<i>neomycin-bacitracin-</i> <i>polymyxin</i>	864	NEW ZEALAND WHEY PROTEIN.....	396	NITRO-TIME.....	126
<i>neomycin-polymyxin b gu</i>	513	NEWFLORA.....	498	NITYR.....	836
<i>neomycin-polymyxin b-</i> <i>dexameth</i>	850	NEWGEN.....	403	NIVA THYROID.....	463
<i>neomycin-polymyxin-</i> <i>gramicidin</i>	864	NEXA PLUS.....	403	NIVESTYM.....	533
<i>neomycin-polymyxin-hc</i>	850, 870	NEXAVAR.....	96	NIX LICE PREVENTION....	349
NEONATAL COMPLETE...	403	NEXIUM.....	475	<i>nizatidine</i>	473
NEONATAL FE.....	366	NEXIUM PACKET.....	475	NOBELA.....	334
NEONATAL PLUS VITAMIN	403	NEXIVA.....	657, 784	NOC DURNA (MEN).....	429
NEONATAL-DHA.....	403	NEXLETOL.....	128	NOC DURNA (WOMEN)....	430
NEOPHE.....	395	NEXLIZET.....	139	NOLIRA.....	345
Neo-Polycin.....	864	NEXOBRID.....	298	NORA-BE.....	257
Neo-Polycin Hc.....	850	NEXPLANON.....	245	NORDITROPIN FLEXPRO..	451
NEORAL.....	34, 546	NEXTSTELLIS.....	254	<i>norelgestromin-</i> <i>ethin.estradiol</i>	260
NEOSALUS.....	307	NGENLA.....	451	<i>noreth-ethinyl estradiol-iron</i> ..	254
NEO-SYNALAR.....	285	<i>niacin</i>	134, 419	<i>norethindrone</i> (<i>contraceptive</i>).....	257
NEO-SYNALAR KIT.....	285	<i>niacin (inositol niacinate)</i>	419	<i>norethindrone acetate</i>	462
NEO-VITAL RX.....	403	<i>niacinamide</i>	419	<i>norethindrone ac-eth</i> <i>estradiol</i>	254, 442
NEOVITE.....	384	Niacor.....	134	<i>norethindrone-e.estradiol-</i> <i>iron</i>	254, 255
NEPHRO VITAMINS.....	357	<i>nicardipine</i>	145	Norgesic Forte.....	552
NEPHRON FA.....	357	NICOTINAMIDE (WITH CHROMIUM).....	384	<i>norgestimate-ethinyl</i> <i>estradiol</i>	255, 259
NEPHRO-VITE.....	357	<i>nicotine</i>	238	NORITATE.....	342
NEPRO CARB STEADY....	394	<i>nicotine (polacrilex)</i>	237, 238	NORLIQVA.....	145
NERLYNX.....	86	NICOTROL NS.....	238	NORMAL SALINE FLUSH...	413
NESINA.....	430	<i>nifedipine</i>	145	NORM-JECT.....	675, 676, 784
NESTABS ABC.....	403	NIFEREX (FERROUS ASPARTO GLYC).....	368		
		NIGHTTIME UNDERPANTS L-XL.....	633, 784		
		Nikki (28).....	254		

NORM-JECT TUBERKULIN 676, 784	NOVOLOG PENFILL U-100 INSULIN..... 459	NYVEPRIA..... 533
NORMLGEL AG..... 283	NOVOLOG U-100 INSULIN ASPART..... 459	OASIS ULTRA FENESTRATED..... 350, 785
NORPACE..... 127	NOVOPEN ECHO..... 645, 785	OASIS WOUND MATRIX FENESTRATED..... 350, 785
NORPACE CR..... 126	NOVOSEVEN RT..... 529	OASIS WOUND MATRIX MESHED..... 350, 785
NORPRAMIN..... 180	NOXAFIL..... 55	OB COMPLETE..... 384
NORTHERA..... 147	NOXIPAK..... 326	OB COMPLETE ONE..... 403
Nortrel 0.5/35 (28)..... 255	NP THYROID..... 463	OB COMPLETE PETITE..... 403
NORTREL 1/35 (21)..... 255	NRF2 ACTIVATOR..... 10	OB COMPLETE PREMIER..... 403
Nortrel 1/35 (28)..... 255	NUBEQA..... 88	OB COMPLETE WITH DHA..... 404
Nortrel 7/7/7 (28)..... 259	NUCALA..... 878, 879	OBAGI ELASTIDERM..... 301
<i>nortriptyline</i> 180	NUCORT..... 327	OBAGI NU-DERM BLENDER..... 301
NORVASC..... 145	NUCYNTA..... 17	OBAGI NU-DERM CLEAR.. 301
NORVIR..... 77	NUCYNTA ER..... 17	OBAGI NU-DERM SUNFADER..... 303
NOSE CLIP..... 686, 784	NUDEXTA..... 233	OBAGI-C CLARIFYING SERUM..... 303
NOURIANZ..... 182	NUGUT BOWEL SUPPORT PROBIOTIC..... 498	OBAGI-C THERAPY NIGHT 303
NOVA MAX GLUCOSE TEST..... 585, 784	NU-IRON..... 366	OBIZUR..... 532
NOVA MAX PLUS GLUC- KETON METER..... 599, 784	NUJO..... 299	OBSTETRIX DHA..... 404
NOVA SAFETY LANCETS 623, 785	NUJU..... 299	OBSTETRIX DHA PRENATAL DUO..... 404
NOVA SUREFLEX LANCETS..... 623, 785	NULEV..... 479, 522	OBSTETRIX EC..... 404
NOVACORT..... 328	NULIBRY..... 834	OBSTETRIX ONE..... 389, 390, 404
NOVAFERRUM YAY IRON..... 368	NUMBONEX..... 345	OBSTETRIX DHA..... 404
NOVAMAX PLUS GLU-KET 623, 785	NUMBRINO..... 888	OBTREX DHA..... 404
NOVAREL..... 452	NUMOISYN..... 10, 841	OALIVA..... 545
NOVAVAX COVID 2024- 25(PF)(EUA)..... 113	NUPLAZID..... 190	OCELLA..... 255
NOVOEIGHT..... 531	NURTEC ODT..... 219	OCM..... 353
NOVOFINE 32..... 644, 785	NUTRASEB..... 307	<i>octreotide acetate</i> 462, 463, 511
NOVOFINE PLUS..... 645, 785	NUTRISOURCE FIBER..... 506	OCUFLOX..... 865
NOVOLIN 70/30 U-100 INSULIN..... 453	NUTROPIN AQ NUSPIN..... 451	OCUSOFT LID SCRUB ALLERGY..... 309
NOVOLIN 70-30 FLEXPEN U-100..... 453	NUVA III..... 690, 785	ODACTRA..... 105
NOVOLIN N FLEXPEN..... 453	NUVAGEL..... 690, 785	ODEFSEY..... 65
NOVOLIN N NPH U-100 INSULIN..... 453	NUVARING..... 261	ODOMZO..... 93
NOVOLIN R FLEXPEN..... 454	NUVAXOVID 2025-2026 (PF)..... 113	OFEV..... 99, 893
NOVOLIN R REGULAR U100 INSULIN..... 454	NUVAZIL II..... 690, 785	OFF ACTIVE..... 330
NOVOLOG FLEXPEN U- 100 INSULIN..... 459	NUVESSA..... 895	OFF DEEP WOODS..... 330
NOVOLOG MIX 70-30 U- 100 INSULN..... 454	NUVIGIL..... 227	<i>ofloxacin</i> 68, 865, 870
NOVOLOG MIX 70- 30FLEXPEN U-100..... 455	NUWIQ..... 531	OGSIVEO..... 84
	NUZYRA..... 51, 83	OHTUVAYRE..... 871
	Nyamyc..... 285	OJEMDA..... 91
	Nylia 1/35 (28)..... 255	OJJAARA..... 84
	Nylia 7/7/7 (28)..... 259	<i>olanzapine</i> 190, 207
	NYMALIZE..... 144	
	NYNUTEY..... 345	
	NYPOZI..... 533	
	<i>nystatin</i> 54, 286, 840	
	<i>nystatin-triamcinolone</i> 290	
	Nystop..... 286	

<i>olanzapine-fluoxetine</i>	179, 190, 208	OMNIPOD 5 INTRO(G6/LIBRE2PLUS).....	692, 786	ONE-A-DAY PRENATAL-1. 404
<i>olive oil</i>	240	OMNIPOD DASH INTRO KIT (GEN 4).....	692, 786	ONE-A-DAY TRUBIOTICS..499
<i>olmesartan</i>	125	OMNIPOD DASH PDM KIT (GEN 4).....	645, 786	ONE-A-DAY WOMEN VITACRAVES.....385
<i>olmesartan-amlodipin- hcthiazid</i>	122	OMNIPOD DASH PODS (GEN 4).....	692, 786	ONE-A-DAY WOMEN'S 50 PLUS.....385
<i>olmesartan- hydrochlorothiazide</i>	123	OMNITROPE.....	451	ONE-A-DAY WOMEN'S COMPLETE.....385
<i>olopatadine</i>	852, 889	OMVOH.....	484	ONE-DAILY MULTI.....386
OLPRUVA.....	836	OMVOH PEN.....	484	ONETOUCH DELICA PLUS LANC DEV.....624, 787
OLUMIANT.....	35, 262	ON CALL EXPRESS CONTROL.....	624, 786	ONETOUCH DELICA PLUS LANCET.....624, 787
OLUX.....	322	ON CALL EXPRESS METER.....	624, 786	ONETOUCH DELICA SAFETY LANCET.....624, 787
OLUX-E.....	322	ON CALL EXPRESS TEST STRIP.....	585, 786	ONETOUCH ULTRA CONTROL.....624, 787
OMBRA COMPRESSOR SYSTEM.....	686, 785	ON CALL LANCET.....	624, 786	ONETOUCH ULTRA TEST 586, 787
OMECLAMOX-PAK.....	482	ON CALL LANCING DEVICE.....	624, 786	ONETOUCH ULTRA2 METER.....624, 787
<i>omega 3-dha-epa-fish oil</i>	137	ONAPGO.....	185	ONETOUCH ULTRASOFT 2 LANCET.....624, 787
OMEGA MONOPURE.....	137	ONCOPLEX.....	10	ONETOUCH VERIO FLEX METER.....624, 787
OMEGA MONOPURE DHA EC.....	137	ONCOPLEX ES.....	10	ONETOUCH VERIO HIGH CONTROL.....624, 787
OMEGA MONOPURE EPA EC.....	137	<i>ondansetron</i>	470	ONETOUCH VERIO MID CONTROL.....624, 787
<i>omega-3 acid ethyl esters</i> ...	134	<i>ondansetron hcl</i>	470	ONETOUCH VERIO REFLECT METER.....624, 787
<i>omega-3 fatty acids-fish oil</i> ..	137	ONE A DAY MEN COMPLETE.....	384	ONETOUCH VERIO TEST STRIPS.....586, 788
OMEGA-3 KRILL OIL.....	137	ONE DAILY ESSENTIAL....	384	ONEVITE DAILY MULTIVITAMIN.....390
<i>omega-3s-dha-epa-fish oil</i> ...	137	ONE DAILY MEN'S 50 PLUS W-D3.....	385	ONEXTON.....269
OMEGAPURE 900-TG.....	138	ONE DAILY MEN'S HEALTH.....	385	ONFI.....159, 204
OMEGAPURE PRM.....	138	ONE DAILY MULTI-VIT W- MINERAL.....	385	ONGENTYS.....183
OMEGAPURE-600 EC.....	138	ONE DAILY MULTIVITAMIN	390	ON-GO COVID-19 AG AT HOME TEST.....602, 788
OMEGAPURE-780 EC.....	138	ONE DAILY MULTIVITAMIN-IRON.....	385	ON-THE-GO LANCETS 624, 788
OMEGAPURE-820.....	138	ONE DAILY PRENATAL....	404	ONUREG.....90
OMEGAPURE-900 EC.....	138	ONE DAILY WOMEN 50 PLUS(VIT K).....	385	ONYDA XR.....192
<i>omeprazole</i>	475	ONE DAILY WOMEN'S.....	385	ONZDEAXIADEMTAR.....273
<i>omeprazole-sodium bicarbonate</i>	477	ONE-A-DAY MEN VITACRAVES.....	385	ONZDEAXIADEMTAR.....273
OMEZA.....	353	ONE-A-DAY MEN'S 50 PLUS.....	385	ONZDEAXIATAR.....273
OMNARIS.....	889	ONE-A-DAY MEN'S COMPLETE.....	385	ONZDEAXIAVAR.....273
OMNI-BIOTIC AB-10.....	498	ONE-A-DAY PRENATAL....	411	ONZDEAXIAZAR.....273
OMNI-BIOTIC BALANCE....	498			ONZDEOXIA.....269
OMNI-BIOTIC HETOX.....	498			
OMNI-BIOTIC PANDA.....	498			
OMNI-BIOTIC STRESS RELEASE.....	499			
OMNIPOD 5 (G6/LIBRE 2 PLUS).....	691, 785			
OMNIPOD 5 G6-G7 INTRO KT(GEN5).....	691, 786			
OMNIPOD 5 G6-G7 PODS (GEN 5).....	692, 786			

ONZETRA XSAIL.....	222	ORIAHNN.....	461	OXISTAT.....	289
OPCICON ONE-STEP 261, 262		ORILISSA.....	461	OXTELLAR XR.....	164, 165
OPFOLDA.....	834	ORKAMBI.....	887	<i>oxybutynin chloride</i>	523
OPILL.....	257	ORLADEYO.....	153	<i>oxycodone</i>	17
OPIPZA.....	191, 208	ORLYNVAH.....	51	<i>oxycodone-acetaminophen</i>	23, 24, 25
<i>opium tincture</i>	467, 468	Ormalvi.....	549	OXYCONTIN.....	17
OPSUMIT.....	155	<i>orphenadrine citrate</i>	553	<i>oxymorphone</i>	18
OPSYNVI.....	118	<i>orphenadrine-asa-caffeine</i> ...	552	OXYTROL.....	523
OPTICHAMBER ADULT		Orphengesic Forte.....	552	OYSTER SHELL CALCIUM	
MASK-LARGE.....	686, 788	Orquidea.....	257	500.....	361
OPTICHAMBER DIAMOND		ORSERDU.....	100	OYSTER SHELL CALCIUM-	
LG MASK.....	686, 788	ORTHAPHEN.....	337	VIT D3.....	364
OPTICHAMBER DIAMOND		ORTHOVISC.....	551	OZEMPIC.....	432
VHC.....	686, 788	ORTIKOS.....	486	OZOBAX.....	553
OPTICHAMBER DIAMOND-		OSAPLEX.....	363	Pacerone.....	128
MED MSK.....	686, 788	OSAPLEX MK-7.....	363	PACNEX HP.....	274
OPTICHAMBER DIAMOND-		OSCIMIN.....	479, 522	PACNEX LP.....	274
SML MASK.....	687, 788	OSCIMIN SL.....	479, 522	PAIN EASE MEDIUM	
OPTICLEANSE GHI.....	394	<i>oseltamivir</i>	72	STREAM SPRAY.....	335
OPTIMAG 125.....	369	OSENI.....	436	PAIN EASE MIST SPRAY...	335
OPTIMAG NEURO.....	369	OSMOLEX ER.....	185	PAINGO KFT.....	334
OPTIMAG PLUS CALCIUM	363	OSSOPAN MD.....	361	PALFORZIA (LEVEL 0).....	109
OPTION-2.....	261, 262	OSSOPAN-1100.....	361	PALFORZIA (LEVEL 1).....	109
OPTIUM EZ.....	586, 788	OSTACHOL.....	415	PALFORZIA (LEVEL 2).....	109
OPTIUM TEST.....	587, 789	OSTEOPRIME PLUS CALC-		PALFORZIA (LEVEL 3).....	109
OPVEE.....	50	MAGNESIUM.....	363	PALFORZIA (LEVEL 4).....	109
OPZELURA.....	282	OTEZLA.....	36, 296	PALFORZIA (LEVEL 5).....	109
ORACEA.....	83, 340	OTEZLA STARTER.....	36, 296	PALFORZIA (LEVEL 6).....	109
ORACIT.....	519	OTOVEL.....	870	PALFORZIA (LEVEL 7).....	109
ORALAIR.....	105	OVACE.....	297	PALFORZIA (LEVEL 8).....	109
Oralone.....	841	OVACE PLUS.....	297	PALFORZIA (LEVEL 9).....	110
ORALYTE.....	371	OVACE PLUS SHAMPOO..	297	PALFORZIA (LEVEL 10).....	110
ORAMAGICRX.....	842	OVACE PLUS WASH.....	297	PALFORZIA (LEVEL 11 UP-	
ORAPEUTIC.....	842	OVAL TAPE.....	624, 789	DOSE).....	110
ORAPRED ODT.....	448	OVEGA-3.....	138	PALFORZIA INITIAL (1-3	
ORAVIG.....	55	OVIDE.....	349	YRS).....	110
ORAXINOL.....	10	OVIDREL.....	452	PALFORZIA INITIAL (4-17	
<i>oregano oil-flaxseed oil</i>	10	<i>oxaprozin</i>	42	YRS).....	110
ORENCIA.....	33	<i>oxazepam</i>	158, 204	PALFORZIA LEVEL 11	
ORENCIA CLICKJECT.....	33	<i>oxcarbazepine</i>	163, 164	MAINTENANCE.....	110
ORENITRAM.....	153	OXERVATE.....	860	<i>paliperidone</i>	187
ORENITRAM MONTH 1		OXIAICE.....	267	PALYNZIQ.....	838
TITRATION KT.....	153	OXIANUJO.....	299	PAMELOR.....	180
ORENITRAM MONTH 2		OXIANUJO (WITH		PANCREAZE.....	472
TITRATION KT.....	153	HYALURONATE).....	299	PANDEL.....	322
ORENITRAM MONTH 3		OXIATAR.....	275	PANRETIN.....	292
TITRATION KT.....	153	OXIAVARRY.....	275	<i>pantoprazole</i>	475
ORFADIN.....	836	OXIAVARY.....	275	PANXYME PH.....	472
ORGANIC NIPPLE BALM...	308	OXIAZAR.....	275	<i>papaverine</i>	152
ORGOVYX.....	94	<i>oxiconazole</i>	289		

PAPAYA DIGESTIVE		PEDIATRIC COMP-AIR		PERTZYE.....	472
ENZYME CMPLX.....	473	COMPRES NEB.....	687, 790	PETROLEUM GAUZE.....	605, 790
PARADIGM RESERVOIR		PEDIATRIC D-VITE.....	422	PFLEX INSPIRATORY	
.....	645, 789	PEDIATRIC ELECTROLYTE		TRAINER.....	687, 790
PARAGARD T 380A.....	246	.....	371	PHARMABASE BARRIER...	339
PARAGARD T380A		<i>pediatric multivitamin no.171</i>		PHARMACIST CHOICE	
(SINGLE HAND).....	246	.....	397	.....	587, 791
PARI BABY CONV KIT -		PEDIATRIC POLY-VITE.....	397	PHARMACIST CHOICE	
SIZE 1.....	687, 789	PEDIATRIC POLY-VITE		GLUCOSE SYS.....	624, 790
PARI BABY CONV KIT -		WITH IRON.....	399	PHASEAL ASSEMBLY	
SIZE 2.....	687, 789	PEDIATRIC TRI-VITE.....	397	FIXTURE.....	680, 791
PARI BABY CONV KIT -		<i>peg 3350-electrolytes.....</i>	509	PHASEAL CONNECTOR	
SIZE 3.....	687, 789	<i>peg3350-sod sul-nacl-kcl-</i>		LUER LOCK.....	680, 791
PARI LC SPRINT		<i>asb-c.....</i>	509	PHASEAL INFUSION	
NEBULIZER SET.....	661, 789	PEGASYS.....	70	ADAPTER.....	680, 791
PARI LC SPRINT SINUS		<i>peg-electrolyte soln.....</i>	509	PHASEAL INFUSION	
.....	661, 789	PEMAZYRE.....	93	CLAMP.....	680, 791
PARI TREK S COMBO		PEN NEEDLE.....	645, 790	PHASEAL INJECTOR LUER	
PACK.....	687, 789	<i>pen needle, diabetic....</i>	645, 790	.....	680, 791
PARI TREK S COMPACT		<i>pen needle, diabetic, safety</i>		PHASEAL INJECTOR LUER	
COMPRESSOR.....	687, 789	.....	645, 790	LOCK.....	680, 791
PARI TREK S PORTABLE		PENBRAYA (PF).....	111	PHASEAL PROTECTOR	
PWR KIT.....	687, 789	<i>penciclovir.....</i>	298	.....	680, 791
<i>paricalcitol.....</i>	834	<i>penicillamine.....</i>	36, 49	PHASEAL SECONDARY	
PARNATE.....	173	<i>penicillin v potassium.....</i>	76	SET.....	657, 791
<i>paroxetine hcl.....</i>	175	<i>pentamidine.....</i>	74	PHASEAL Y-SITE.....	657, 791
<i>paroxetine</i>		PENTASA.....	486	PHEBURANE.....	836
<i>mesylate(menop.sym).....</i>	461	<i>pentazocine-naloxone.....</i>	27	PHEDRAX.....	286
PASER.....	65	PENTIPS PEN NEEDLE		<i>phenazopyridine.....</i>	519
PAXIL.....	175	.....	645, 790	<i>phenelzine.....</i>	173
PAXIL CR.....	175	<i>pentoxifylline.....</i>	534	Phenergan.....	469, 873, 875
PAXLOVID.....	78	Pepcid.....	473	PHENEX-1.....	359, 395
PAXLYTE.....	417	PEPCIX.....	373	PHENEX-2.....	395
<i>pazopanib.....</i>	99	PEPTAMEN JUNIOR PHGG		<i>phenobarb-hyoscy-atropine-</i>	
PCCA ACCUPEN-15...603, 789		.....	394	<i>scop.....</i>	481
PCCA SUSPENDIT		<i>perampanel.....</i>	158, 159	<i>phenobarbital.....</i>	159, 233
ANHYDROUS.....	241	Percocet.....	24, 25	PHENOHYTRO.....	481, 482
PEAK AIR PEAK FLOW		PERFECT POINT SAFETY		<i>phenol.....</i>	104
METER.....	681, 789	LANCETS.....	624, 790	<i>phenoxybenzamine.....</i>	152
<i>pedi multivit no.194-iron sulf</i>	399	PERFOROMIST.....	882	<i>phenylalanine.....</i>	356
PEDIALYTE		PERIDEX.....	840	<i>phenylephrine hcl.....</i>	860
ELECTROLYTE.....	371	<i>perindopril erbumine.....</i>	120	<i>phenyleph-tropicamide in</i>	
PEDIALYTE		Periogard.....	840	<i>water.....</i>	848
ELECTROLYTE WATER.....	371	<i>permethrin.....</i>	349	Phenyleph.....	162
PEDIALYTE SPARKLING		<i>perphenazine.....</i>	189	<i>phenytoin.....</i>	163
RUSH.....	371	<i>perphenazine-amitriptyline..</i>	179	<i>phenytoin sodium extended.</i>	163
PEDIAPRED.....	448	PERSONAL BEST FULL		PHEODOYO.....	284
PEDIATRIC BEAR		RANGE.....	681, 790	PHEOXIA.....	286
NEBULIZER.....	687, 789	PERSONAL BEST LOW		PHEXXI.....	245
		RANGE.....	681, 790	PHEYO.....	291

Philith.....	255	PMS SOOTHE.....	10	PR BENZOYL PEROXIDE ..	274
PHOSPHALINE.....	136	PNEUMOVAX-23.....	112	PR CREAM.....	339
PHOSPHOLINE IODIDE.....	847	<i>pnv no.95-ferrous fumarate-</i>		PR NATAL 400.....	405
PHOSPHOROUS		<i>fa</i>	404	PR NATAL 400 EC.....	405
SUPPLEMENT.....	371	PNV TABS 20-1.....	411	PR NATAL 430.....	405
PHOTREXA CROSS-		PNV-DHA.....	390	PR NATAL 430 EC.....	405
LINKING KIT.....	849	PNV-DHA + DOCUSATE ...	404	PRADAXA.....	544
PHYSIOLYTE.....	360	PNV-OMEGA.....	386	PRAKETAMIDE.....	346
PHYSIOSOL IRRIGATION..	360	PNV-SELECT.....	405	<i>pralidoxime</i>	48
<i>phytonadione (vitamin k1)</i> ...	424	POCKET CHAMBER...687, 792		PRALUENT PEN.....	134, 135
PIFELTRO.....	61	POCKET PEAK FLOW		<i>pramipexole</i>	185
PIKO 1.....	681, 791	METER.....	681, 792	PRAMOSONE.....	328
PILLOW MASK CHILD 687, 791		PODOCON.....	331	<i>prasterone (dhea)</i>	1
<i>pilocarpine hcl</i>	842, 847, 849	<i>podofilox</i>	331	<i>prasugrel hcl</i>	542
PILOT COVID-19 AT-HOME		POKONZA.....	372	<i>pravastatin</i>	133
TEST.....	602, 791	POLY HUB NEEDLE ...	676, 792	<i>praziquantel</i>	53
<i>pimecrolimus</i>	300	Polycin.....	864	<i>prazosin</i>	152
<i>pimozide</i>	188	<i>polymyxin b sulf-</i>		PREBIOMAX.....	499
Pimtrea (28).....	247	<i>trimethoprim</i>	864	PREBIOTIC FIBER.....	506
<i>pindolol</i>	141	<i>polysaccharide iron complex</i>		PREBIOTIC FIBER (FOS)...	506
<i>pioglitazone</i>	460	.....	366	PREBIOTIC FIBER	
<i>pioglitazone-glimepiride</i>	436	<i>polysorbate 80</i>	242	DIGESTIVE.....	506
<i>pioglitazone-metformin</i>	435	POLY-TUSSIN AC.....	892	PREBIOTIC INULIN-FOS....	507
PIP BLOOD GLUCOSE		POLY-VI-FLOR		PRECISION.....	625, 792
MONITOR.....	624, 791	(ARCOFOLIN).....	400	PRECISION GLUCOSE	
PIP BLOOD GLUCOSE		POLY-VI-FLOR DROPS.....	400	CONTROL SOLN.....	625, 792
TEST STRIP.....	587, 792	POLY-VI-FLOR DROPS		PRECISION	
PIP GLUCOSE CONTROL		(ARCOFOLIN).....	400	GLUCOSE/KETONE	
SOLN L1-L2.....	625, 792	POLY-VI-FLOR IRON		CONTR.....	625, 793
PIP LANCET.....	625, 792	DROP(ARCOFO).....	400	PRECISION PCX PLUS	
PIP PEN NEEDLE.....	645, 792	POLY-VI-FLOR W-		TEST.....	588, 793
PIQRAY.....	97	IRON(ARCOFOLIN).....	400	PRECISION PCX TEST	
<i>pirfenidone</i>	893	POLY-VITA DROPS.....	397	.....	588, 793
<i>piroxicam</i>	40	POLY-VITA WITH IRON.....	399	PRECISION POINT OF	
<i>pitavastatin calcium</i>	132	POMALYST.....	101	CARE TEST.....	589, 793
PIXEL COVID19 HOME		PONVORY.....	846	PRECISION Q-I-D TEST	
COLLECT KIT.....	602, 792	PONVORY 14-DAY		.....	589, 794
PLANTAGO-HOMACCORD	466	STARTER PACK.....	846	PRECISION XTRA	
PLAQUENIL.....	32, 57	POPULUS COMPOSITUM..	466	KETONE-GLUCOSE...599, 794	
PLATINUM TEST STRIP		Portia 28.....	255	PRECISION XTRA	
.....	588, 792	<i>posaconazole</i>	55	MONITOR.....	625, 794
PLAVIX.....	542	<i>potassium aa (bisglycinate)</i> ..	372	PRECISION XTRA TEST	
PLEGISOL.....	870	<i>potassium chloride</i>	372, 373	.....	589, 794
PLEGRIDY.....	844	<i>potassium citrate</i>	519	PRECOSE.....	430
PLENURA.....	326	<i>potassium citrate-citric acid</i> ..	519	PRED FORTE.....	855
PLENVU.....	509	<i>potassium gluconate</i>	373	PRED MILD.....	855
PLEXION.....	269	<i>potassium iodide</i>	364	PRED-G S.O.P.....	850
PLEXION CLEANSING		<i>potassium, sodium</i>		<i>prednicarbate</i>	323
CLOTHS.....	269	<i>phosphates</i>	371	<i>prednisoln sp-moxiflox-</i>	
PLEXION NS.....	297	<i>povidone-iodine</i>	866	<i>bromfen</i>	851

<i>prednisolone</i>	449	PRENATAL + DHA.....	405	PRENATE	
<i>prednisolone acetate</i>	856	PRENATAL 19.....	406	ESSENTIAL(IRON-ASP-GL)	
<i>prednisolone acetate (pf)</i>	855	PRENATAL 19 (WITH		.....	390
<i>prednisolone acetate-</i>		DOCUSATE).....	406	PRENATE MINI (FERR ASP	
<i>bromfenac</i>	860	PRENATAL COMPLETE.....	406	GLYCIN).....	412
<i>prednisolone acetate-</i>		PRENATAL ESSENTIALS..	406	PRENATE PIXIE.....	412
<i>nepafenac</i>	860	PRENATAL FORMULA.....	406	PRENATE RESTORE.....	408
<i>prednisolone sod ph-</i>		PRENATAL FORMULA-		PRENATE STAR.....	412
<i>bromfenac</i>	860	DHA.....	406	PREPIDIL.....	425
<i>prednisolone sod ph-</i>		PRENATAL GUMMIES.....	411	PRESERA.....	308
<i>moxiflox</i>	850	PRENATAL		PRESERVISION AREDS 2	
<i>prednisolone sodium</i>		GUMMIES(ZINC CHELATE)		PLUS MV.....	4, 386
<i>phosphate</i>	449, 856	.....	386	PRESERVISION AREDS-2.....	4
<i>prednisolone-moxiflo-</i>		PRENATAL MULTI.....	406	PRESSURE ACTIVATED	
<i>nepafenac</i>	851	PRENATAL MULTI-DHA		LANCETS.....	625, 795
<i>prednisolone-moxifloxacin</i>		(ALGAL OIL).....	406	PRESTALIA.....	119
<i>hcl</i>	850	PRENATAL MULTI-		<i>pretomanid</i>	66
<i>prednisolone-moxiflox-</i>		DHA(WITH VIT K).....	406	PREVACID.....	475
<i>bromfen</i>	851	PRENATAL		PREVACID SOLUTAB.....	476
<i>prednisolon-moxiflox-</i>		MULTIVITAMINS.....	406	Prevalite.....	129
<i>ketorolac</i>	851	PRENATAL ONE DAILY.....	407	PREVENT DROPSAFE PEN	
<i>prednisone</i>	449	PRENATAL PLUS.....	407	NEEDLE.....	645, 795
PREDNISONE INTENSOL..	449	PRENATAL PLUS		PREVIDENT.....	839, 840
<i>pregabalin</i>		(CALCIUM CARB).....	407	PREVIDENT 5000	
.....	162, 214, 231, 232, 233	PRENATAL PLUS DHA.....	407	BOOSTER PLUS.....	839
Pregen DHA.....	405	PRENATAL PLUS VITAMIN-		PREVIDENT 5000 DRY	
PREGNYL.....	452	MINERAL.....	407	MOUTH.....	839
PRELIEF.....	467	PRENATAL TABLET.....	407	PREVIDENT 5000 ENAMEL	
PREMARIN.....	445, 896	<i>prenatal vit no.179-iron-folic</i>	407	PROTECT.....	839
PREMIER BLU GLUCOSE		PRENATAL VITAMIN.....	407	PREVIDENT 5000 ORTHO	
METER.....	625, 794	PRENATAL VITAMIN PLUS		DEFENSE.....	839
PREMIER CLASSIC		LOW IRON.....	407	PREVIDENT 5000 PLUS.....	839
GLUCOSE METER.....	625, 794	PRENATAL VITAMIN WITH		PREVIDENT 5000	
PREMIER COMPACT		MINERALS.....	408	SENSITIVE.....	839
GLUCOSE METER.....	625, 794	<i>prenatal vit-iron fum-folic ac</i>	408	PREVIDENT KIDS.....	840
PREMIER TEST STRIP		PRENATAL WITH DHA-		PREVNAR 20 (PF).....	112
.....	590, 795	FOLIC ACID.....	408	PREV-RX.....	390
PREMIER VOICE		PRENATAL-U.....	390	PREVYMIS.....	68
GLUCOSE METER.....	625, 795	PRENATE AM.....	390	PREZCOBIX.....	63, 76, 77
PREMIUM BLOOD		PRENATE CHEWABLE.....	390	PREZISTA.....	77
GLUCOSE MONITOR.....	625, 795	PRENATE DHA.....	390	PRIALT.....	12
PREMIUM V10.....	590, 625, 795	PRENATE DHA (FERR ASP		PRIFTIN.....	66, 78
PREMPHASE.....	442	GLYCIN).....	411	PRILO PATCH.....	346
PREMPRO.....	443	PRENATE ELITE.....	412	PRILOSEC.....	476
PRENAISSANCE.....	405	PRENATE ELITE (IRON		PRIMACARE.....	408
PRENAISSANCE PLUS.....	405	ASP GLYC).....	412	PRIMADOPHILUS BIFIDUS	499
PRENATA.....	405	PRENATE ENHANCE.....	408	PRIMADOPHILUS	
PRENATABS FA.....	405	PRENATE ESSENTIAL.....	390	ORIGINAL.....	499
PRENATABS RX.....	405			<i>primaquine</i>	57
PRENATAL.....	407, 411			PRIMEAIRE.....	687, 795

PRIMIDAR.....	499	PROBIOTIC		PRODIGY AUTOCODE	
<i>primidone</i>	159	ACIDOPHILUS(14-STRN)...	501	MONITOR SYST	625, 797
Primlev.....	24, 25	PROBIOTIC COLON		PRODIGY CONTROL	
PRIMSOL.....	53	SUPPORT	501	SOLUTION, LOW	626, 797
PRIORIX (PF).....	108, 116, 117	PROBIOTIC DIGEST SUPP		PRODIGY CONTROL	
PRISTIQ.....	177	(4-STRN).....	501	SOLUTION,HIGH.....	626, 797
PRO COMFORT INSULIN		PROBIOTIC DIGEST SUPP		PRODIGY INSULIN	
SYRINGE.....	646, 795, 796	(6-STRN).....	501	SYRINGE.....	646, 797
PRO COMFORT LANCET		PROBIOTIC		PRODIGY LANCETS..	626, 797
.....	625, 796	DIGEST(L.RHAM,INULN)...	501	PRODIGY LANCING	
PRO COMFORT PEN		PROBIOTIC		DEVICE	626, 797
NEEDLE.....	646, 796	DIGEST(LACTO,BIFIDO)....	501	PRODIGY MINI-MIST	
PRO COMFORT SAFETY		PROBIOTIC FORMULA		NEBULIZER.....	661, 797
LANCET	625, 796	(INULIN).....	501	PRODIGY NO CODING	
PRO COMFORT TENS		PROBIOTIC PEARLS		.....	591, 797
ELECTRODE.....	660, 796	ACIDOPHILUS.....	501	PRODIGY POCKET METER	
PRO COMFORT TENS		PROBIOTIC PEARLS		.....	626, 797
UNIT	660, 796	COMPLETE.....	502	PRODIGY TWIST TOP	
PRO VOICE V8-V9 TEST		PROBIOTIC PEARLS		LANCET	626, 797
STRIP	590, 796	WOMEN'S	502	PRODIGY VOICE	
PRO VOICE V9 GLUCOSE		PROBIOTIC-10.....	502	GLUCOSE METER.....	626, 798
MONITOR.....	625, 796	PROBIOTIC-IMMUNE.....	502	PROFILNINE.....	529
PROAIR RESPICLICK.....	882	PROBIZEN.....	502	PROFINAC.....	338
PROBACAP	499	PROCARDIA XL.....	145	PROFOLA.....	386
<i>probenecid</i>	524	PROCARE COMPRESSOR		<i>progesterone</i>	462
<i>probenecid-colchicine</i>	524	NEBULIZER.....	687, 796	<i>progesterone micronized</i>	462
PROBICHEW	499	PROCARE PEDIATRIC		PROGLYCEM.....	427
PROBIO DEFENSE.....	499	NEBULIZER.....	687, 796	PROGRAF	546
PROBIOFLEXX.....	499	PROCARE SPACER WITH		PROLASTIN-C	887
PROBIOMAX 350 DF.....	499	ADULT MASK.....	687, 796	Prolate.....	24, 26
PROBIOMAX COMPLETE		PROCARE SPACER WITH		PROLENSA.....	858
DF	499	CHILD MASK.....	687, 797	PROMACTA.....	544
PROBIOMAX DAILY DF.....	500	PROCEL SINGLES.....	396	PROMELLA.....	502
PROBIOMAX DF.....	500	Procentra.....	212	<i>promethazine</i>	470, 873, 875
PROBIOMAX IG 26 DF.....	500	PRO-CEPTION.....	660, 797	<i>promethazine-codeine</i>	891
PROBIOMAX LEAN DF.....	500	PROCHAMBER.....	687, 797	<i>promethazine-dm</i>	891
PROBIOMAX PLUS DF.....	500	<i>prochlorperazine</i>	470	<i>promethazine-phenylephrine</i>	
PROBIOMAX SB DF.....	500	<i>prochlorperazine maleate</i>		.....	871
PROBIOMAX SERENITY ...	500	.....	189, 469	Promethegan.....	470, 873, 875
PROBIONEXX.....	500	PROCORT	47	PROMETRIUM.....	462
PROBIOTIC.....	501	PROCRT	528	PROMISEB	297, 308
PROBIOTIC (B.		Proctocort.....	46, 323	PRONAL	330
COAGULANS).....	500	PROCTOFOAM HC.....	47	PRONEB MAX	
PROBIOTIC (S.BOULARDII)		Procto-Med Hc.....	47, 323	COMPRESSOR-LC PLUS	
.....	500	Proctosol Hc.....	47, 323	.....	688, 798
PROBIOTIC (WITH		Proctozone-Hc.....	47, 323	PRONEB MAX	
VITAMIN D3).....	500	PROCYSBI	512	COMPRESSR-LC SPRINT	
PROBIOTIC ACIDOPHILUS		PRODIGY AUTOCODE		.....	688, 798
(4 STRN).....	501	METER.....	625, 797	PRONEB ULTRA II FILTER	
				ASSEM.....	688, 798

PROOXIA.....	304	PURE COMFORT SAFETY		QUDEXY XR.....	165, 166
<i>propafenone</i>	127	PEN NEEDLE.....	646, 798	<i>quercetin</i>	419
<i>proparacaine</i>	862	PUREAIR MINI NEBULIZER		Questran.....	129
PROPIMEX-2.....	395	.....	688, 798	Questran Light.....	129
<i>propranolol</i>	142	PURECOMFORT PEAK		<i>quetiapine</i>	189, 208
<i>propranolol-</i>		FLOW METER.....	681, 799	QUICKVUE AT-HOME	
<i>hydrochlorothiazid</i>	152	PUREVITA ALPHA LIPOIC		COVID-19 TEST.....	602, 799
<i>propylthiouracil</i>	438	ACID.....	4	QUICKVUE SARS	
PROSCAR.....	517	PUREVITA FOLIC ACID....	424	ANTIGEN.....	602, 799
PROSILK.....	690, 798	PUREVITA MAGNESIUM		QUIDROXZAR.....	329
PROSILK GEL.....	339	OXIDE.....	369	QUIHOXAXIA.....	330
PROSOURCE.....	396	PUREVITA SUPER B-		QUIHOXVAR.....	330
PROTECT IRON LIQUID....	368	COMPLEX.....	358	QUILLICHEW ER.....	197, 198
PROTHELIAL.....	842	PUREVITA VITAMIN A.....	415	QUILLIVANT XR.....	198, 199
PROTONIX.....	476	PUREVITA VITAMIN B1.....	416	<i>quinapril</i>	120
<i>protriptyline</i>	180	PUREVITA VITAMIN B12....	418	<i>quinapril-hydrochlorothiazide</i>	
PROVATE PELVIC ORGAN		PUREVITA VITAMIN B2.....	418	.....	120
SUPPORT.....	798, 896	PUREVITA VITAMIN B3.....	419	<i>quinidine gluconate</i>	127
PROVENT.....	688, 798	PUREVITA VITAMIN B5.....	419	<i>quinidine sulfate</i>	127
PROVENT STARTER. 688,	798	PUREVITA VITAMIN B6.....	419	<i>quinine sulfate</i>	57
PROVERA.....	462	PUREVITA VITAMIN C.....	421	QUINIXIL.....	327
PROVIDA OB.....	408	PUREVITA VITAMIN D3....	422	QUINJA.....	283
PROVIGIL.....	227	PUREVITA VITAMIN E.....	423	QUINTET AC.....	591, 626, 799
PROVIMIN.....	394	PURIXAN.....	89	QUINTET BLOOD	
PROVISC.....	864	PUSH BUTTON SAFETY		GLUCOSE METER.....	626, 799
PROXIVOL.....	345	LANCETS.....	626, 799	QUINTET GLUCOSE TEST	
PROZAC.....	175	PYLERA.....	482	STRIPS.....	591, 799
<i>prucalopride</i>	477	<i>pyrazinamide</i>	66	QUIT 2.....	238
PRUCLAIR.....	308	PYRIDIUM.....	519	QUIT 4.....	238, 239
PRUMYX.....	308	<i>pyridostigmine bromide</i> . 48,	550	QULIPTA.....	219
Pruradik.....	349	<i>pyridoxine (vitamin b6)</i>	419	QUTENZA.....	347
PSORINOHEEL.....	466	<i>pyrimethamine</i>	57	QUVIVIQ.....	235
<i>psyllium husk</i>	507	PYRUKYND.....	543	QVAR REDIHALER.....	878
<i>psyllium husk (with sugar)</i> ...	507	QALSODY.....	548	<i>rabeprazole</i>	476
PULMICORT.....	878	QBRELIS.....	120	RADIAGEL.....	309
PULMICORT FLEXHALER. 878		QBREXZA.....	285	RADIAPLEXRX.....	339
PULMO-AIDE		Q-CARE RX Q2.....	602	RADICAVA ORS.....	549
COMPRESSOR.....	688, 798	Q-CARE RX Q4.....	602	RADICAVA ORS STARTER	
PULMONEB LT		QDOLO.....	18	KIT SUSP.....	549
COMPRESSOR NEBUL		QELBREE.....	201, 202	RADIOGARDASE.....	48
.....	688, 798	QFITLIA.....	525	RAGWITEK.....	105
PULMOSAL.....	241	QFITLIA PEN.....	525	RALDESY.....	176
PULMOZYME.....	888	QINLOCK.....	99	<i>raloxifene</i>	462
PURAZIL.....	295	QLOSI.....	849	<i>ramelteon</i>	218
PURE COMFORT		QNASL.....	889	<i>ramipril</i>	120
LANCETS.....	626, 798	QTERN.....	433	<i>ranolazine</i>	126
PURE COMFORT PEN		QUAKE VIBRATORY PEP		RAPAFLO.....	517
NEEDLE.....	646, 798	.....	688, 799	RAPID SARS-COV-2 AG	
PURE COMFORT SAFETY		QUALAQUIN.....	57	HOME TEST.....	602, 799
LANCETS.....	626, 798	<i>quazepam</i>	204, 234		

RAPIDGO FLU AND COVID-19 TEST.....	602, 800	RELEUKO.....	533	REPOZEN SLEEP AID.....	217
RAPPORT VACUUM THERAPY.....	658, 800	RELEXII.....	199	RESISTANCE FORMULA	
<i>rasagiline</i>	183	RELIAMED LANCET... ..	626, 800	PROBIOTIC.....	502
RASUVO (PF).....	32, 33	RELIAMED MINI LANCING DEVICE.....	626, 800	RESPA-AR.....	871
RAVICTI.....	836	RELIAMED SAFETY SEAL LANCETS.....	626, 800	RESTASIS.....	856
RAYALDEE.....	835	RELIBIOTIC.....	502	RESTASIS MULTIDOSE.....	856
RAYASAL.....	331	RELION ALL-IN-ONE METER.....	626, 800	RESTIMO.....	342
RAYOS.....	449	RELION CONFIRM.....	626, 800	RESTORE.....	353, 605, 802
REBIF (WITH ALBUMIN)....	844	RELION CONFIRM-MICRO.....	592, 801	RESTORE CALCIUM	
REBIF REBIDOSE.....	844	RELION MICRO GLUCOSE MONITOR.....	626, 801	ALGINATE.....	353
REBIF TITRATION PACK... ..	844	RELION PRIME METER.....	627, 801	RESTORE FUSION RENAL SUPPORT.....	394
REBINYN.....	529	RELION PRIME TEST STRIPS.....	592, 801	RESTORE RENAL SUPPORT.....	394
REBYOTA.....	466	RELION ULTIMA.....	593, 801	RESTORIL.....	204, 234
RECEDO.....	339	RELISTOR.....	50	RETACRIT.....	528
Reclipsen (28).....	255	RELIZORB.....	604, 801	RETEVMO.....	100
RECOMBIMATE.....	532	RELPAK.....	222	RETIN-A.....	278
RECOMBIVAX HB (PF).....	106, 107	RELTONE.....	473	RETIN-A MICRO.....	277
RECONSTITUTE.....	660, 800	REMEDIENT.....	386	RETIN-A MICRO PUMP.....	277
RECORLEV.....	426	REMERON.....	173	RETROVIR.....	62
RECOTHROM.....	536	REMERON SOLTAB.....	173	REUSABLE NEBULIZER KIT.....	688, 802
RECOTHROM SPRAY KIT.....	536	REMIFEMIN MENOPAUSE..	10	REVATIO.....	155
RECTIV.....	46	REMODULIN.....	154	REVCIVI.....	834
<i>red beet</i>	10	REMYDA.....	342	REVEAL BLOOD	
<i>red beet-sour cherry extract..</i>	10	RENACIDIN.....	513	GLUCOSE METER.....	627, 802
<i>red yeast rice</i>	10	RENAMENT.....	394	REVEAL TEST STRIP.....	593, 802
<i>red yeast rice extract</i>	10	RENEEL.....	466	REVITAFLOK.....	502
REFUAH PLUS.....	592, 800	RENOVAR.....	103, 351	REVLIMID.....	101
REFUAH PLUS GLUCOSE CONTROL.....	626, 800	RENTHYROID.....	463	REVUFORJ.....	85
REFUAH PLUS GLUCOSE MONITOR.....	626, 800	REVELA.....	516	REXTOVY.....	51
REGENECARE.....	345	<i>repaglinide</i>	432	REXULTI.....	191
REGENECARE WITH ALOE.....	346	REPATHA PUSHTRONEX..	135	REYATAZ.....	77
REGLAN.....	478	REPATHA SURECLICK.....	135	REYVOW.....	224
REGRANEX.....	354	REPATHA SYRINGE.....	135	REZDIFFRA.....	545
REGULOID (ASPARTAME).....	507	REPEL.....	330	REZLIDHIA.....	96
REGULOID (PSYLLIUM HUSK).....	507	REPEL SPORTSMEN.....	330	REZUROCK.....	36
REGULOID (PSYLLIUM HUSK-SUCRO).....	507	REPHRESH PRO-B.....	502	REZVOGLAR KWIKPEN.....	455
REJUVAFLOR.....	502	REPLENS EXTERNAL COMFORT.....	896	RHOFADE.....	342
RELAFEN DS.....	39	REPLICARE DRESSING.....	353, 802	RHOPRESSA.....	868
RELAGARD.....	895	REPLICARE THIN.....	353, 802	<i>ribavirin</i>	71, 77
RELAX NIGHT CALM.....	217	REPLICARE ULTRA DRESSING.....	353, 802	<i>riboflavin (vitamin b2)</i>	418
RELCARE.....	416			<i>ribose</i>	392
RELENZA DISKHALER.....	72			RIDAURA.....	33
				<i>rifabutin</i>	66, 78
				<i>rifampin</i>	66, 78
				RIGHTEST CONTROL SOLUTION HIGH.....	627, 802

RIGHTEST CONTROL	<i>ropivacaine(pf)-0.9 %</i>	SAFETY PEN NEEDLE
SOLUTION NORM..... 627, 802	<i>sodchlor</i> 45	 646, 804
RIGHTEST GD500	Rosadan..... 342	SAFETY SEAL LANCETS
LANCING DEVICE..... 627, 802	ROSADAN..... 342	 627, 804
RIGHTEST GL300	ROSITARA..... 342	SAFETY-LET LANCETS
LANCETS..... 627, 802	ROSULA..... 270	 627, 804
RIGHTEST GM550	ROSULA CLEANSING	SAFRYCYN..... 339
SYSTEM..... 627, 802	CLOTHS..... 270	SAFYRAL..... 255
RIGHTEST GS550 TEST	<i>rosuvastatin</i> 133	SAIZEN SAIZENPREP..... 451
STRIPS..... 593, 803	Rosyrah..... 258	Sajazir..... 143
RIGHTEST GT333	ROSZET..... 140	SALAGEN (PILOCARPINE) 842
GLUCOSE METER..... 627, 803	ROTARIX..... 108, 117	SALICATE..... 332
RIGHTEST GT333 TEST	ROTATEQ VACCINE.. 108, 117	<i>salicylic acid</i> 332
STRIP..... 594, 803	ROVIS..... 342	<i>salicylic acid-ceramides no.1</i>
RILUTEK..... 549	ROWASA..... 486	 332
<i>riluzole</i> 549	Roweepra..... 171	SALIMEZ..... 332
<i>rimantadine</i> 73	Roweepra Xr..... 171	SALIMEZ FORTE..... 332
<i>ringer's</i> 360	ROXICODONE..... 18	SALIVAMAX..... 841
RINVOQ..... 35, 282, 487	ROXYBOND..... 18	SALOXICIN..... 11
RINVOQ LQ..... 35	ROZEREM..... 218	<i>salsalate</i> 43
RIOMET..... 460	ROZLYTREK..... 99	SALVAX..... 332
<i>risedronate</i> 440	RUBBER MOUTHPIECE	SALVAX DUO PLUS..... 331
RISPERDAL..... 187, 208	 688, 803	SALYCIM..... 332
<i>risperidone</i> 187, 208	RUBRACA..... 97	SALYNTRA..... 332
RITALIN..... 200, 228	RUCONEST..... 527	SAMBUCUS ELDERBERRY
RITALIN LA..... 199, 200	<i>rufinamide</i> 172	ORIGINAL..... 11
RITEFLO AEROCHAMBER	RUKOBIA..... 59	SAMBUCUS
..... 688, 803	RUMILO..... 267	ELDERBERRY-VITAMIN C. 414
<i>ritonavir</i> 77	RYALTRIS..... 888	SAMBUCUS
<i>rivaroxaban</i> 527	RYBELSUS..... 432	HONEYBERRY NIGHT..... 217
<i>rivastigmine</i> 243	RYDAPT..... 99	SAMI THE SEAL..... 688, 804
<i>rivastigmine tartrate</i> 243	RYDEX..... 892	SAMI THE SEAL MASK
RIVELSA..... 258	RYLAZE..... 90	 688, 805
RIVFLOZA..... 514	RYNODERM..... 332	SAMSCA..... 150
RIXUBIS..... 529	RYPLAZIM..... 540	SANADERMRX..... 327
<i>rizatriptan</i> 222	RYTARY..... 182	SANCUSO..... 470
R-NATAL OB..... 412	SABAL-HOMACCORD..... 466	SANDIMMUNE..... 34, 546
ROAOXIA..... 337	SABRIL..... 162	SANDOSTATIN..... 463, 511
ROBINSON CLEAR VINYL	<i>saccharin</i> 359	SANTYL..... 309
CATHETER..... 694, 803	<i>saccharomyces boulardii</i> 502	SAPHRIS..... 185, 208
ROBINUL..... 480	<i>saccharomyces boulardii-</i>	<i>sapropterin</i> 837
ROBINUL FORTE..... 480	<i>yeast</i> 502	SAROXIA..... 275
ROCALTROL..... 423, 835	<i>sacubitril-valsartan</i> 124	SAVAYSA..... 527
ROCKLATAN..... 863	SAFESNAP INSULIN	SAVELLA..... 177, 215
<i>roflumilast</i> 880	SYRINGE..... 646, 803	<i>saw palmetto</i> 11
ROLVEDON..... 533	SAFESNAP SYRINGE 676, 804	<i>saw palmetto-zinc picolinate</i> .. 11
ROMVIMZA..... 99	SAFETY LANCETS..... 627, 804	SAWYER CONTROLLED
<i>ropinirole</i> 185	<i>safety needles</i> 676, 804	RELEASE..... 330
<i>ropivacaine (pf)-nacl,iso-osm</i> 45		<i>saxagliptin</i> 430
		<i>saxagliptin-metformin</i> 437

SCALACORT.....	323	<i>sertraline</i>	175	SIMPLERA SYNC SENSOR	
SCALACORT DK.....	323	<i>sesame oil</i>	240	.....	627, 806
SCARCARE.....	339, 690	Setlakin.....	255	SIMPLI PEN NEEDLE..	647, 806
SCARCIN PAD PLUS..	690, 805	<i>sevelamer carbonate</i>	516	SIMPLY SALINE WOUND	
SCARCINPAD.....	690, 805	<i>sevelamer hcl</i>	516	WASH.....	351
SCARHEAL.....	690, 805	SEVENFACT.....	529	SIMPLYTHICK.....	241
SCARSILK.....	690, 805	<i>sevoflurane</i>	44	SIMPONI.....	30, 31, 488
SCARSILK GEL.....	339	SEYSARA.....	83, 264	SIMPONI ARIA.....	30, 31
SCARTRATE.....	339	SF.....	840	<i>simvastatin</i>	133
SCEMBLIX.....	99	SF 5000 PLUS.....	840	SINEMET.....	182
<i>schisandra</i>	11	SFROWASA.....	486	SINGLE-LET.....	627, 806
SCLEROSOL		Sharobel.....	257	SINGULAIR.....	879
INTRAPLEURAL.....	893	SHINGRIX (PF).....	117	SINUSTAR NEBULIZER	
<i>scopolamine base</i>	468	SIDESTREAM.....	661, 805	.....	661, 806
SEBUDERM.....	308	SIDESTREAM MASK..	688, 805	SINUVA.....	885, 890
SECUADO.....	186	SIDESTREAM NEBULIZER		<i>sirolimus</i>	547, 548
SECURESAFE INSULIN		.....	661, 805	SIRTURO.....	65
SYRINGE.....	647, 805	SIDESTREAM PLUS..	661, 805	SIRVANA.....	275
SECURESAFE PEN		SIGNIFOR.....	463	<i>sitagliptin</i>	431
NEEDLE.....	647, 805	SIKLOS.....	543	SIVEXTRO.....	76
SEGLENTIS.....	27	SILADERM.....	690, 805	SKIN THERAPY.....	308
SEGLUROMET.....	433	SILADONE.....	690, 805	SKY SAFETY PEN NEEDLE	
SELECT-OB.....	408	SILASTIC FOLEY		.....	647, 806
SELECT-OB (FOLIC ACID).	408	CATHETER.....	694, 805	SKYCLARYS.....	548
SELECT-OB + DHA.....	408	<i>sildenafil</i>		SKYLA.....	246
<i>selegiline hcl</i>	183	(<i>pulm.hypertension</i>).....	155	SKYRIZI.....	280, 484
<i>selenium</i>	373	SILENOR.....	236	SKYTROFA.....	452
<i>selenium sulfide</i>	297	SILICONE MASK.....	688, 805	SLEEP CALM.....	217
<i>selenomethionine</i>	373	SILICONE MASK - INFANT		SLEEP IMMUNE HEALTH..	217
SELF-CATHETER, FEMALE		.....	688, 805	SLEEP SUPPORT	
.....	694, 805	SILIGENTLE AG.....	353	(MELATONIN-HERB).....	217
SELZENTRY.....	59	SILIQ.....	281	SLEEP TONITE VALERIAN....	5
SEMGLEE(INSULIN		SIL-K.....	690, 805	SLOW FE.....	366
GLARGINE-YFGN).....	455	<i>silodosin</i>	517	SLOW RELEASE IRON.....	366
SEMGLEE(INSULIN		SILTREX.....	691, 805	SLOWMAG MUSCLE	
GLARG-YFGN)PEN.....	455	SILVADENE.....	298	RECOVERY.....	369
SE-NATAL 19.....	408	<i>silver nitrate</i>	283, 284	SLYND.....	257
SE-NATAL 19 CHEWABLE.	408	<i>silver nitrate applicators</i>	331	SMART SENSE LANCETS	
SENIOR PROBIOTIC.....	502	<i>silver sulfadiazine</i>	298	.....	627, 806
<i>senna leaf</i>	510	SILVRSTAT.....	284	SMART SENSE	
SENOKOT.....	510	SIMBRINZA.....	849	MONITORING SYSTEM	
SENOKOT KIDS.....	510	SIMILAC PRENATAL.....	409	.....	627, 806
SENOKOT-CHAMOMILE....	510	SIMILAC PROBIOTIC TRI-		SMART SENSE TEST	
SENSIPAR.....	440	BLEND.....	503	STRIPS.....	594, 806
SEPHIENCE.....	838	SIMLANDI(CF).....	30, 31, 488	SMARTDIABETES	
SEREVENT DISKUS.....	882	SIMLANDI(CF)		VANTAGE.....	627, 806
SERNIVO.....	323	AUTOINJECTOR.....	29, 31, 488	SMARTEST CONTROL	
SEROQUEL.....	189, 208	Simliya (28).....	247	.....	627, 806
SEROQUEL XR.....	190, 208	Simpesse.....	247	SMARTEST EJECT....	627, 806
SEROSTIM.....	451	SIMPLERA SENSOR..	627, 806	SMARTEST LANCET..	627, 806

SMARTEST PERSONA		SPACE CHAMBER WITH
GLUCOSE METER..... 627, 806		MEDIUM MASK.....689, 808
SMARTEST PERSONA		SPACE CHAMBER WITH
STARTER.....628, 806		SMALL MASK.....689, 808
SMARTEST PRONTO		SPECTRACEF 67
GLUCOSE METER..... 628, 807		SPECTRAGEL..... 353, 808
SMARTEST PRONTO		SPECTRAVITE ADULT 390
STARTER.....628, 807		SPECTRAVITE ADULT 50
SMARTEST PROTEGE		PLUS..... 386
.....628, 807		SPECTRAVITE MEN 50
SMARTEST SMART CODE		PLUS..... 386
METER.....628, 807		SPECTRAVITE MEN'S..... 386
SMARTEST TALKING		SPECTRAVITE WOMEN.... 390
METER.....628, 807		SPECTRAVITE WOMEN 50
SMARTEST TEST 594, 807		PLUS..... 386
SMARTNEB		SPEEDICATH (FEMALE)
COMPRESSOR		694, 808
NEBULIZER..... 688, 807		SPEEDYSWAB COVID-19
SMOOTH TEXTURE FIBER507		AND FLU..... 602, 808
SOAANZ..... 149		SPEEDYSWAB COVID-19
<i>sodium bicarb-sodium</i>		HOME TEST 602, 808
<i>chloride</i> 240		SPEVIGO..... 281
<i>sodium chlor 0.9%</i>		SPIKEVAX 2024-2025(12Y
<i>bacteriostat</i> 359, 413		UP)(PF)..... 113
<i>sodium chloride</i>		SPIKEVAX 2025-2026(12Y
.....241, 359, 360, 373		UP)(PF)..... 114
<i>sodium chloride 0.45 %</i> 413		SPIKEVAX 2025-26 (6M-
<i>sodium chloride 0.9 %</i> . 359, 413		11Y) (PF)..... 114
<i>sodium chloride 0.9 %</i>		<i>spinosad</i> 349
<i>(flush)</i> 413		SPINRAZA (PF).....554
<i>sodium citrate</i> 526		SPIRIVA RESPIMAT 880
<i>sodium citrate in 0.9 % nacl</i> .526		SPIRIVA WITH
<i>sodium citrate-citric acid</i> 519		HANDIHALER..... 880
SODIUM FLUORIDE 5000		<i>spironolactone</i> 121, 148
DRY MOUTH.....840		<i>spironolacton-</i>
SODIUM FLUORIDE 5000		<i>hydrochlorothiaz</i> 149
PLUS..... 840		SPORANOX..... 56
<i>sodium fluoride-pot nitrate</i> ...840		SPRAVATO..... 174
<i>sodium oxybate</i> 227		SPRAY AND STRETCH.....335
<i>sodium phenylbutyrate</i> 837		Sprintec (28)..... 255
<i>sodium polystyrene</i>		SPRITAM.....171
<i>sulfonate</i> 360		SPRIX.....39
<i>sodium succinate</i> 240		SPRYCEL.....99
<i>sodium,potassium,mag</i>		Sps (With Sorbitol).....360
<i>sulfates</i> 509		SPS (WITH SORBITOL).....360
SOFDRA.....285		Sronyx..... 255
SOFIA SARS ANTIGEN FIA		SSD 298
.....602, 807		SSKI..... 364
SOFIA2 FLU-SARS		SSS 10-5..... 270
ANTIGEN FIA..... 602, 807		ST JOSEPH ASPIRIN... 44, 542
	SOGROYA..... 452	
	SOHONOS..... 548	
	SOLESTA..... 698	
	<i>solifenacin</i> 521	
	SOLQUA 100/33.....437	
	SOLOSEC..... 59	
	SOLOX GEL.....284	
	SOLTAMOX.....100	
	SOLU-CORTEF ACT-O-	
	VIAL (PF).....449	
	SOLUPAK.....334	
	SOLUS V2 AUDIBLE	
	METER..... 628, 807	
	SOLUS V2 CONTROL	
	SOLUTION, LOW 628, 807	
	SOLUS V2 CONTROL	
	SOLUTION,HIGH..... 628, 807	
	SOLUS V2 LANCETS. 628, 807	
	SOLUS V2 LANCING	
	DEVICE..... 628, 807	
	SOLUS V2 TEST STRIPS	
	595, 808	
	SOLUVITA MULTIVITAMIN	
	FLUORIDE..... 400	
	SOMA..... 553	
	SOMAVERT..... 450	
	SONAFINE..... 308	
	SOOLANTRA..... 342	
	SOOTHENEB	
	COMPRESSOR	
	NEBULIZER..... 689, 808	
	SOOTHENEB MESH	
	NEBULIZER..... 661, 808	
	SOOTHING NIGHT 218	
	SOPORDREN..... 218	
	<i>sorafenib</i> 96	
	<i>sorbitol</i> 241, 508, 513	
	<i>sorbitol-mannitol</i> 513	
	SORILUX.....295	
	SORIXIA.....275	
	<i>sotalol</i> 127, 142	
	Sotalol Af..... 127, 142	
	SOTYKTU.....281	
	SOTYLIZE..... 127, 142	
	SOVALDI..... 71	
	SOVUNA..... 32, 57	
	SPACE CHAMBER..... 689, 808	
	SPACE CHAMBER WITH	
	LARGE MASK..... 689, 808	

<i>st. john's wort</i>	2	SULFACLEANSE 8-4	270	SURE COMFORT PEN	
ST. JOSEPH ASPIRIN ..	44, 542	<i>sulfadiazine</i>	78	NEEDLE	647, 809
<i>stavudine</i>	62	<i>sulfamethoxazole-</i>		SURE COMFORT SAFETY	
STEGLATRO	434	<i>trimethoprim</i>	53	PEN NEEDLE	647, 809
STEGLUJAN	434	SULFAMYLON	299	SURE RESULT DSS	
STELARA	280, 484	<i>sulfasalazine</i>	36, 486	PREMIUM PACK	337
STEQEYMA	280, 484	SULFATRIM	53	SUREBIOTIC	503
STERILANCE TL	628, 808	<i>sulindac</i>	39	SURE-FINE PEN NEEDLES	
STERILE DROPTAINERS		SUMADAN	270	.....	648, 809
.....	603, 808	SUMADAN XLT	270, 343	SUREFLEX DEVICE WITH	
<i>sterile talc</i>	893	<i>sumatriptan</i>	222	LANCETS	628, 810
STERITALC	893	<i>sumatriptan succinate</i>	222	SUREFLEX LANCING	
STIMUFEND	534	<i>sumatriptan-naproxen</i>	224	DEVICE	628, 810
STIOLTO RESPIMAT	883	SUMAXIN	271	SURE-JECT INSULIN	
STIVARGA	96	SUMAXIN CP	271	SYRINGE	648, 810
STOP SMOKING AID	239	<i>sunitinib malate</i>	99	SURE-LANCE	628, 810
STRATACTX	353, 808	SUNLENCA	51	SURE-LANCE ULTRA THIN	
STRATAGRT	353, 808	SUNOSI	227	.....	628, 810
STRATAMARK	339	SUNRISE COMPRESSOR-		SURE-PEN LANCING	
STRATATRIZ	340	NEBULIZER	689, 809	DEVICE	628, 810
STRATAXRT	353, 808	SUPARTZ FX	551	SURE-TEST EASYPLUS	
STRATTERA	202	SUPER B-50 COMPLEX	358	MINI	595, 629, 810
STRAVIX	348	SUPER ENERGY HERBAL		SURE-TEST EASYPLUS	
STRENSIQ	833	COMPLEX	11	MINI METER	629, 810
STRESS B WITH ZINC	358	SUPER THIN LANCETS		SURE-TOUCH LANCET	
STRIBILD	64	.....	628, 809	.....	629, 810
STRIVERDI RESPIMAT	881	SUPERIOR JOINT		SURGIFOAM	536
STROMEKTOL	53	SUPPORT	2	SURGUARD2 SAFETY	
STRONG IODINE	103, 365	SUPERIOR MEN'S MULTI ..	386	.....	677, 811
STUART ONE	409	SUPERIOR OMEGA3 WITH		SURVANTA	888
SUBOXONE	236	VIT D	138	SUSVIMO	862, 868
Subvenite	169	SUPERIOR PROBIOTIC	503	SUSVIMO (INITIAL FILL)	
Subvenite Starter (Blue) Kit		SUPERIOR SLEEP	218	.....	862, 868
.....	169, 206	SUPERIOR WOMEN'S		SUTAB	510
Subvenite Starter (Green)		MULTI	387	SUTENT	99
Kit	169, 206	SUPLENA CARB STEADY ..	395	SWEET OIL	240, 241
Subvenite Starter (Orange)		SUPPRELIN LA	460	Syeda	255
Kit	170, 206	SUPRANE	44	SYMAX DUOTAB	479, 522
SUCRAID	473	SUPRAX	67	SYMAX FASTABS	479, 522
<i>sucralfate</i>	511	SUPREP BOWEL PREP KIT		SYMAX-SL	479, 522
SUFLAVE	510	.....	510	SYMAX-SR	479, 523
SULAR	145	SURE COMFORT INS.		SYMBICORT	885
<i>sulconazole</i>	289	SYR. U-100	647, 809	SYMBRAVO	156
<i>sulfacetamide sodium</i> ..	297, 865	SURE COMFORT INSULIN		SYMDEKO	887
<i>sulfacetamide sodium (acne)</i>		SYRINGE	647, 809	SYMFI	65
.....	267	SURE COMFORT		SYMFI LO	65
<i>sulfacetamide sodium-sulfur</i>	270	LANCETS	628, 809	SYMLINPEN 120	430
<i>sulfacetamide sod-sulfur-</i>		SURE COMFORT LANCING		SYMLINPEN 60	430
<i>urea</i>	270, 343	PEN	628, 809	SYMPAZAN	160, 204
<i>sulfacetamide-prednisolone</i>	850			SYMPROIC	50

SYMTUZA.....	64	T:SLIM X2 CONTROL-IQ		TANDEM T:SLIM ASFT 30	
SYNALAR.....	323	.....	693, 812	PK14 23".....	697, 813
SYNALAR CREAM KIT.....	327	TAB-A-VITE.....	391	TANDEM T:SLIM ASFT XC	
SYNALAR OINTMENT KIT.....	327	TAB-A-VITE MULTIVITAMIN		PK10 23".....	697, 813
SYNALAR TS.....	328	W-IRON.....	387, 391	TANDEM T:SLIM ASFT XC	
SYNAREL.....	460	TABLOID.....	89	PK14 23".....	697, 813
SYNDROS.....	209, 469, 897	TABRECTA.....	99	TANDEM T:SLIM TRUSTL	
SYNJARDY.....	433	TACLONEX.....	279	PK10 23".....	697, 813
SYNJARDY XR.....	433	<i>tacrolimus</i>	300, 546	Tanlor.....	553
SYNOJOYNT.....	551	<i>tadalafil</i>	355, 518	Taperdex.....	449
SYNOVX CALM.....	5	<i>tadalafil (pulm. hypertension)</i>		TAPERDEX.....	450
SYNOVX DJD.....	2	.....	155	TARCEVA.....	86
SYNOVX RECOVERY.....	2	TADLIQ.....	155	TARDEOXIA.....	273
SYNOVX RELIEF.....	11	TAFINLAR.....	91	TARDIMAXIA.....	275
SYNTERMA PLUS.....	334	<i>tafluprost (pf)</i>	867	Targadox.....	83
SYNTHROID.....	465	TAGRISSO.....	86	TARGRETIN.....	101, 292
SYNVISC.....	551	TAKE ACTION.....	261, 262	Tarina 24 Fe.....	256
SYNVISC-ONE.....	551	TAKHZYRO.....	153	Tarina Fe 1/20 (28).....	256
SYPRINE.....	49	TALICIA.....	482	Tarina Fe 1-20 Eq (28).....	256
<i>syringe (disposable)....</i>	677, 811	TALTZ AUTOINJECTOR.....	282	TARON-C DHA.....	387
SYRINGE 3CC/20GX1"		TALTZ AUTOINJECTOR (2		TARON-PREX PRENATAL-	
.....	677, 811	PACK).....	281	DHA.....	391, 409
SYRINGE 3CC/21GX1"		TALTZ AUTOINJECTOR (3		TAROXIA.....	275
.....	677, 811	PACK).....	282	TARPEYO.....	450
SYRINGE 3CC/21GX1-1/2"		TALTZ SYRINGE.....	282	TASCENSO ODT.....	846
.....	677, 811	TALZENNA.....	97	TASIGNA.....	99
SYRINGE 3CC/22GX1"		TAMIFLU.....	72	<i>tasimelteon</i>	218
.....	677, 811	<i>tamoxifen</i>	100	TASMAR.....	182
SYRINGE 3CC/22GX3/4"		<i>tamsulosin</i>	517	<i>tavaborole</i>	289
.....	678, 812	TANDEM MOBI AUTOSOFT		TAVALISSE.....	526
SYRINGE 3CC/25GX1"		30 KT 23".....	697, 812	TAVNEOS.....	28
.....	678, 812	TANDEM MOBI AUTOSOFT		TAYTULLA.....	256
SYRINGE AVITENE.....	537	XC KIT 5".....	697, 812	<i>tazarotene</i>	278, 295, 340
<i>syringe with needle</i>	678, 812	TANDEM MOBI AUTOSOFT		TAZORAC.....	295
SYRINGE WITHOUT		XC KT 23".....	697, 812	TAZVERIK.....	92
NEEDLE.....	678, 812	TANDEM MOBI		TD GOLD LEVEL 1	
SYZYGIUM COMPOSITUM	466	AUTOSOFT30 14PK 23		CONTROL.....	629, 813
SZOSIL.....	691, 812	.....	697, 813	TD GOLD LEVEL 2	
T.E.D. ANTI-EMBOLISM		TANDEM MOBI		CONTROL.....	629, 813
STOCKING.....	600, 660, 812	AUTOSOFTXC 14PK 23		TECFIDERA.....	845
T.E.D. KNEE LENGTH-M-		.....	697, 813	TECHLITE INSULIN	
LONG.....	600, 812	TANDEM MOBI		SYRINGE.....	648, 813
T.E.D. KNEE LENGTH-S-		AUTOSOFTXC 14PK 5"		TECHLITE INSULN	
REGULAR.....	600, 812	.....	697, 813	SYR(HALF UNIT).....	648, 813, 814
T.R.U.E. TEST ALLERGEN	105	TANDEM MOBI SYSTEM		TECHLITE LANCETS.....	629, 814
T:FLEX.....	660, 812	.....	693, 813	TECHLITE PEN NEEDLE	
T:SLIM X2.....	660, 812	TANDEM MOBI TRUSTEEL		.....	648, 814
T:SLIM X2 BASAL-IQ		KIT 23".....	697, 813	TECHLITE PLUS PEN	
INSULIN PMP.....	693, 812	TANDEM T:SLIM ASFT 30		NEEDLE.....	648, 814
		PK10 23".....	697, 813		

TECHNA NAT UNSWT	TERUMO INSULIN	THRESHOLD IMT TRAINER
TROCHE BASEG2..... 240, 242	SYRINGE..... 648, 649, 815	689, 816
TECNU..... 343	TERUMO SYRINGE 678, 815	THRESHOLD PEP DEVICE
TEGLUTIK..... 549	TEST N'GO BLOOD	689, 816
TEGRETOL..... 165, 207	GLUCOSE SYSTEM... 629, 815	THRIVITE RX..... 409
TEGRETOL XR..... 165, 207	TEST N'GO TEST 596, 816	THROMBI-GEL.....537
TEKTURN..... 155	TESTIM..... 428	THROMBIN-JMI..... 537
TELCARE CONTROL. 629, 814	TESTOPEL.....428	THROMBI-PAD..... 537
TELCARE LANCETS.. 629, 814	TESTOPLEX PLUS..... 11	THYQUIDITY.....465
TELCARE TEST STRIPS	<i>testosterone</i> 428, 429	<i>thyroid (pork)</i> 464
.....595, 814	<i>testosterone cypionate</i> 428	Tiadyt Er..... 144
TELIORA..... 326	<i>testosterone enanthate</i> 428	<i>tiagabine</i> 162
<i>telmisartan</i> 125	TETOXIA..... 326	TIAZAC..... 144
<i>telmisartan-amlodipine</i> 122	<i>tetrabenazine</i> 225	TIBSOVO.....96
<i>telmisartan-</i>	<i>tetracaine hcl</i> 862	<i>ticagrelor</i> 541
<i>hydrochlorothiazid</i> 123	<i>tetracaine hcl (pf)</i> 862	TICANASE.....889
<i>temazepam</i> 204, 234	<i>tetracycline</i> 83	TIGLUTIK..... 549
TEMBEXA..... 84	Texacort.....323	TIKOSYN..... 128
<i>temozolomide</i> 87	TEZRULY..... 152	Tilia Fe.....259
TEMPO REFILL KIT WITH	TEZSPIRE.....879	<i>timol-brimon-dorzol-</i>
GAUZE..... 629, 814	THALITONE..... 150	<i>bimato(pf)</i> 848
TEMPO SMART BUTTON	THALOMID..... 56, 101	<i>timolol</i> 861
.....660, 814	THEO-24..... 880	<i>timolol maleate</i> 142, 861
TEMPO WELCOME KIT	<i>theophylline</i> 880	<i>timolol maleate (pf)</i> 861
.....629, 814	THERABREATH.....842	<i>timolol-bimatoprost</i> 859
Tencon.....28	THERABREATH DRY	<i>timolol-brimon-dorzol-</i>
TENIVAC (PF)..... 110, 111	MOUTH..... 842	<i>bimatop</i> 848
<i>tenofovir disoproxil fumarate</i>	THERAHONEY 353, 816	<i>timolol-brimonidi-</i>
.....63, 69	THERA-M..... 387	<i>dorzolam(pf)</i> 858
TENORETIC 100..... 146	THERANATAL.....409	<i>timolol-brimonidine-</i>
TENORETIC 50..... 146	THERANATAL COMPLETE 409	<i>dorzolamid</i> 848
TENORMIN..... 141	THERANATAL ONE..... 409	<i>timolol-dorzolam-</i>
TENS 502..... 660, 814	THERANATAL OVAVITE.... 412	<i>bimatopro(pf)</i> 858
TENS 504..... 660, 815	THERANATAL PLUS..... 409	<i>timolol-dorzolamide-</i>
TENSCARE ITOUCH SURE	THERAPEUTIC	<i>bimatopros</i> 858
.....633, 815	MOISTURIZING CREAM.... 308	TIMOPTIC OCUDOSE (PF) 861
TEPMETKO.....99	THERAPEUTIC-M..... 387	<i>tinidazole</i> 59
<i>terazosin</i> 152	THERA-VITE MAX-M..... 387	<i>tiopronin</i> 513
<i>terbinafine hcl</i> 54	THEREMS MULTIVITAMIN.391	<i>tiotropium bromide</i> 880
<i>terbutaline</i> 883	<i>thiamine hcl (vitamin b1)</i> 416	TIROSINT.....465
<i>terconazole</i> 894	<i>thiamine mononitrate (vit b1)</i>	TIROSINT-SOL..... 465
<i>teriflunomide</i> 846	416	TISSEEL VHSD
<i>teriparatide</i> 438	THICK AND EASY.....241	(APROTININ, SYN)..... 344
Terrell..... 44	THIN LANCETS.....629, 816	TIVICAY.....60
TERSI FOAM.....298	THINPRO INSULIN	TIVICAY PD.....60
TERUMO ALLERGY	SYRINGE..... 649, 816	<i>tizanidine</i> 553
SYRINGE..... 678, 815	THIOLA.....513	TLANDO.....429
TERUMO HYPODERMIC	THIOLA EC.....513	TM-VITE RX..... 358
NEEDLE/SYRIN..... 678, 815	<i>thioridazine</i> 189	TOBI.....886
	<i>thiothixene</i> 189	TOBI PODHALER..... 886

TOBRADEX.....	850	<i>trandolapril-verapamil</i>	119	TRIJARDY XR.....	437
TOBRADEX ST.....	850	<i>tranexamic acid</i>	535	TRIKAFTA.....	887
<i>tobramycin</i>	864, 886	TRANSDERM-SCOP.....	468	Tri-Legest Fe.....	259
<i>tobramycin in 0.225 % nacl</i>	886	<i>tranylcypromine</i>	174	TRILEPTAL.....	165
<i>tobramycin with nebulizer</i>	886	TRANZAREL.....	346	Tri-Linyah.....	259
<i>tobramycin-dexamethasone</i>	850	TRAVATAN Z.....	867	TRILOAN II SUIK.....	450
<i>tobramycin-vancomycin</i>		<i>travoprost</i>	867	TRILOAN SUIK.....	450
.....	851, 864	<i>trazodone</i>	176	Tri-Lo-Estarylla.....	259
TOBREX.....	864	TRECATOR.....	66	Tri-Lo-Marzia.....	259
TOLAK.....	291	TRELEGY ELLIPTA.....	885	Tri-Lo-Mili.....	259
<i>tolcapone</i>	182	TREMFYA.....	280, 485	Tri-Lo-Sprintec.....	259
<i>tolmetin</i>	39	TREMFYA ONE-PRESS		TRI-LUMA.....	304
TOLSURA.....	56	.....	280, 484	TRILURON.....	551
<i>tolterodine</i>	523	TREMFYA PEN.....	280, 485	<i>trimethobenzamide</i>	469
<i>tolvaptan</i>	150	TREMFYA PEN		<i>trimethoprim</i>	53
<i>tolvaptan (polycys kidney</i>		INDUCTION PK-CROHN....	484	Tri-Mili.....	259
<i>dis)</i>	517	<i>treprostinil sodium</i>	154	<i>trimipramine</i>	180
TOOMEY SYRINGE....	678, 816	TRESIBA FLEXTOUCH U-		TRIMO-SAN JELLY.....	895
TOPAMAX.....	166	100.....	456	TRINATAL RX 1.....	409
TOPCARE CLICKFINE.....	649, 816	TRESIBA FLEXTOUCH U-		TRINATE.....	409
TOPCARE ULTRA		200.....	456	TRINTELLIX.....	178
COMFORT.....	649, 816, 817	TRESIBA U-100 INSULIN...	456	TRIONEX.....	295
TOPCARE UNIVERSAL1		TRESNI.....	40	TRIPLE OMEGA 3-6-9.....	138
LANCET.....	629, 817	<i>tretinoin</i>	278	Tri-Sprintec (28).....	259
Topicort.....	324	<i>tretinoin (antineoplastic)</i>	100	TRISTART DHA.....	409
TOPICORT.....	324	<i>tretinoin microspheres</i>	278	TRIUMEQ.....	64
<i>topiramate</i>	166, 167	TRETEN.....	532	TRIUMEQ PD.....	64
TOPROL XL.....	141	TREXALL.....	33, 89	TRIVIA COMPLETE.....	391
<i>toremifene</i>	100	<i>triacetin</i>	291	TRIVISC.....	551
TORONOVA II SUIK.....	39	<i>triamcinolone acetonide</i>		TRI-VITAMIN (A-D-FOL)-	
TORONOVA SUIK.....	39	.....	324, 450, 841	FLUORIDE.....	400
Torpenz.....	95	<i>triamterene</i>	149	Trivora (28).....	259
<i>torsemide</i>	149	<i>triamterene-</i>		Tri-Vylibra.....	260
TOSYMRA.....	223	<i>hydrochlorothiazid</i>	149, 150	Tri-Vylibra Lo.....	259
TOTALVISC.....	864	Trianex.....	324	TROJAN ULTRA RIBBED	
TOUCH-TROL.....	694, 817	TRIASIL.....	324	CONDOM.....	658, 817
TOUJEO MAX U-300		<i>triazolam</i>	204, 234	TROKENDI XR.....	167, 168
SOLOSTAR.....	455	TRIBENZOR.....	122	<i>tropicamide</i>	852
TOUJEO SOLOSTAR U-300		TRICARE.....	409	<i>trospium</i>	523
INSULIN.....	456	TRI-CHLOR.....	332	TRUBIOTICS.....	503
Tovet Emollient.....	324	<i>trichloroacetic acid</i>	332	TRUBIOTICS BABY.....	503
TOVET KIT.....	327	TRICITRATES.....	519	TRUBIOTICS GUMMY.....	503
TOVIAZ.....	523	TRICOR.....	130	TRUBIOTICS KIDS	
TPOXX (NATIONAL		Triderm.....	324	CHEWABLE.....	503
STOCKPILE).....	84	<i>trientine</i>	49	TRUBIOTICS KIDS GUMMY	
TRACLEER.....	155	Tri-Estarylla.....	259	.....	503
TRADJENTA.....	431	TRIFERIC.....	367	TRUDHESA.....	220
<i>tramadol</i>	18, 19	<i>trifluoperazine</i>	189	TRUE COMFORT INSULIN	
<i>tramadol-acetaminophen</i>	27	<i>trifluridine</i>	866	SYRINGE.....	649, 817
<i>trandolapril</i>	120	<i>trihexyphenidyl</i>	183		

TRUE COMFORT LANCET 629, 817	TRUSTEEL INFUSION SET 23"..... 697, 820	TYBOST..... 837
TRUE COMFORT PEN NEEDLE..... 650, 817	TRUSTEEL INFUSION SET 32"..... 698, 820	Tydemy.....256
TRUE COMFORT PRO INS SYRINGE..... 650, 817	TRUSTEX LATEX CONDOM..... 658, 820	TYENNE..... 35
TRUE COMFORT SAFE INSULIN SYRG..... 650, 818	TRUSTEX LUBRICATED CONDOMS.....658, 820	TYENNE AUTOINJECTOR... 35
TRUE COMFORT SAFETY PEN NEEDLE.....650, 818	TRUSTEX NON-LUB CONDOMS.....658, 820	TYKERB..... 85
TRUE COVER CONDOM 658, 818	TRUSTEX-RIA LUB/SPERMICIDE..... 658, 820	TYMLOS.....438
TRUE METRIX AIR GLUCOSE METER..... 629, 818	TRUSTEX-RIA LUBRICATED CONDOMS 658, 820	TYREX-2..... 396
TRUE METRIX GLUCOSE METER.....629, 818	TRUSTEX-RIA NON-LUB CONDOMS.....658, 820	TYRVAYA.....890
TRUE METRIX GLUCOSE TEST STRIP.....596, 818	TRUVADA..... 62	TYVASO..... 154
TRUE METRIX GO GLUCOSE METER..... 629, 818	TRUZONE PEAK FLOW METER.....681, 820	TYVASO DPI..... 154
TRUE METRIX LEVEL 1 630, 818	TRYNGOLZA.....118, 128	TYVASO INSTITUTIONAL START KIT..... 154
TRUE METRIX LEVEL 2 630, 818	TRYPTIR.....847	TYVASO REFILL KIT..... 154
TRUE METRIX LEVEL 3 630, 819	TRYVIO..... 118	TYVASO STARTER KIT.....154
TRUE2GO BLOOD GLUCOSE SYSTEM... 630, 819	TUBERCULIN SYRINGE 678, 820, 821	UBRELVY.....219
TRUEDRAW LANCING DEVICE..... 630, 819	<i>tuberculin-allergy syringes</i> 678, 821	UCERIS.....486
TRUEPLUS INSULIN 650, 651, 819	TUDORZA PRESSAIR.....881	UDENYCA.....534
TRUEPLUS KETONE..694, 819	TUKYSA..... 92	UDENYCA AUTOINJECTOR.....534
TRUEPLUS LANCETS630, 819	Tulana.....258	UDENYCA ONBODY..... 534
TRUEPLUS PEN NEEDLE 651, 819	TULIVITE.....368	ULESFIA.....350
TRUERESULT BLOOD GLUCOSE SYSTM.....630, 819	TURALIO..... 100	ULORIC.....524
TRUETEST TEST STRIPS 596, 819	<i>turmeric root extract</i> 11	ULTANE..... 44
TRUETRACK BLOOD GLUCOSE SYSTEM... 630, 820	<i>turmeric root ext-sour cherry.</i> 11	ULTICARE.....651, 679, 822
TRUETRACK SMART SYSTEM.....630, 820	<i>turmeric root-ginger root ext..</i> 11	ULTICARE INSULIN SYRINGE..... 651, 821
TRUETRACK TEST.... 597, 820	<i>turmeric-ginger-black pepper.</i> 11	ULTICARE INSULN SYR(HALF UNIT)..... 651, 821
TRULANCE..... 471, 483	<i>turmeric-turmeric ext-pepper.</i> 11	ULTICARE LOW DEAD SPACE SYRING.....678, 821
TRULICITY..... 432	<i>turmeric-turmeric root extract</i> 11	ULTICARE PEN NEEDLE 651, 821
TRUMENBA..... 112	Turqoz (28).....256	ULTICARE SAFETY PEN NEEDLE..... 651, 821
TRUQAP.....84	TUXARIN ER.....891	ULTICARE SAFETY SYRINGE..... 679, 821, 822
TRUSKIN.....348	TWIIST REFILL KT(CSST- NDL-SYR).....692, 821	ULTICARE TB SAFETY SYRINGE..... 679, 822
	TWIIST RFL(INFUS-CSST- NDL-SYR).....692, 821	ULTIGUARD SAFEPAK- INSULIN SYR..... 651, 652, 822
	TWIIST STARTER KIT 692, 821	ULTIGUARD SAFEPAK- PEN NEEDLE.....652, 822
	TWINRIX (PF)..... 105	ULTI-LANCE.....630, 822
	TWIRLA.....260	ULTILET BASIC LANCETS 630, 822
	TWIST LANCETS.....630, 821	ULTILET CLASSIC LANCETS..... 630, 823
	TWYNEO.....276	ULTILET INSULIN SYRINGE..... 652, 823
	TYBLUME.....256	ULTILET LANCETS.....630, 823

ULTILET PEN NEEDLE 652, 823	ULTRA-THIN II (SHORT) PEN NDL.....654, 826	UNISTIK 3 EXTRA LANCET 631, 828
ULTILET SAFETY LANCETS.....630, 823	ULTRA-THIN II INS PEN NEEDLES.....654, 826	UNISTIK 3 GENTLE 631, 828
ULTIMA MONITOR.....630, 823	ULTRA-THIN II INSULIN SYRINGE.....655, 826	UNISTIK 3 NORMAL LANCET.....631, 828
ULTIMA TEST STRIPS 597, 823	ULTRA-THIN II LANCETS 631, 826	UNISTIK COMFORT LANCETS.....631, 828
ULTRA B-100 COMPLEX (FOODBASE).....358	ULTRATRAK.....597, 827	UNISTIK CZT LANCET 631, 828
ULTRA BONEUP.....363	ULTRATRAK GLUCOSE METER.....631, 826	UNISTIK EXTRA LANCETS 632, 828
ULTRA CMFT INS SYR (HALF UNIT).....652, 823	ULTRATRAK HIGH-LOW CONTROL.....631, 826	UNISTIK NORMAL LANCETS.....632, 828
ULTRA COMFORT INSULIN SYRINGE.....652, 653, 824	ULTRATRAK NORMAL CONTROL.....631, 826	UNISTIK PRO LANCET 632, 829
ULTRA FLO INSUL SYR(HALF UNIT).....653, 824	ULTRATRAK ULTIMATE 598, 631, 827	UNISTIK SAFETY.....632, 829
ULTRA FLO INSULIN SYRINGE.....653, 824	ULTRAVATE.....296, 325	UNISTIK TOUCH LANCETS 632, 829
ULTRA FLO PEN NEEDLE 653, 824	UNIFINE OTC PEN NEEDLE.....655, 827	UNISTRIP LOW CONTROL 632, 829
ULTRA MOISTURE.....308	UNIFINE PENTIPS.....655, 827	UNISTRIP1 TEST STRIP 598, 829
ULTRA PRENATAL PLUS DHA.....410	UNIFINE PENTIPS MAXFLOW.....655, 827	UNITHROID.....465
ULTRA THIN II LANCETS 630, 824	UNIFINE PENTIPS PLUS 655, 828	UNIVERSAL 1 LANCETS 632, 829
ULTRA THIN LANCETS 630, 824	UNIFINE PENTIPS PLUS MAXFLOW.....655, 827	UNZDOMDIOXIAZAR.....273
ULTRA THIN PEN NEEDLE 653, 824	UNIFINE PROTECT...655, 828	UP4 PROBIOTICS KIDS CUBES.....503
ULTRA THIN PLUS LANCETS.....630, 824	UNIFINE SAFECONTROL PEN NEEDLE.....655, 828	UP4 PROBIOTICS MEN'S..503
ULTRA TLC LANCETS631, 825	UNIFINE ULTRA PEN NEEDLE.....655, 828	UP4 PROBIOTICS PLUS PREBIOTIC.....503
ULTRACARE INSULIN SYRINGE.....653, 825	UNILET COMFORTOUCH LANCET.....631, 828	UP4 PROBIOTICS ULTRA..504
ULTRA-CARE LANCETS 631, 825	UNILET GP LANCET..631, 828	UP4 PROBIOTICS WOMEN'S.....504
ULTRACARE PEN NEEDLE 654, 825	UNILET LANCET.....631, 828	UP4 PROBIOTICS- PREBIOTICS KIDS.....504
ULTRA-FINE INS SYR (HALF UNIT).....654, 825	UNILET LANCETS.....631, 828	UPNEEQ (PF).....848
ULTRA-FINE INSULIN SYRINGE.....654, 825	UNILET SUPER THIN LANCETS.....631, 828	UPTRAVI.....152
ULTRA-FINE PEN NEEDLE 654, 825	UNISOM SIMPLE SLUMBERS.....218	URAMAXIN.....332, 333
ULTRAFOAM.....537	UNISPEND ANHYDROUS SWEET.....242	URAMAXIN GT.....331, 332
ULTRALANCE LANCETS 631, 825	UNISTIK 2 DEVICE 631, 828	<i>urea</i> 309, 333
ULTRASAL-ER.....332	UNISTIK 2 EXTRA LANCET 631, 828	UREA NAIL STICK.....333
ULTRA-THIN II (SHORT) INS SYR.....654, 826	UNISTIK 2 NORMAL LANCET.....631, 828	UREAPRO.....149
	UNISTIK 3 COMFORT LANCET.....631, 828	URELLE.....75, 520
		URETRON D-S.....75, 520
		URIBEL TABS.....75, 520
		URIMAR-T.....75, 520
		URNEVA.....75, 520
		UROCIT-K 10.....519
		UROCIT-K 15.....519

UROGESIC-BLUE.....	75, 521	<i>varenicline tartrate</i>	239	VEREGEN.....	329
URO-MP.....	75, 521	VARISOFT INFUSION SET		VERIFINE INSULIN	
UROQID-ACID NO.2.....	75, 519	23".....	698, 830	SYRINGE.....	656, 830, 831
URO-SP.....	76, 521	VARISOFT INFUSION SET		VERIFINE PEN NEEDLE	
UROXATRAL.....	517	32".....	698, 830	.....	656, 831
URSO FORTE.....	473	VARISOFT INFUSION SET		VERIFINE PLUS PEN	
<i>ursodiol</i>	473	43".....	698, 830	NEEDLE.....	656, 831
URYL.....	76, 521	VARITHENA		VERIFINE PLUS PEN	
VAFSEO.....	525	ADMINISTRATION PACK		NEEDLE-SHARP.....	656, 831
VAGIFEM.....	896	.....	680, 830	VERIFINE SAFETY	
VAGINAL		VARIVAX (PF).....	109, 117	LANCET MINI.....	632, 831
CONTRACEPTIVE FILM.....	262	VAROPHEN		VERIFINE UNIVERSAL	
<i>valacyclovir</i>	72	(DICLOFENAC).....	337	LANCET.....	632, 831
VALCHLOR.....	291	VAROXIA.....	276	Veripred 20.....	450
VALCYTE.....	68	VARUBI.....	471	VERKAZIA.....	856
<i>valerian</i>	11	VASCEPA.....	134	VERQUVO.....	126
<i>valerian root</i>	11	VASELINE WHITE		VERSACLOZ.....	188
<i>valganciclovir</i>	68	PETROLEUM.....	340	VERTIGOHEEL.....	466
VALINE 1000.....	357	VASERETIC.....	120	VERZENIO.....	92
VALINE AMINO ACID		VASHE.....	351	VESICARE.....	521
SUPPLEMENT.....	357	VASOTEC.....	121	VESICARE LS.....	521
VALIUM.....	158, 204	VAXCHORA VACCINE.....	109, 112	Vestura (28).....	256
<i>valproic acid</i>	160, 207	VAXNEUVANCE (PF).....	112	VEVEN.....	300
<i>valproic acid (as sodium</i>		VCF CONTRACEPTIVE		VEVYE.....	856
<i>salt)</i>	160, 207	FILM.....	262	VFEND.....	56
<i>valsartan</i>	125	VCF CONTRACEPTIVE		V-GO 20.....	692, 831
<i>valsartan-</i>		GEL.....	262	V-GO 30.....	692, 831
<i>hydrochlorothiazide</i>	123	VECAMYL.....	150	V-GO 40.....	692, 831
VALTOCO.....	160, 204	VECTICAL.....	296	VIBERZI.....	483, 504
VALTREX.....	72	VEGETARIAN BONEUP.....	363	VIBRANT.....	660, 831
Valtya.....	256	Velivet Triphasic Regimen		VIBRANT STARTER KIT	
Vanadom.....	553	(28).....	260	.....	660, 831
VANOCOCIN.....	69	VELPHORO.....	516	VICTOZA 2-PAK.....	432
<i>vancomycin</i>	69	VELSIPITY.....	487	VICTOZA 3-PAK.....	432
VANDAZOLE.....	895	VELTASSA.....	360	VIEKIRA PAK.....	71
VANFLYTA.....	93	VEMLIDY.....	69	Vienna.....	256
VANISHPOINT INSULIN		VENCLEXTA.....	91	<i>vigabatrin</i>	162
SYRINGE.....	655, 829	VENCLEXTA STARTING		Vigadrone.....	162
VANISHPOINT SYRINGE		PACK.....	91	VIGAFYDE.....	162
.....	655, 656, 679, 829, 830	ENELEX.....	354	VIGAMOX.....	865
VANISHPOINT		<i>venlafaxine</i>	178	Vigpoder.....	162
TUBERCULIN SYRINGE		<i>venlafaxine besylate</i>	178	VIIBRYD.....	178
.....	679, 830	VENNGEL II.....	338	VIJOICE.....	836
VANOS.....	325	VENNGEL ONE.....	338	<i>vilazodone</i>	178
VANOXIDE-HC.....	274	VENTAVIS.....	154	VIMPAT.....	161
VANRAFIA.....	118	VENTOLIN HFA.....	882	VIOKACE.....	472
VAPRO PLUS INTERMITT		Venxxiva.....	513	Viorele (28).....	248
CATHETER.....	694, 830	VEOZAH.....	425	VIOS AEROSOL DELIVERY	
VAQTA (PF).....	106	<i>verapamil</i>	128, 145	SYSTEM.....	689, 831
VARDIMAXIA.....	276	VERDESO.....	325	VIRACEPT.....	77

VIRAGRAPHIS.....	11	VITAMIN K.....	424	VRAYLAR.....	191, 208
VIRASAL.....	333	Vitamin K1.....	424	VTAMA.....	296
VIRAZOLE.....	78	<i>vitamin k2</i>	424	VUITY.....	849
VIREAD.....	63, 70	<i>vitamin k2 (mk-4)</i>	424	VUMERITY.....	845
VISCO-3.....	551	VITRAKVI.....	101	VUSION.....	289
VISION HEALTH.....	4	VITREXYL.....	387	VYALEV.....	182
VISION OPTIMIZER.....	4, 387	VITREXYL PLUS IRON.....	387	Vyfemla (28).....	256
VISTA ADVANCED		VITRON-C.....	368	VYKAT XR.....	897
AREDS2.....	4, 387	VIVAGUARD INO CTRL		Vylibra.....	256
VISTA MEIBO EYELID		SOLN-L1,2,3.....	632, 831	VYNDAMAX.....	427
CLEANSING.....	309	VIVAGUARD INO CTRL		VYNDAQEL.....	427
VISTASEAL-FIBRIN		SOLN-L1,L3.....	632, 831	VYTONE.....	284
SEALANT.....	537	VIVAGUARD INO CTRL		VYTORIN 10-10.....	140
VISTOGARD.....	102	SOLN-L2.....	632, 832	VYTORIN 10-20.....	140
<i>vit a palmitate-vit c-vit d3</i>	397	VIVAGUARD INO		VYTORIN 10-40.....	140
<i>vit b comp-folic-choline-inosi</i>	358	GLUCOSE METER.....	632, 832	VYTORIN 10-80.....	140
<i>vit c-echinacea purpurea xt</i>	11	VIVAGUARD INO SMART		VYVANSE.....	200
VITABEX IRON.....	368	GLUC METER.....	632, 832	VYVGART HYTRULO.....	549
VITAFOL FE PLUS.....	410	VIVAGUARD INO TEST		VYZULTA.....	867
VITAFOL FE+ (WITH		STRIP.....	598, 832	WAINUA.....	427
DOCUSATE).....	410	VIVAGUARD LANCET.....	632, 832	WAKIX.....	227
VITAFOL GUMMIES.....	412	VIVAGUARD LANCING		<i>warfarin</i>	526
VITAFOL ULTRA.....	410	DEVICE.....	632, 832	<i>water for irrigation, sterile</i>	360
VITAFOL-OB.....	410	VIVAGUARD SAFETY		WAYRILZ.....	527
VITAFOL-OB+DHA.....	410	LANCET.....	632, 832	WAYZEN.....	331
VITAFOL-ONE.....	410	VIVELLE-DOT.....	445	WEEKLY-D.....	423
VITAFUSION PRENATAL...	387	VIVJOA.....	55	WEGOVY.....	897
VITAJOY ADULT MULTI.....	387	VIVONEX PEDIATRIC.....	395	WELCHOL.....	129
VITAJOY BIOTIN.....	420	VIVOTIF.....	109, 111	WELERIS.....	331
VITAJOY DAILY C.....	421	VIZIMPRO.....	86	WELIREG.....	93
VITAL AF 1.2 CAL.....	395	VIZZ.....	849	WELLBUTRIN SR.....	180
VITAL PEPTIDE 1.5 CAL...	395	VOGELXO.....	429	WELLBUTRIN XL.....	180
VITALVASC.....	11	Volnea (28).....	248	WELLFOLA.....	387
VITAMEDMD ONE RX.....	410	VONJO.....	94	WELLPRO-31.....	504
<i>vitamin a</i>	415	VONVENDI.....	535	Wera (28).....	256
<i>vitamin a palmitate</i>	415	VOQUEZNA.....	466	WESCAP-C DHA.....	388
<i>vitamin b complex</i>	358	VOQUEZNA DUAL PAK.....	482	WESCAP-PN DHA.....	391
VITAMIN B COMPLEX-		VOQUEZNA TRIPLE PAK...	483	WESCAPS.....	358
ELECTROLYTES.....	358	VORANIGO.....	85	WESNATAL DHA	
<i>vitamin b12-folic acid</i>	417	<i>voriconazole</i>	56	COMPLETE.....	410
VITAMIN C FIZZY DRINK...	414	VORTEX HOLDING		WESNATE DHA.....	410
VITAMIN C WITH ROSE		CHAMBER.....	689, 832	WES-PHOS 250 NEUTRAL	
HIPS.....	421	VORTEX VHC PEDIATRIC		.....	371, 518
Vitamin D2.....	423	MASK.....	689, 832	WESTAB MAX.....	416, 424
<i>vitamin d2-vitamin k1</i>	421	VOSEVI.....	70	WESTAB ONE.....	416, 424
<i>vitamin d3-vitamin k2</i>	421	VOTRIENT.....	100	WESTAB PLUS.....	411
<i>vitamin e (dl, acetate)</i> ..	309, 423	VOWST.....	466	WESTGEL DHA.....	411
<i>vitamin e acetate (bulk)</i>	240, 423	VOXZOGO.....	438	WHYTEDERM SURGIPAK.....	354
<i>vitamin e-safflower oil</i>	308	VOYDEYA.....	525	WHYTEDERM TDPAK.....	327
<i>vitamin e-vitamins a and d</i> ...	308	VP-CH-PNV.....	410		

WHYTEDERM TRILASIL PAK..... 327	XARELTO DVT-PE TREAT 30D START..... 527	XTANDI..... 88
WIDE-SEAL DIAPHRAGM 60.....603, 832	XATMEP.....33, 89	Xulane..... 260
WIDE-SEAL DIAPHRAGM 65.....603, 832	XCELLENT C..... 421	XULTOPHY 100/3.6..... 437
WIDE-SEAL DIAPHRAGM 70.....603, 832	XCELLENT E.....415	XUREA..... 333
WIDE-SEAL DIAPHRAGM 75.....603, 832	XCELLISTEM..... 349	XURIDEN..... 835
WIDE-SEAL DIAPHRAGM 80.....603, 832	XCLAIR.....308	XYBIOTIC.....504
WIDE-SEAL DIAPHRAGM 85.....603, 833	XCOPRI.....173	XYLIDERM..... 346
WIDE-SEAL DIAPHRAGM 90.....603, 833	XCOPRI MAINTENANCE PACK.....173	XYLIGEL.....842
WIDE-SEAL DIAPHRAGM 95.....603, 833	XDEMVI..... 847	XYLIMELTS.....842
WILATE..... 532	XELJANZ.....35, 487	XYMOBOLX..... 356
WILLIS THE WHALE COMPRESSR NEB..... 689, 833	XELJANZ XR.....35, 487	XYMODINE..... 365
WINLEVI.....264	XELODA..... 90	XYNTHA..... 532
WINREVAIR..... 118	XELPROS.....867	XYNTHA SOLOFUSE..... 532
WINTERGREEN OIL.....347	Xelria Fe..... 257	XYOSTED..... 429
Wixela Inhub.....885	XELSTRYM..... 200, 212	XYREM.....227
WOMEN'S 50 PLUS ADVANCED.....388	XEMBIFY.....108	XYWAV.....227
WOMENS DAILY GUMMIES 388	XENAZINE.....225	Yargesa..... 835
WOMEN'S DAILY MULTIVITAMIN..... 388, 391	XENLETA..... 76	YASMIN (28)..... 257
WOMEN'S MULTIVITAMIN COLLAGEN..... 388	XEPI..... 284	YAXATARXYN..... 304
WOMEN'S PRENATAL PLUS DHA.....411	XERESE.....298	YAZ (28)..... 257
WOUNDGELHA MATRIX...339	XERMELO.....467	YCANTH.....333
WPR PLUS.....334	XEROFORM.....605, 833	YESINTEK.....280, 484
Wymzya Fe.....256	XEROFORM PETROLATUM DRESSING 605, 833	YEZTUGO..... 51
WYNZORA.....280	XEROFORM PETROLATUM OVERWRAP.....605, 833	YOGURT PLUS CALCIUM GUMMIES..... 364
XACIATO.....894	XHANCE.....890	YOKATAR..... 304
XADAGO.....184	XIFAXAN..... 78	YONI FIT BLADDER SUPPORT..... 633, 833
XALATAN.....867	XIGDUO XR..... 433	YONSA..... 86, 88
XALIX.....333	XIIDRA.....856	YORVIPATH.....462
XALKORI.....88	XILAPAK.....328	YOSPRALA.....542
XANAX.....158, 204	XIMINO.....84, 264	YUM-YUM DOPHILUS.....504
XANAX XR.....158, 205	XIRUN.....331	YUPELRI.....881
XARACOLL.....45	XOFLUZA.....72	YUTREPIA.....154
Xarah Fe.....260	XOLAIR.....877	Yuvaferm.....896
XARELTO.....528	XOLEGEL.....289	Zafemy.....260
	XOLREMDI.....527	<i>zafirlukast</i> 879
	XOPENEX HFA.....882	<i>zaleplon</i> 234
	XOSPATA.....93	ZALVIT.....412
	XPHOZAH.....355	ZANAFLEX.....553
	XPOVIO.....92, 100	Zarah.....257
	XROMI.....543	ZARONTIN.....171
	XRYLIX (DICLOFENAC- KINES TAPE).....338	Zarontin.....171
	XTAMPZA ER.....19, 20	ZARXIO.....534
		ZATEAN-PN DHA.....391
		ZATEAN-PN PLUS.....388
		ZAVESCA.....835
		ZAVZPRET.....219
		ZCORT.....450

ZEGALOGUE		<i>ziprasidone hcl</i> 186, 208
AUTOINJECTOR.....	427	ZIRGAN.....866
ZEGALOGUE SYRINGE.....	427	ZITHRANOL.....296
ZEJULA.....	97	ZITHROMAX.....74
ZELAPAR.....	184	ZITHROMAX TRI-PAK.....74
ZELBORAF.....	91	ZITHROMAX Z-PAK.....74
ZELSUVMI.....	262	ZITUVIO.....431
ZEMAIRA.....	887	ZMA CLEAR.....271
ZEMBRACE SYMTOUCH...	223	ZOCOR.....133
ZEMPLAR.....	835	ZOKINVY.....838
Zenatane.....	263	ZOLINZA.....93
ZENPEP.....	472	<i>zolmitriptan</i> 223
ZENPHOR.....	353, 354, 833	ZOLOFT.....175
Zenzedi		<i>zolpidem</i> 234
.....200, 201, 212, 213, 229, 230		ZOMACTON.....452
ZEPATIER.....	70	ZOMIG.....223
ZEPBOUND.....	897	Zomig.....224
ZEPOSIA.....	487, 846	ZONEGRAN.....171
ZEPOSIA STARTER KIT		ZONISADE.....171
(28-DAY).....	487, 846	<i>zonisamide</i> 171
ZEPOSIA STARTER PACK		ZONTIVITY.....543
(7-DAY).....	487, 847	ZORTRESS.....548
ZERVIAE.....	852	ZORVOLEX.....40
ZESTORETIC.....	120	ZORYVE.....283, 296, 298
ZESTRIL.....	121	Zovia 1-35 (28).....257
ZETIA.....	136	ZOVIRAX.....72, 298
ZETONNA.....	890	ZTALMY.....168
ZIAGEN.....	62	ZTLIDO.....346
ZICLOCIN.....	337	ZUBSOLV.....236
ZICLOPRO.....	337	Zumandimine (28).....257
<i>zidovudine</i>	63	ZUNVEYL.....243
ZIEXTENZO.....	534	ZURZUVAE.....174
ZILACAINE PATCH.....	346, 691	ZYCLARA.....329
ZILBRYSQ.....	550	ZYDELIG.....96, 97
<i>zileuton</i>	876	ZYFLO.....876
ZILOVAL.....	346	ZYKADIA.....88
ZILXI.....	343	ZYLET.....851
ZIMHI.....	51	ZYLOPRIM.....524
<i>zinc amino acid chelate</i>	373	ZYMFENTRA.....30, 489
ZINC BALANCE.....	374	ZYNRELEF.....46
<i>zinc citrate</i>	373	ZYPITAMAG.....133
<i>zinc gluc, oxide-ascorbic</i>		ZYPRAM.....47
<i>acid</i>	374	ZYPREXA.....190, 208
<i>zinc gluconate</i>	373	ZYTIGA.....86, 88
<i>zinc glycinate</i>	373	ZYVOX.....76
<i>zinc oxide</i>	340	
<i>zinc sulfate</i>	374	
ZINGIBER.....	416	
ZIOPTAN (PF).....	868	
ZIPHEX.....	412	