# Medicare Employer HMO Plan

The difference is clear

Dear Group Medicare Beneficiary,

At Humana, helping you achieve lifelong well-being is our mission. With over 30 years of experience with Medicare, we've learned how to be a better partner in health.

We're excited to let you know that St. Tammany Parish School Board has asked Humana to offer you a Medicare Advantage and Prescription Drug Plan that gives you more benefits than Original Medicare.

## Learn more about the Humana Medicare Employer plan

- Review the enclosed materials. This packet includes information on your Group Medicare healthcare coverage along with extra services Humana provides.
- If you have questions about your premium, please call your benefits administrator at 985-898-6424.

## How to enroll

To begin your Humana coverage, please enroll before your effective date by filling out the enrollment form and mailing it to:

**Attn: Renee Mothershead**
**321 N. Theard Street**
**Covington, LA 70433**

- You must complete a separate application for each family member eligible for your plan.
- Please keep a copy of your application for your records.

We look forward to serving you now and for many years to come.

Sincerely,
Group Medicare Operations

## We're here for you even before you enroll

**Humana Group Medicare**
Customer Care

1-866-396-8810 (TTY: 711)
Monday – Friday
8 a.m. – 9 p.m., Eastern time

**Please call our Group Medicare Customer Care representatives if you have any questions about the plan or enrollment in the plan.**

Our automated phone system may answer your call on weekends and some public holidays. Please leave your name and telephone number and we'll call you back by the end of the next business day.

2020

# Summary of Benefits

## Humana Medicare Employer™ HMO Plan

**HMO 076/945**
St. Tammany Parish School Board


Humana®

Our service area includes the following: **Louisiana**: Acadia, Ascension, Assumption, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, East Baton Rouge, East Carroll, East Feliciana, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Richland, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Tammany, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana;

The employer, union or trust determines where they are going to offer the plan.

# Let's talk about **Humana Medicare Employer HMO,**

Find out more about the Humana Medicare Employer HMO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

## To be eligible

To join Humana Medicare Employer HMO, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

## Plan name:

Humana Medicare Employer HMO

## How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern time.

Or visit our website: **Humana.com**

Humana Medicare Employer HMO has a network of doctors, hospitals, and other providers. If you use a provider that is not in our network, neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

## A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

# Monthly Premium, Deductible and Limits

| | IN-NETWORK |
|---|---|
| **PLAN COSTS** | |
| **Monthly premium**<br>You must keep paying your Medicare Part B premium. | For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator. |
| **Medical deductible** | This plan does not have a deductible. |
| **Maximum out-of-pocket responsibility**<br>The most you pay for copays, coinsurance and other costs for medical services for the year. | **In-Network Maximum Out-of-Pocket**<br>**$1,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, Fitness Program ; Health Education Services ; Meal Benefit ; Smoking Cessation (Additional) and the Plan Premium.<br><br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. |

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | |
| Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | **$0** per admit |
| **OUTPATIENT HOSPITAL COVERAGE** | |
| Outpatient hospital visits | **$0** copay |
| Ambulatory surgical center | **$0** copay |
| **DOCTOR OFFICE VISITS** | |
| **Primary care provider (PCP)** | **$10** copay |
| **Specialists** | **$20** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **PREVENTIVE CARE** | |
| Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Covered at no cost when you see an in-network provider. Any additional preventive services approved by Medicare during the contract year will be covered. | **Covered at no cost** when you see an in-network provider. |
| **EMERGENCY CARE** | |
| **Emergency room**<br>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | **$50** copay for Medicare-covered emergency room visit(s) |
| **Urgently needed services**<br>Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | **$10** to **$20** copay |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | |
| **Diagnostic radiology** | **$0** to **$20** copay |
| **Lab services** | **$0** copay |
| **Diagnostic tests and procedures** | **$0** to **$20** copay |
| **Outpatient X-rays** | **$0** to **$20** copay |
| **Radiation Therapy** | **$0** to **$20** copay |
| **HEARING SERVICES** | |
| **Medicare-covered hearing** | **$20** copay |
| **DENTAL SERVICES** | |
| **Medicare-covered dental** | **$20** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **VISION SERVICES** | |
| **Medicare-covered vision services** | **$0** to **$20** copay |
| **Diabetic eye exam** | **$0** copay |
| **Eyewear (post-cataract)** | **$20** copay |
| **MENTAL HEALTH SERVICES** | |
| **Inpatient**<br>The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.<br>190 day lifetime limit in a psychiatric facility | **$0** per admit |
| **Outpatient group and individual therapy visits** | Outpatient therapy visit:<br>**$0** to **$20** copay |
| **SKILLED NURSING FACILITY** | |
| Our plan covers up to 100 days in a SNF.<br><br>No 3-day hospital stay is required.<br>Plan pays $0 after 100 days | **$0** copay per day for days 1-100 |
| **PHYSICAL THERAPY** | |
| | **$0** to **$20** copay |
| **AMBULANCE** | |
| | **$0** copay |
| **TRANSPORTATION** | |
| | Not covered |
| **PART B PRESCRIPTION DRUGS** | |
| | **$0** copay |
| **ALLERGY** | |
| **Allergy Shots & Serum** | **$10** to **$20** copay |

***Note:*** *some services require prior authorization and referrals from providers.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK |
|---|---|
| **CHIROPRACTIC SERVICES** | |
| **Medicare-covered chiropractic visit(s)** | **$20** copay |
| **DIABETES MANAGEMENT TRAINING** | |
| | **$0** copay |
| **FOOT CARE (PODIATRY)** | |
| **Medicare-covered foot care** | **$20** copay |
| **HOME HEALTH CARE** | |
| | **$0** copay |
| **MEDICAL EQUIPMENT/SUPPLIES** | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **0%** of the cost |
| **Medical Supplies** | **0%** of the cost |
| **Prosthetics (artificial limbs or braces)** | **0%** of the cost |
| **Diabetes monitoring supplies** | **0%** of the cost |
| **OUTPATIENT SUBSTANCE ABUSE** | |
| **Outpatient group and individual substance abuse treatment visits** | Outpatient substance abuse treatment visit:<br>**$0** to **$20** copay |
| **REHABILITATION SERVICES** | |
| **Occupational and speech therapy** | **$0** to **$20** copay |
| **Cardiac rehabilitation** | **$0** to **$20** copay |
| **Pulmonary rehabilitation** | **$0** to **$20** copay |
| **RENAL DIALYSIS** | |
| **Renal dialysis** | **$0** copay |
| **Kidney disease education services** | **$0** copay |
| **FITNESS AND WELLNESS** | |
| | SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes. |

***Note:*** *some services require prior authorization and referrals from providers.*

| | IN-NETWORK |
|---|---|
| **HOSPICE**<br>You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice. | |

***Note:*** *some services require prior authorization and referrals from providers.*

# Notes

# Notes

# Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights 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, **1-800-368-1019, 800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

## Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

### Multi-Language Interpreter Services

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# Find out **more**

You can see our plan's provider directory at our website at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.
If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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2020

# Prescription Drug Schedule

## Humana Medicare Employer™ Plan

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**Rx 120**
St. Tammany Parish School Board


Humana®

# Let's talk about **Humana Medicare Employer Rx,**

Find out more about the Humana Medicare Employer Rx plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, ask us for the "Evidence of Coverage" or you will receive one after you enroll.

# Monthly Premium, Deductible and Limits

**Pharmacy (Part D) deductible** This plan does not have a deductible.

# Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,020**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

| Tier | Standard Retail Pharmacy | Standard Mail Order |
|---|---|---|
| **30-day supply** | | |
| **1 (Generic or Preferred Generic)** | **$15** copay | **$15** copay |
| **2 (Preferred Brand)** | **$40** copay | **$40** copay |
| **3 (Non-Preferred Drug)** | **$60** copay | **$60** copay |
| **4 (Specialty Tier)** | **$60** copay | **$60** copay |
| **90-day supply** | | |
| **1 (Generic or Preferred Generic)** | **$45** copay | **$30** copay |
| **2 (Preferred Brand)** | **$120** copay | **$80** copay |
| **3 (Non-Preferred Drug)** | **$180** copay | **$120** copay |
| **4 (Specialty Tier)** | N/A | N/A |

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. See the Prescription Drug Guide to identify commonly prescribed prescription drugs in each tier.

## ADDITIONAL DRUG COVERAGE

### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,020**.
You will continue to pay the same amount as when you were in the initial coverage stage.

### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350**, you pay the greater of:

- **$3.60** for generic (including brand drugs treated as generic) and a **$8.95** copay for all other drugs, or
- **5%** coinsurance (**$60** maximum out-of-pocket per prescription for a one-month supply) regardless of tier.

# Notes

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# Find out **more**

You can see our plan's pharmacy directory at our website at **https://www.humana.com/finder/pharmacy/** or call us at the number listed at the beginning of this booklet and we will send you one.

You can see our plan's drug formulary at our website at **www.humana.com/medicaredruglist** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage HMO, PPO organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

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2020

# Prescription Drug Guide

## Humana Medicare Employer Plan Abbreviated Formulary

Partial list of covered drugs

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN.

2

This abridged formulary was updated on 11/13/2019 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana Medicare Employer Plan at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit Humana.com.

Instructions for getting information about all covered drugs are inside.

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# Welcome to Humana Medicare Employer Plan!

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this drug list (formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan," it means the Humana Medicare Employer Plan . This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2020. For a complete, updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

### What is the abridged Humana Medicare Employer formulary?

A formulary is the entire list of covered drugs or medicines selected by the Humana Medicare Employer Plan. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. The Humana Medicare Employer Plan worked with a team of doctors and pharmacists to make a formulary that represents the prescription drugs we think you need for a quality treatment program. The Humana Medicare Employer Plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana Medicare Employer Plan network pharmacy, and other plan rules are followed. For more information on how to fill your medicines, please review your Evidence of Coverage.

This document is a partial formulary, which means it includes only some of the drugs covered by the Humana Medicare Employer Plan. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you're thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, call the Group Medicare Customer Care number listed in your enrollment materials. If you're a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card Monday through Friday, from 8 a.m. - 9 p.m. Eastern Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

### Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes. Changes that can affect you this year:

- **New generic drugs**. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
  - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Formulary?"
- **Drugs removed from the market**. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes**. We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. Or we may make

changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

We'll notify members who are affected by the following changes to the formulary:
- When a drug is removed from the formulary
- When prior authorization, quantity limits, or step-therapy restrictions are added to a drug or made more restrictive
- When a drug is moved to a higher cost-sharing tier

If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Formulary?"

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year.

**What if you're affected by a Drug List change?**

We'll notify you by mail at least 30 days before one of these changes happens or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of January 1, 2020. We'll update the printed formularies each month and they'll be available on **Humana.com/medicaredruglist**.

To get updated information about the drugs that Humana covers, please visit **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

**How do I use the formulary?**

There are two ways to find your drug in the formulary:

**Medical condition**

The formulary starts on page 10. We've put the drugs into groups depending on the type of medical conditions that they're used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 10. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 5 for more information on Utilization Management Requirements).

**Alphabetical listing**

If you're not sure about your drug's group, you should look for your drug in the Index that begins on page 42. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you'll see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

Prescription drugs are grouped into one of four tiers.
The Humana Medicare Employer Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

- **Tier 1 - Generic or Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for the plan
- **Tier 2 - Preferred Brand:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Generic or Preferred Generic, and at a lower cost to you than Tier 3 Non-Preferred Drug
- **Tier 3 - Non-Preferred Drug:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 2 Preferred Brand drug
- **Tier 4 - Specialty Tier:** Some injectables and other high-cost drugs

**How much will I pay for covered drugs?**

The Humana Medicare Employer Plan pays part of the costs for your covered drugs and you pay part of the costs, too.

The amount of money you pay depends on:

- Which tier your drug is on
- Whether you fill your prescription at a network pharmacy
- Your current drug payment stage - please read your Evidence of Coverage (EOC) for more information

If you qualified for extra help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage (EOC) or call Group Medicare Customer Care to find out what your costs are.

**Are there any restrictions on my coverage?**

Some covered drugs may have additional requirements or limits on coverage. These are called Utilization Management Requirements. These requirements and limits may include:

- **Prior Authorization (PA):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs to be covered under your plan. This means that you'll need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you don't get approval, the Humana Medicare Employer Plan may not cover the drug.
- **Quantity Limits (QL):** For some drugs, the Humana Medicare Employer Plan limits the amount of the drug that is covered. The Humana Medicare Employer Plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, the Humana Medicare Employer Plan requires that you first try certain drugs to treat your medical condition before coverage is available for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan will then cover Drug B.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider can fax information about your condition and need for those drugs to the Humana Medicare Employer Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 10.

You can also visit **Humana.com/medicaredruglist** to get more information about the restrictions applied to specific covered drugs.

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" on page 6 for information about how to request an exception.

**What if my drug isn't on the formulary?**

If your drug isn't included in this list of covered drugs, visit **Humana.com/medicaredruglist** to see if your plan covers your drug. You can also call Group Medicare Customer Care and ask if your drug is covered.

If the Humana Medicare Employer Plan doesn't cover your drug, you have two options:

- You can ask Group Medicare Customer Care for a list of similar drugs that the Humana Medicare Employer Plan covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

Talk to your health care provider to decide if you should switch to another drug that is covered or if you should request a formulary exception so that it can be considered for coverage.

**How do I request an exception to the formulary?**

You can ask the Humana Medicare Employer Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.

- **Formulary exception:** You can request that your drug be covered if it's not on the formulary.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was granted to cover a drug that was not on the formulary.

Generally, the Humana Medicare Employer Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or other restrictions wouldn't be as effective in treating your health condition and/or would cause adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception. When you ask for an exception, you should submit a statement from your health care provider that supports your request. This is called a supporting statement.

Generally, we must make the decision within 72 hours of receiving your health care provider's supporting statement. You can request a quicker, or expedited, exception if you or your health care provider thinks your health would seriously suffer if you wait as long as 72 hours for a decision. Once an expedited request is received, we must give you a decision no later than 24 hours after we get your health care provider's supporting statement.

**Will my plan cover my drugs if they are not on the formulary?**

You may take drugs that your plan doesn't cover. Or, you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you're a member of the plan.

Here is what we'll do for each of your current Part D drugs that aren't on the formulary, or if you have limited ability to get your drugs:

- We'll temporarily cover a 30-day supply of your drug unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 30 days of a drug) when you go to a pharmacy.
- There will be no coverage for the drugs after your first 30-day supply, even if you've been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you're a resident of a long-term care facility and you take Part D drugs that aren't on the formulary, we'll cover a 30-day supply unless you have a prescription written for fewer days (in which case we will allow multiple fills to provide up to a total of 30 days of a drug) during the first 90 days you're a member of our plan. We'll cover a 31-day emergency supply of your drug unless you have a prescription for fewer days (in which we will allow multiple fills to provide up to a total of 31 days of a drug) while you request a formulary exception if:

- You need a drug that's not on the formulary *or*
- You have limited ability to get your drugs *and*
- You're past the first 90 days of membership in the plan

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include:

- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting
- Members who transfer from one skilled-nursing facility to another and use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, the Humana Medicare Employer Plan will cover as much as a 30-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. The Humana Medicare Employer Plan will review requests for continuation of therapy on a case-by-case basis understanding when you're on a stabilized drug regimen that, if changed, is known to have risks.

**Transition extension**

The Humana Medicare Employer Plan will consider on a case-by-case basis an extension of the transition period if your exception request or appeal hasn't been processed by the end of your initial transition period. We'll continue to provide necessary drugs to you if your transition period is extended.

A Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Prescription Drug Guides are displayed.

**Humana Pharmacy® makes it easy to manage your prescriptions with mail delivery solutions**

You may be able to fill your medicines through Humana Pharmacy – Humana's mail-delivery pharmacy. You can have your maintenance medicines, specialty medicines, or supplies mailed to a place that's most convenient for you. You should get your new prescription by mail in 7 – 10 days after Humana Pharmacy has received your prescription and all the necessary information. Refills should arrive within 5 – 7 days. To get started or learn more, visit hprxweb.com. You can also call Humana Pharmacy at 1-855-899-3134 (TTY: 711) Monday – Friday, 8 a.m. to 11 p.m., and Saturday, 8 a.m. to 6:30 p.m., Eastern time.

Other pharmacies are available in our network.

## For More Information

For more detailed information about your Humana Medicare Employer Plan prescription drug coverage, please read your Evidence of Coverage (EOC) and other plan materials.

If you have questions about Humana, please visit our website at **Humana.com/medicaredruglist**. The Drug List Search tool lets you search for your drug by name or drug type.

If you have general questions about Medicare prescription drug coverage, please call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**. You can also visit **www.medicare.gov**.

# Humana Medicare Employer Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 42.

**Remember: This is only a partial list of drugs covered by Humana.** If your prescription drug isn't listed in this partial formulary, please visit our website at **Humana.com**. Our additional contact information is listed on the previous page.

**How to read your formulary**

The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:
**DL** - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
**MO** - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.

The second column lists the tier of the drug. See page 5 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 5 for more information about these requirements.

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Analgesics** | | |
| BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG BUCCAL FILM **DL** | 2 | QL (60 per 30 days) |
| *bupap 50 mg-300 mg tablet* **MO** | 1 | PA,QL (180 per 30 days) |
| *butalbital-acetaminophn 50-325* **MO** | 1 | QL (180 per 30 days) |
| *butalb-acetamin-caff 50-325-40* **MO** | 1 | QL (180 per 30 days) |
| *butalbital-asa-caffeine cap* **MO** | 1 | PA,QL (180 per 30 days) |
| *butorphanol 1 mg/ml vial* **DL** | 1 | QL (960 per 30 days) |
| *celecoxib 100 mg, 200 mg, 400 mg, 50 mg capsule* **MO** | 1 | QL (60 per 30 days) |
| *diclofenac sod ec 25 mg, 50 mg, 75 mg tab* **MO** | 1 | |
| *diclofenac sodium 1% gel* **MO** | 1 | |
| EMBEDA 100 MG-4 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 20 MG-0.8 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 30 MG-1.2 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 50 MG-2 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 60 MG-2.4 MG CAPSULE, EXTEND RELEASE, ORAL ONLY; EMBEDA 80 MG-3.2 MG CAPSULE, EXTEND RELEASE, ORAL ONLY **DL** | 2 | QL (60 per 30 days) |
| *endocet 10 mg-325 mg tablet; endocet 2.5 mg-325 mg tablet; endocet 5 mg-325 mg tablet; endocet 7.5 mg-325 mg tablet* **DL** | 1 | QL (360 per 30 days) |
| ESGIC 50 MG-325 MG-40 MG TABLET **MO** | 1 | QL (180 per 30 days) |
| FIORINAL 50 MG-325 MG-40 MG CAPSULE **MO** | 3 | PA,QL (180 per 30 days) |
| *hydrocodone-acetamin 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg; hydrocodone-acetamin 2.5-325; hydrocodone-acetamin 7.5-325* **DL** | 1 | QL (360 per 30 days) |
| *hydrocodone-ibuprofen 10-200; hydrocodone-ibuprofen 10-200 mg, 5-200 mg, 7.5-200 mg; hydrocodone-ibuprofen 7.5-200* **DL** | 1 | QL (150 per 30 days) |
| *ibuprofen 400 mg, 600 mg, 800 mg tablet* **MO** | 1 | |
| *meloxicam 15 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *meloxicam 7.5 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| MOBIC 15 MG TABLET **MO** | 3 | PA,QL (30 per 30 days) |
| NAPROSYN 500 MG TABLET **MO** | 3 | PA |
| NORCO 10 MG-325 MG TABLET; NORCO 5 MG-325 MG TABLET; NORCO 7.5 MG-325 MG TABLET **DL** | 1 | PA,QL (360 per 30 days) |
| *oxycodone hcl 10 mg, 15 mg, 20 mg, 30 mg, 5 mg tablet* **DL** | 1 | QL (360 per 30 days) |
| *oxycodon-acetaminophen 2.5-325; oxycodon-acetaminophen 7.5-325; oxycodone-acetaminophen 10-325; oxycodone-acetaminophen 5-325* **DL** | 1 | QL (360 per 30 days) |
| *tramadol hcl 50 mg tablet* **DL** | 1 | QL (240 per 30 days) |
| ULTRAM 50 MG TABLET **DL** | 3 | QL (240 per 30 days) |
| VOLTAREN 1 % TOPICAL GEL **MO** | 3 | PA |
| XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG CAPSULE SPRINKLE **DL** | 2 | QL (60 per 30 days) |

Need more information about the indicators displayed by the drug names? Please go to page 9.

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Anesthetics** | | |
| *lidocaine 5% ointment* MO | 1 | PA |
| *lidocaine 5% patch* MO | 1 | PA,QL (90 per 30 days) |
| *lidocaine hcl 0.5% vial; lidocaine hcl 1% ampul; lidocaine hcl 1.5% ampul; lidocaine hcl 2% ampul; lidocaine hcl 4% ampul* MO | 1 | |
| *lidocaine hcl 0.5% vial; lidocaine hcl 1% vial; lidocaine hcl 2% vial; lidocaine hcl 4% solution* MO | 1 | |
| *lidocaine hcl 2% jelly* MO | 1 | |
| *lidocaine viscous 2 % mucosal solution* MO | 1 | |
| *lidocaine-prilocaine cream* MO | 1 | |
| **Anti-Addiction/Substance Abuse Treatment Agents** | | |
| *acamprosate calc dr 333 mg tab* MO | 1 | |
| *buprenorphine 2 mg, 8 mg tablet sl* MO | 1 | QL (90 per 30 days) |
| CHANTIX 0.5 MG, 1 MG TABLET MO | 3 | QL (56 per 28 days) |
| *disulfiram 250 mg, 500 mg tablet* MO | 1 | |
| *naloxone 0.4 mg/ml vial* MO | 1 | |
| *naloxone 0.4 mg/ml, 1 mg/ml carpuject; naloxone 2 mg/2 ml syringe* MO | 1 | |
| *naltrexone 50 mg tablet* MO | 1 | |
| NARCAN 4 MG/ACTUATION NASAL SPRAY MO | 2 | QL (2 per 30 days) |
| SUBOXONE 12 MG-3 MG SUBLINGUAL FILM MO | 3 | PA,QL (60 per 30 days) |
| SUBOXONE 2 MG-0.5 MG SUBLINGUAL FILM; SUBOXONE 4 MG-1 MG SUBLINGUAL FILM; SUBOXONE 8 MG-2 MG SUBLINGUAL FILM MO | 3 | PA,QL (90 per 30 days) |
| VIVITROL 380 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE DL | 4 | QL (1 per 28 days) |
| ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET; ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET; ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET; ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET MO | 1 | QL (90 per 30 days) |
| ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET MO | 1 | QL (30 per 30 days) |
| ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET MO | 1 | QL (60 per 30 days) |
| **Antibacterials** | | |
| *amoxicillin 250 mg, 500 mg capsule* MO | 1 | |
| *amox-clav 250-125 mg, 500-125 mg, 875-125 mg tablet* MO | 1 | |
| *azithromycin 250 mg, 500 mg tablet* MO | 1 | |
| *aztreonam 1 gm vial* MO | 1 | |
| *baciim 50,000 unit vial* MO | 1 | |
| *bacitracin 50,000 unit vial* MO | 1 | |
| BESIVANCE 0.6 % EYE DROPS,SUSPENSION MO | 3 | ST |
| BETHKIS 300 MG/4 ML SOLUTION FOR NEBULIZATION DL | 4 | PA |

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *cefaclor 250 mg, 500 mg capsule* **MO** | 1 | |
| *cefdinir 300 mg capsule* **MO** | 1 | |
| *cefepime hcl 1 gm vial; cefepime hcl 1 gram, 2 gram vial* **MO** | 1 | |
| *cefotetan 1 gm vial; cefotetan 10 gm vial; cefotetan 2 gm vial* **MO** | 1 | |
| *cefoxitin 1 gm vial; cefoxitin 10 gm vial; cefoxitin 2 gm vial* **MO** | 1 | |
| *ceftriaxone 1 gm add-vant vial; ceftriaxone 1 gm vial; ceftriaxone 1 gram, 10 gram, 100 gram, 2 gram, 250 mg, 500 mg bulk bag; ceftriaxone 1 gram, 10 gram, 100 gram, 2 gram, 250 mg, 500 mg vial; ceftriaxone 10 gm vial; ceftriaxone 2 gm add vial; ceftriaxone 2 gm vial* **MO** | 1 | |
| *cefuroxime axetil 250 mg, 500 mg tab* **MO** | 1 | |
| *cephalexin 250 mg, 500 mg capsule* **MO** | 1 | |
| CIPRO 250 MG, 500 MG TABLET **MO** | 3 | |
| *ciprofloxacin hcl 100 mg, 250 mg, 500 mg, 750 mg tab* **MO** | 1 | |
| CLEOCIN 100 MG VAGINAL SUPPOSITORY **MO** | 3 | |
| *clindamycin 1 %, 150 mg/ml, 300 mg/2 ml, 600 mg/4 ml, 900 mg/6 ml addvan; clindamycin ph 1% solution; clindamycin ph 900 mg/6 ml vl* **MO** | 1 | |
| *daptomycin 350 mg, 500 mg vial* **DL** | 4 | |
| *dicloxacillin 250 mg, 500 mg capsule* **MO** | 1 | |
| DIFICID 200 MG TABLET **DL** | 4 | QL (20 per 10 days) |
| *doxycycline hyclate 100 mg, 20 mg tab* **MO** | 1 | |
| *doxycycline mono 100 mg, 50 mg cap* **MO** | 1 | |
| ERYTHROCIN 500 MG INTRAVENOUS SOLUTION **MO** | 1 | |
| *erythromycin 250 mg, 333 mg, 500 mg filmtab; erythromycin dr 250 mg, 333 mg, 500 mg tablet* **MO** | 1 | |
| *imipenem-cilastatin 250 mg, 500 mg vl* **MO** | 1 | |
| LEVAQUIN 250 MG, 500 MG, 750 MG TABLET **MO** | 3 | |
| *linezolid 100 mg/5 ml susp* **DL** | 4 | QL (1800 per 30 days) |
| *linezolid 600 mg/300 ml-d5w* **MO** | 1 | |
| *meropenem iv 1 gm vial; meropenem iv 1 gram, 500 mg vial* **MO** | 1 | |
| *metronidazole 250 mg, 500 mg tablet* **MO** | 1 | |
| *metronidazole top 1% gel pump; metronidazole topical 0.75% gl; metronidazole topical 1% gel; metronidazole vaginal 0.75% gl* **MO** | 1 | |
| *mupirocin 2% ointment* **MO** | 1 | |
| *mupirocin 2% cream* **MO** | 1 | |
| *nafcillin 1 gm add-van vial; nafcillin 1 gm vial; nafcillin 10 gm bulk vial; nafcillin 2 gm add-vant vial; nafcillin 2 gm vial* **MO** | 1 | |
| *nitrofurantoin mcr 100 mg, 25 mg, 50 mg cap* **MO** | 1 | QL (90 per 365 days) |
| *nitrofurantoin mono-mcr 100 mg* **MO** | 1 | QL (90 per 365 days) |

Need more information about the indicators displayed by the drug names? Please go to page 9.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *paromomycin 250 mg capsule* **MO** | 1 | |
| *penicillin vk 125 mg/5 ml, 250 mg/5 ml soln* **MO** | 1 | |
| *penicillin vk 250 mg, 500 mg tablet* **MO** | 1 | |
| *piperacil-tazobact 13.5 gm vl; piperacil-tazobact 13.5 gram, 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram; piperacil-tazobact 2.25 gm vl; piperacil-tazobact 3.375 gm vl; piperacil-tazobact 4.5 gm vial* **MO** | 1 | |
| *polymyxin b sulfate vial* **MO** | 1 | |
| *silver sulfadiazine 1% cream* **MO** | 1 | |
| *sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet* **MO** | 1 | |
| SUPRAX 400 MG CAPSULE **MO** | 3 | |
| TEFLARO 400 MG, 600 MG INTRAVENOUS SOLUTION **DL** | 4 | |
| *tetracycline 250 mg, 500 mg capsule* **MO** | 1 | |
| *tigecycline 50 mg vial* **DL** | 4 | |
| TYGACIL 50 MG INTRAVENOUS SOLUTION **DL** | 4 | |
| *vancomycin 1 gm vial; vancomycin 1,000 mg, 1.25 gram, 1.5 gram, 10 gram, 250 mg, 5 gram, 50 mg/ml, 500 mg, 750 mg vial; vancomycin 250 mg/5 ml soln; vancomycin hcl 1,000 mg, 1.25 gram, 1.5 gram, 10 gram, 250 mg, 5 gram, 50 mg/ml, 500 mg, 750 mg vial; vancomycin hcl 10 gm vial; vancomycin hcl 5 gm vial* **MO** | 1 | |
| *vancomycin hcl 125 mg capsule* **MO** | 1 | QL (120 per 30 days) |
| VIBRAMYCIN 100 MG CAPSULE **MO** | 3 | |
| VIGAMOX 0.5 % EYE DROPS **MO** | 3 | PA |
| ZITHROMAX 250 MG, 500 MG TABLET **MO** | 3 | |
| ZITHROMAX TRI-PAK 500 MG TABLET **MO** | 3 | |
| **Anticonvulsants** | | |
| CELONTIN 300 MG CAPSULE **MO** | 3 | |
| *ethosuximide 250 mg capsule* **MO** | 1 | |
| *gabapentin 100 mg, 300 mg, 400 mg capsule* **MO** | 1 | QL (270 per 30 days) |
| *gabapentin 600 mg, 800 mg tablet* **MO** | 1 | QL (180 per 30 days) |
| *lamotrigine 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14) tablet; lamotrigine odt 100 mg, 150 mg, 200 mg, 25 mg, 25 mg (21) -50 mg (7), 25 mg (35), 25 mg (42) -100 mg (7), 25 mg (84) -100 mg (14), 25 mg(14)-50 mg (14)-100 mg (7), 50 mg, 50 mg (42) -100 mg (14) tablet; lamotrigine odt kit (blue); lamotrigine odt kit (green); lamotrigine odt kit (orange); lamotrigine tab start kit-blue; lamotrigine tab start kt-green; lamotrigine tab start kt-orang* **MO** | 1 | |
| *levetiracetam 1,000 mg, 750 mg tablet* **MO** | 1 | |
| *levetiracetam 250 mg, 500 mg tablet* **MO** | 1 | QL (30 per 30 days) |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| MYSOLINE 250 MG, 50 MG TABLET DL | 4 | PA |
| NEURONTIN 100 MG, 300 MG, 400 MG CAPSULE DL | 4 | PA,QL (270 per 30 days) |
| NEURONTIN 600 MG, 800 MG TABLET DL | 4 | PA,QL (180 per 30 days) |
| *phenobarbital 100 mg, 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg tablet* MO | 1 | QL (90 per 30 days) |
| PHENYTEK 200 MG, 300 MG CAPSULE MO | 1 | |
| *phenytoin sod ext 100 mg, 200 mg, 300 mg cap* MO | 1 | |
| *primidone 250 mg, 50 mg tablet* MO | 1 | |
| *topiramate 100 mg, 200 mg, 50 mg tablet* MO | 1 | QL (120 per 30 days) |
| VIMPAT 10 MG/ML ORAL SOLUTION MO | 3 | QL (1395 per 30 days) |
| VIMPAT 100 MG, 50 MG TABLET MO | 3 | QL (30 per 30 days) |
| VIMPAT 150 MG, 200 MG TABLET MO | 3 | QL (60 per 30 days) |
| VIMPAT 200 MG/20 ML INTRAVENOUS SOLUTION MO | 3 | |
| **Antidementia Agents** | | |
| *donepezil hcl 10 mg tablet* MO | 1 | QL (60 per 30 days) |
| *donepezil hcl 10 mg, 23 mg, 5 mg tablet; donepezil hcl odt 10 mg, 23 mg, 5 mg tablet* MO | 1 | QL (30 per 30 days) |
| *ergoloid mesylates 1 mg tab* DL | 4 | |
| EXELON PATCH 13.3 MG/24 HOUR, 4.6 MG/24 HR, 9.5 MG/24 HR TRANSDERMAL MO | 3 | PA,QL (30 per 30 days) |
| *memantine hcl 10 mg, 5 mg tablet* MO | 1 | PA,QL (60 per 30 days) |
| *memantine hcl er 14 mg, 21 mg, 28 mg, 7 mg capsule* MO | 1 | PA,QL (30 per 30 days) |
| NAMENDA 10 MG, 5 MG TABLET MO | 3 | PA,QL (60 per 30 days) |
| NAMENDA TITRATION PAK 5 MG-10 MG TABLETS IN A DOSE PACK MO | 3 | PA,QL (98 per 30 days) |
| NAMENDA XR 14 MG, 21 MG, 28 MG, 7 MG CAPSULE SPRINKLE,EXTENDED RELEASE MO | 3 | PA,QL (30 per 30 days) |
| NAMENDA XR 7 MG-14 MG-21 MG-28 MG CAPSULE,SPRINKLE,EXT REL, DOSE PACK MO | 3 | PA,QL (28 per 28 days) |
| NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| NAMZARIC 7/14/21/28 MG-10 MG CAPSULE,SPRINKLE,EXTEND RELEASE,DOSE PACK MO | 2 | QL (28 per 28 days) |
| *rivastigmine 1.5 mg, 3 mg capsule* MO | 1 | QL (90 per 30 days) |
| **Antidepressants** | | |
| *amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tab* MO | 1 | PA |
| *chlordiazepo-amitriptyl 5-12.5; chlordiazepox-amitriptyl 10-25* DL | 1 | PA |
| *amoxapine 100 mg, 150 mg, 25 mg, 50 mg tablet* MO | 1 | |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *bupropion hcl sr 150 mg tablet* **MO** | 1 | QL (90 per 30 days) |
| *bupropion hcl xl 300 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *citalopram hbr 20 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| CYMBALTA 20 MG, 30 MG, 60 MG CAPSULE,DELAYED RELEASE **MO** | 3 | QL (60 per 30 days) |
| *desipramine 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tablet* **MO** | 1 | PA |
| *duloxetine hcl dr 20 mg, 30 mg, 40 mg, 60 mg cap* **MO** | 1 | QL (60 per 30 days) |
| *escitalopram 10 mg tablet* **MO** | 1 | QL (45 per 30 days) |
| *escitalopram 20 mg, 5 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *fluoxetine hcl 10 mg, 40 mg capsule* **MO** | 1 | QL (60 per 30 days) |
| *phenelzine sulfate 15 mg tab* **MO** | 1 | |
| REMERON 15 MG, 30 MG, 45 MG TABLET **MO** | 3 | QL (30 per 30 days) |
| *sertraline hcl 100 mg tablet* **MO** | 1 | QL (60 per 30 days) |
| *sertraline hcl 25 mg, 50 mg tablet* **MO** | 1 | QL (90 per 30 days) |
| *tranylcypromine sulf 10 mg tab* **MO** | 1 | |
| *trazodone 100 mg, 150 mg, 300 mg, 50 mg tablet* **MO** | 1 | |
| TRINTELLIX 10 MG, 20 MG, 5 MG TABLET **MO** | 3 | ST,QL (30 per 30 days) |
| *venlafaxine hcl er 37.5 mg cap* **MO** | 1 | QL (30 per 30 days) |
| *venlafaxine hcl er 75 mg cap* **MO** | 1 | QL (90 per 30 days) |
| WELLBUTRIN XL 150 MG 24 HR TABLET, EXTENDED RELEASE **DL** | 4 | PA,QL (90 per 30 days) |
| **Antiemetics** | | |
| *aprepitant 125 mg, 40 mg capsule* **MO** | 1 | B vs D,QL (2 per 28 days) |
| *dronabinol 10 mg, 2.5 mg, 5 mg capsule* **MO** | 1 | B vs D,QL (120 per 30 days) |
| EMEND 125 MG, 40 MG CAPSULE **MO** | 3 | PA,QL (2 per 28 days) |
| *meclizine 12.5 mg, 25 mg tablet* **MO** | 1 | |
| *metoclopramide 10 mg, 5 mg tablet* **MO** | 1 | |
| *ondansetron hcl 4 mg, 8 mg tablet* **MO** | 1 | B vs D,QL (90 per 30 days) |
| *prochlorperazine 25 mg supp* **MO** | 1 | |
| *promethazine 12.5 mg, 25 mg, 50 mg suppos; promethazine 12.5 mg, 25 mg, 50 mg suppository* **MO** | 1 | PA |
| *promethazine 12.5 mg, 25 mg, 50 mg tablet* **MO** | 1 | PA |
| SANCUSO 3.1 MG/24 HOUR TRANSDERMAL PATCH **MO** | 3 | QL (4 per 30 days) |
| **Antifungals** | | |
| *ciclopirox 0.77% gel* **MO** | 1 | |
| *ciclopirox 8% solution* **MO** | 1 | |
| *clotrimazole 10 mg troche* **MO** | 1 | |
| *fluconazole 100 mg, 150 mg, 200 mg, 50 mg tablet* **MO** | 1 | |
| *flucytosine 250 mg, 500 mg capsule* **DL** | 4 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *griseofulvin micro 500 mg tab* MO | 1 | |
| MENTAX 1 % TOPICAL CREAM MO | 3 | |
| *naftifine hcl 1% cream; naftifine hcl 2% cream* MO | 1 | ST |
| NATACYN 5 % EYE DROPS,SUSPENSION MO | 3 | |
| *nystatin 100,000 unit/gm oint* MO | 1 | |
| *nystatin 100,000 unit/ml susp* MO | 1 | |
| *nystatin 500,000 unit oral tab* MO | 1 | |
| *nystatin-triamcinolone ointm* MO | 1 | |
| *nystop 100,000 unit/gram topical powder* MO | 1 | |
| *terbinafine hcl 250 mg tablet* MO | 1 | QL (90 per 365 days) |
| *terconazole 0.4% cream; terconazole 0.8% cream* MO | 1 | |
| **Antigout Agents** | | |
| *allopurinol 100 mg, 300 mg tablet* MO | 1 | |
| COLCRYS 0.6 MG TABLET MO | 2 | QL (120 per 30 days) |
| *probenecid 500 mg tablet* MO | 1 | |
| *probenecid-colchicine tablet* MO | 1 | |
| ULORIC 40 MG, 80 MG TABLET MO | 3 | ST,QL (30 per 30 days) |
| **Antimigraine Agents** | | |
| *dihydroergotamine 1 mg/ml amp* DL | 4 | |
| *dihydroergotamine 4 mg/ml spry* DL | 4 | QL (8 per 30 days) |
| ERGOMAR 2 MG SUBLINGUAL TABLET DL | 4 | QL (20 per 28 days) |
| *migergot 2 mg-100 mg rectal suppository* DL | 4 | QL (20 per 28 days) |
| *sumatriptan succ 100 mg, 25 mg, 50 mg tablet* MO | 1 | QL (9 per 30 days) |
| **Antimyasthenic Agents** | | |
| *guanidine hcl 125 mg tablet* MO | 1 | |
| MESTINON TIMESPAN 180 MG TABLET,EXTENDED RELEASE DL | 4 | PA |
| *pyridostigmine br 30 mg, 60 mg tablet* MO | 1 | |
| **Antimycobacterials** | | |
| *dapsone 100 mg, 25 mg tablet* MO | 1 | |
| *isoniazid 100 mg/ml, 50 mg/5 ml solution; isoniazid 100 mg/ml, 50 mg/5 ml vial* MO | 1 | |
| PASER 4 GRAM GRANULES DELAYED-RELEASE PACKET MO | 1 | |
| RIFATER 50 MG-120 MG-300 MG TABLET MO | 3 | |
| **Antineoplastics** | | |
| ALUNBRIG 180 MG, 90 MG, 90 MG (7)- 180 MG (23) TABLET; ALUNBRIG 90 MG (7)-180 MG (23) TABLETS IN A DOSE PACK DL | 4 | PA,QL (30 per 30 days) |
| ALUNBRIG 30 MG TABLET DL | 4 | PA,QL (180 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *anastrozole 1 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *bicalutamide 50 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| CABOMETYX 20 MG, 40 MG, 60 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| *cyclophosphamide 25 mg, 50 mg capsule* **MO** | 1 | B vs D |
| ELITEK 1.5 MG, 7.5 MG INTRAVENOUS SOLUTION **DL** | 4 | PA |
| ERIVEDGE 150 MG CAPSULE **DL** | 4 | PA,QL (28 per 28 days) |
| ERLEADA 60 MG TABLET **DL** | 4 | PA,QL (120 per 30 days) |
| *etoposide 100 mg/5 ml vial* **MO** | 1 | B vs D |
| *hydroxyurea 500 mg capsule* **MO** | 1 | |
| IBRANCE 100 MG, 125 MG, 75 MG CAPSULE **DL** | 4 | PA,QL (21 per 28 days) |
| INLYTA 1 MG TABLET **DL** | 4 | PA,QL (180 per 30 days) |
| INLYTA 5 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |
| *letrozole 2.5 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *leucovorin cal 500 mg/50 ml vl; leucovorin calcium 10 mg/ml, 100 mg, 200 mg, 350 mg, 50 mg, 500 mg vial; leucovorin calcium 10 mg/ml, 100 mg, 200 mg, 350 mg, 50 mg, 500 mg vl* **MO** | 1 | B vs D |
| *leucovorin calcium 10 mg, 15 mg, 25 mg, 5 mg tab* **MO** | 1 | |
| LEUKERAN 2 MG TABLET **DL** | 4 | |
| *mercaptopurine 50 mg tablet* **MO** | 1 | |
| *mesna 1 gram/10 ml vial* **MO** | 1 | B vs D |
| MESNEX 400 MG TABLET **DL** | 4 | |
| ODOMZO 200 MG CAPSULE **DL** | 4 | PA,QL (30 per 30 days) |
| OPDIVO 100 MG/10 ML INTRAVENOUS SOLUTION **DL** | 4 | PA,QL (40 per 28 days) |
| REVLIMID 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG CAPSULE **DL** | 4 | PA,QL (28 per 28 days) |
| RITUXAN 10 MG/ML CONCENTRATE,INTRAVENOUS **DL** | 4 | PA |
| SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |
| SPRYCEL 140 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| SPRYCEL 20 MG TABLET **DL** | 4 | PA,QL (90 per 30 days) |
| SUTENT 12.5 MG, 25 MG, 37.5 MG, 50 MG CAPSULE **DL** | 4 | PA,QL (28 per 28 days) |
| *tamoxifen 10 mg, 20 mg tablet* **MO** | 1 | |
| TARGRETIN 1 % TOPICAL GEL **DL** | 4 | PA |
| TARGRETIN 75 MG CAPSULE **DL** | 4 | PA,QL (300 per 30 days) |
| THALOMID 100 MG, 200 MG, 50 MG CAPSULE **DL** | 4 | PA,QL (30 per 30 days) |
| *topotecan hcl 4 mg, 4 mg/4 ml (1 mg/ml) vial; topotecan hcl 4 mg/4 ml vial* **DL** | 4 | B vs D |
| XTANDI 40 MG CAPSULE **DL** | 4 | PA,QL (120 per 30 days) |
| ZYTIGA 250 MG TABLET **DL** | 4 | PA,QL (120 per 30 days) |
| ZYTIGA 500 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| **Antiparasitics** | | |
| ALBENZA 200 MG TABLET DL | 4 | |
| BILTRICIDE 600 MG TABLET DL | 4 | PA |
| DARAPRIM 25 MG TABLET DL | 4 | QL (90 per 30 days) |
| *hydroxychloroquine 200 mg tab* MO | 1 | |
| *ivermectin 3 mg tablet* MO | 1 | |
| *lindane 1% shampoo* MO | 1 | |
| *permethrin 5% cream* MO | 1 | |
| *primaquine 26.3 mg tablet* MO | 1 | |
| *quinine sulfate 324 mg capsule* MO | 1 | PA,QL (42 per 7 days) |
| **Antiparkinson Agents** | | |
| *amantadine 100 mg capsule* MO | 1 | |
| *amantadine 100 mg tablet* MO | 1 | |
| AZILECT 0.5 MG, 1 MG TABLET DL | 4 | PA,QL (30 per 30 days) |
| *benztropine mes 0.5 mg, 1 mg, 2 mg tab; benztropine mes 0.5 mg, 1 mg, 2 mg tablet* MO | 1 | PA |
| *bromocriptine 2.5 mg tablet* MO | 1 | |
| *carbidopa-levo 10-100 mg, 25-100 mg, 25-250 mg odt; carbidopa-levodopa 10-100 tab; carbidopa-levodopa 25-100 tab; carbidopa-levodopa 25-250 tab* MO | 1 | |
| *carbidopa-levo er 25-100 tab; carbidopa-levo er 50-200 tab* MO | 1 | |
| *entacapone 200 mg tablet* MO | 1 | QL (300 per 30 days) |
| NEUPRO 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR TRANSDERMAL 24 HOUR PATCH MO | 3 | QL (30 per 30 days) |
| *pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg tablet* MO | 1 | |
| *rasagiline mesylate 0.5 mg, 1 mg tab* MO | 1 | QL (30 per 30 days) |
| *ropinirole hcl 0.5 mg, 1 mg, 2 mg tablet* MO | 1 | QL (90 per 30 days) |
| RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE; RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE MO | 3 | ST,QL (360 per 30 days) |
| RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE MO | 3 | ST,QL (270 per 30 days) |
| RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE MO | 3 | ST,QL (300 per 30 days) |
| *selegiline hcl 5 mg capsule* MO | 1 | |
| *tolcapone 100 mg tablet* DL | 4 | PA |
| *trihexyphenidyl 2 mg/5 ml elx* MO | 1 | PA |
| **Antipsychotics** | | |
| ABILIFY MAINTENA 300 MG, 400 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE DL | 4 | QL (1 per 28 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE **DL** | 4 | QL (1 per 28 days) |
| ARISTADA 1,064 MG/3.9 ML SUSPENSION, EXTEND.REL. IM SYRINGE **MO** | 4 | QL (3.9 per 56 days) |
| ARISTADA 441 MG/1.6 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (1.6 per 28 days) |
| ARISTADA 662 MG/2.4 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (2.4 per 28 days) |
| ARISTADA 882 MG/3.2 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL** | 4 | QL (3.2 per 28 days) |
| *clozapine 100 mg tablet* **MO** | 1 | QL (270 per 30 days) |
| *clozapine 25 mg tablet* **MO** | 1 | QL (1080 per 30 days) |
| *fluphenazine 2.5 mg/5 ml elix* **MO** | 1 | |
| *haloperidol 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg tablet* **MO** | 1 | |
| INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML INTRAMUSCULAR SYRINGE **DL** | 4 | QL (1.5 per 28 days) |
| INVEGA SUSTENNA 156 MG/ML INTRAMUSCULAR SYRINGE **DL** | 4 | QL (1 per 28 days) |
| INVEGA SUSTENNA 39 MG/0.25 ML INTRAMUSCULAR SYRINGE **MO** | 3 | QL (1.5 per 28 days) |
| INVEGA TRINZA 273 MG/0.875 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (0.87 per 90 days) |
| INVEGA TRINZA 410 MG/1.315 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (1.31 per 90 days) |
| INVEGA TRINZA 546 MG/1.75 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (1.75 per 90 days) |
| INVEGA TRINZA 819 MG/2.625 ML INTRAMUSCULAR SYRINGE **MO** | 4 | QL (2.62 per 90 days) |
| *loxapine 10 mg, 25 mg, 5 mg, 50 mg capsule* **MO** | 1 | |
| PERSERIS 120 MG, 90 MG ABDOMINAL SUBCUTANEOUS EXTEND RELEASE SUSP SYRINGE KIT **DL** | 4 | QL (1 per 28 days) |
| *pimozide 1 mg, 2 mg tablet* **MO** | 1 | |
| *quetiapine fumarate 200 mg, 25 mg, 50 mg tab* **MO** | 1 | QL (120 per 30 days) |
| RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML INTRAMUSCULAR SYRINGE **MO** | 3 | QL (2 per 28 days) |
| RISPERDAL CONSTA 50 MG/2 ML INTRAMUSCULAR SYRINGE **DL** | 4 | QL (2 per 28 days) |
| *thioridazine 10 mg, 100 mg, 25 mg, 50 mg tablet* **MO** | 1 | |
| *thiothixene 1 mg, 10 mg, 2 mg, 5 mg capsule* **MO** | 1 | |
| *ziprasidone hcl 20 mg, 40 mg, 60 mg, 80 mg capsule* **MO** | 1 | QL (60 per 30 days) |
| **Antispasticity Agents** | | |
| *baclofen 10 mg, 20 mg tablet* **MO** | 1 | |
| *dantrolene sodium 100 mg, 25 mg, 50 mg cap* **MO** | 1 | |
| *tizanidine hcl 2 mg, 4 mg tablet* **MO** | 1 | |
| **Antivirals** | | |
| *abacavir-lamivudine-zidov tab* **DL** | 4 | QL (60 per 30 days) |
| *acyclovir 400 mg, 800 mg tablet* **MO** | 1 | |
| *acyclovir 5% ointment* **MO** | 1 | PA |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| ATRIPLA 600 MG-200 MG-300 MG TABLET **DL** | 4 | QL (30 per 30 days) |
| BIKTARVY 50 MG-200 MG-25 MG TABLET **DL** | 4 | QL (30 per 30 days) |
| CRIXIVAN 200 MG CAPSULE **MO** | 2 | QL (450 per 30 days) |
| CRIXIVAN 400 MG CAPSULE **MO** | 3 | QL (270 per 30 days) |
| DAKLINZA 30 MG, 60 MG, 90 MG TABLET **DL** | 4 | PA,QL (28 per 28 days) |
| DENAVIR 1 % TOPICAL CREAM **MO** | 3 | PA |
| DESCOVY 200 MG-25 MG TABLET **DL** | 4 | QL (30 per 30 days) |
| *entecavir 0.5 mg, 1 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| EPCLUSA 400 MG-100 MG TABLET **DL** | 4 | PA,QL (28 per 28 days) |
| FLUMADINE 100 MG TABLET **MO** | 3 | |
| FUZEON 90 MG SUBCUTANEOUS SOLUTION **DL** | 4 | QL (60 per 30 days) |
| GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET **DL** | 4 | QL (30 per 30 days) |
| HARVONI 45 MG-200 MG TABLET; HARVONI 90 MG-400 MG TABLET **DL** | 4 | PA,QL (28 per 28 days) |
| INTRON A 10 MILLION UNIT (1 ML), 10 MILLION UNIT/ML, 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML), 6 MILLION UNIT/ML INJECTION SOLUTION; INTRON A 10 MILLION UNIT (1 ML), 10 MILLION UNIT/ML, 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML), 6 MILLION UNIT/ML SOLUTION FOR INJECTION **DL** | 4 | PA |
| ISENTRESS 400 MG TABLET **DL** | 4 | QL (120 per 30 days) |
| *ledipasvir-sofosbuvir 90-400mg* **DL** | 4 | PA,QL (28 per 28 days) |
| MAVYRET 100 MG-40 MG TABLET **DL** | 4 | PA,QL (84 per 28 days) |
| ODEFSEY 200 MG-25 MG-25 MG TABLET **DL** | 4 | QL (30 per 30 days) |
| *oseltamivir phos 45 mg, 75 mg capsule* **MO** | 1 | QL (112 per 365 days) |
| PEGINTRON 50 MCG/0.5 ML SUBCUTANEOUS KIT **DL** | 4 | PA,QL (4 per 28 days) |
| RELENZA DISKHALER 5 MG/ACTUATION POWDER FOR INHALATION **MO** | 3 | QL (60 per 180 days) |
| *ribavirin 200 mg capsule* **MO** | 1 | QL (168 per 28 days) |
| *ribavirin 200 mg tablet* **MO** | 1 | QL (168 per 28 days) |
| *rimantadine hcl 100 mg tablet* **MO** | 1 | |
| SELZENTRY 300 MG, 75 MG TABLET **DL** | 4 | QL (120 per 30 days) |
| *sofosbuvir-velpatasvir 400-100* **DL** | 4 | PA,QL (28 per 28 days) |
| SOVALDI 200 MG, 400 MG TABLET **DL** | 4 | PA,QL (28 per 28 days) |
| SUSTIVA 200 MG CAPSULE **DL** | 4 | QL (120 per 30 days) |
| SUSTIVA 50 MG CAPSULE **DL** | 4 | QL (480 per 30 days) |
| TIVICAY 25 MG, 50 MG TABLET **DL** | 4 | QL (60 per 30 days) |
| *trifluridine 1% eye drops* **MO** | 1 | |
| TRIZIVIR 300 MG-150 MG-300 MG TABLET **DL** | 4 | QL (60 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| TRUVADA 100 MG-150 MG TABLET; TRUVADA 133 MG-200 MG TABLET; TRUVADA 167 MG-250 MG TABLET; TRUVADA 200 MG-300 MG TABLET DL | 4 | QL (30 per 30 days) |
| *valganciclovir 450 mg tablet* DL | 4 | QL (120 per 30 days) |
| VEMLIDY 25 MG TABLET DL | 4 | QL (30 per 30 days) |
| XOFLUZA 20 MG, 40 MG TABLET MO | 3 | QL (10 per 365 days) |
| ZIRGAN 0.15 % EYE GEL MO | 3 | QL (5 per 30 days) |
| **Anxiolytics** | | |
| *alprazolam 0.25 mg, 0.5 mg, 1 mg tablet* DL | 1 | QL (120 per 30 days) |
| ATIVAN 0.5 MG, 1 MG TABLET DL | 4 | PA,QL (90 per 30 days) |
| *buspirone hcl 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg tablet* MO | 1 | |
| *clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tab; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tablet; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg odt; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg tablet* DL | 1 | |
| *diazepam 10 mg tablet* DL | 1 | QL (120 per 30 days) |
| *hydroxyzine hcl 10 mg, 25 mg, 50 mg tablet* MO | 1 | |
| KLONOPIN 0.5 MG, 1 MG, 2 MG TABLET DL | 3 | PA |
| *lorazepam 0.5 mg, 1 mg tablet* DL | 1 | QL (90 per 30 days) |
| XANAX 0.25 MG, 0.5 MG, 1 MG TABLET DL | 4 | PA,QL (120 per 30 days) |
| **Bipolar Agents** | | |
| *lithium carbonate 150 mg, 300 mg, 600 mg cap* MO | 1 | |
| *lithium carbonate er 300 mg, 450 mg tb* MO | 1 | |
| **Blood Glucose Regulators** | | |
| *acarbose 100 mg, 25 mg, 50 mg tablet* MO | 1 | |
| AMARYL 1 MG, 2 MG, 4 MG TABLET MO | 3 | PA |
| BYDUREON 2 MG VIAL MO | 3 | QL (4 per 28 days) |
| BYDUREON 2 MG/0.65 ML SUBCUTANEOUS PEN INJECTOR MO | 3 | QL (4 per 28 days) |
| BYDUREON BCISE 2 MG/0.85 ML SUBCUTANEOUS AUTO-INJECTOR MO | 3 | QL (3.4 per 28 days) |
| CYCLOSET 0.8 MG TABLET MO | 3 | ST,QL (180 per 30 days) |
| FARXIGA 10 MG, 5 MG TABLET MO | 3 | QL (30 per 30 days) |
| FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO | 2 | |
| FIASP U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MO | 2 | |
| *glipizide 10 mg, 5 mg tablet* MO | 1 | |
| *glipizide er 10 mg, 2.5 mg, 5 mg tablet; glipizide xl 10 mg, 2.5 mg, 5 mg tablet* MO | 1 | |
| GLUCAGEN HYPOKIT 1 MG INJECTION MO | 2 | |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| GLUCAGON EMERGENCY KIT (HUMAN-RECOMB) 1 MG SOLUTION FOR INJECTION MO | 3 | ST |
| GLUCOPHAGE 1,000 MG, 500 MG, 850 MG TABLET MO | 3 | PA |
| GLUCOPHAGE XR 500 MG TABLET,EXTENDED RELEASE MO | 3 | PA,QL (120 per 30 days) |
| GLUCOTROL 10 MG, 5 MG TABLET MO | 3 | |
| GLUMETZA 1,000 MG TABLET,EXTENDED RELEASE DL | 4 | ST,QL (60 per 30 days) |
| GLUMETZA 500 MG TABLET,EXTENDED RELEASE DL | 4 | ST,QL (120 per 30 days) |
| GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET MO | 2 | QL (30 per 30 days) |
| HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MO | 3 | ST |
| HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML SUBCUTANEOUS SOLN DL | 4 | |
| HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML) SUBCUTANEOUS DL | 4 | |
| INVOKAMET 150 MG-1,000 MG TABLET; INVOKAMET 150 MG-500 MG TABLET; INVOKAMET 50 MG-1,000 MG TABLET; INVOKAMET 50 MG-500 MG TABLET MO | 2 | QL (60 per 30 days) |
| INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| INVOKANA 100 MG, 300 MG TABLET MO | 2 | QL (30 per 30 days) |
| JANUMET 50 MG-1,000 MG TABLET; JANUMET 50 MG-500 MG TABLET MO | 2 | QL (60 per 30 days) |
| JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE; JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| JANUVIA 100 MG, 25 MG, 50 MG TABLET MO | 2 | QL (30 per 30 days) |
| JARDIANCE 10 MG, 25 MG TABLET MO | 2 | QL (30 per 30 days) |
| JENTADUETO 2.5 MG-1,000 MG TABLET; JENTADUETO 2.5 MG-500 MG TABLET; JENTADUETO 2.5 MG-850 MG TABLET MO | 2 | QL (60 per 30 days) |
| JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| KAZANO 12.5 MG-1,000 MG TABLET; KAZANO 12.5 MG-500 MG TABLET MO | 3 | PA,QL (60 per 30 days) |
| KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE MO | 3 | QL (60 per 30 days) |
| KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET,EXTENDED RELEASE MO | 3 | QL (30 per 30 days) |
| LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO | 2 | |
| LANTUS U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MO | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| LEVEMIR FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN **MO** | 2 | |
| LEVEMIR U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO** | 2 | |
| *metformin hcl 1,000 mg, 500 mg, 850 mg tablet* **MO** | 1 | |
| *metformin hcl er 500 mg tablet* **MO** | 1 | QL (120 per 30 days) |
| *nateglinide 120 mg, 60 mg tablet* **MO** | 1 | |
| NESINA 12.5 MG, 25 MG, 6.25 MG TABLET **MO** | 3 | PA,QL (30 per 30 days) |
| NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30) SUBCUTANEOUS **MO** | 2 | |
| NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MO** | 2 | |
| NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML SUBCUTANEOUS SUSP **MO** | 2 | |
| NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML INJECTION SOLUTION **MO** | 2 | |
| NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML) SUBCUTANEOUS **MO** | 2 | |
| NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO** | 2 | |
| NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN **MO** | 2 | |
| NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS CARTRIDG **MO** | 2 | |
| NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SUBCUTANEOUS SOLUTION **MO** | 2 | |
| ONGLYZA 2.5 MG, 5 MG TABLET **MO** | 3 | QL (30 per 30 days) |
| OSENI 12.5 MG-15 MG TABLET; OSENI 12.5 MG-30 MG TABLET; OSENI 12.5 MG-45 MG TABLET; OSENI 25 MG-15 MG TABLET; OSENI 25 MG-30 MG TABLET; OSENI 25 MG-45 MG TABLET **MO** | 3 | PA,QL (30 per 30 days) |
| OZEMPIC 0.25 MG OR 0.5 MG (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR **MO** | 2 | QL (1.5 per 28 days) |
| OZEMPIC 1 MG/DOSE (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR **MO** | 2 | QL (3 per 28 days) |
| *pioglitazone hcl 15 mg, 30 mg, 45 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| PROGLYCEM 50 MG/ML ORAL SUSPENSION **MO** | 3 | |
| *repaglinide 0.5 mg, 1 mg, 2 mg tablet* **MO** | 1 | |
| SOLIQUA 100/33 100 UNIT-33 MCG/ML SUBCUTANEOUS INSULIN PEN **MO** | 2 | QL (15 per 24 days) |
| SYMLINPEN 120 2,700 MCG/2.7 ML SUBCUTANEOUS PEN INJECTOR **DL** | 4 | QL (10.8 per 30 days) |
| SYMLINPEN 60 1,500 MCG/1.5 ML SUBCUTANEOUS PEN INJECTOR **DL** | 4 | QL (10.5 per 28 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| SYNJARDY 12.5 MG-1,000 MG TABLET; SYNJARDY 12.5 MG-500 MG TABLET; SYNJARDY 5 MG-1,000 MG TABLET; SYNJARDY 5 MG-500 MG TABLET MO | 2 | QL (60 per 30 days) |
| SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE MO | 2 | QL (60 per 30 days) |
| TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) SUBCUTANEOUS INSULIN PEN MO | 2 | |
| TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) SUBCUTANEOUS PEN MO | 2 | |
| TRADJENTA 5 MG TABLET MO | 2 | QL (30 per 30 days) |
| TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO | 2 | |
| TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS PEN MO | 2 | |
| TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (2 per 28 days) |
| VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (9 per 30 days) |
| VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) SUBCUTANEOUS PEN INJECTOR MO | 2 | QL (9 per 30 days) |
| XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE MO | 3 | QL (30 per 30 days) |
| XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE MO | 3 | QL (60 per 30 days) |
| XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN MO | 2 | QL (15 per 30 days) |
| **Blood Products/Modifiers/Volume Expanders** | | |
| AMICAR 1,000 MG, 500 MG TABLET DL | 4 | PA |
| AMICAR 250 MG/ML (25 %) ORAL SOLUTION DL | 4 | |
| *anagrelide hcl 0.5 mg, 1 mg capsule* MO | 1 | |
| BRILINTA 60 MG, 90 MG TABLET MO | 2 | QL (60 per 30 days) |
| *cilostazol 100 mg, 50 mg tablet* MO | 1 | |
| *clopidogrel 75 mg tablet* MO | 1 | QL (30 per 30 days) |
| *dipyridamole 25 mg, 50 mg, 75 mg tablet* MO | 1 | |
| ELIQUIS 2.5 MG TABLET MO | 2 | QL (60 per 30 days) |
| ELIQUIS 5 MG, 5 MG (74 TABS) TABLET; ELIQUIS 5 MG, 5 MG (74 TABS) TABLETS IN A DOSE PACK MO | 2 | QL (74 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *enoxaparin 100 mg/ml, 150 mg/ml syringe* **MO** | 1 | QL (28 per 28 days) |
| *enoxaparin 30 mg/0.3 ml, 60 mg/0.6 ml syr* **MO** | 1 | QL (16.8 per 28 days) |
| *fondaparinux 2.5 mg/0.5 ml syr* **MO** | 1 | QL (15 per 30 days) |
| *fondaparinux 5 mg/0.4 ml syr* **DL** | 4 | QL (12 per 30 days) |
| FULPHILA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (1.2 per 28 days) |
| NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE; NEULASTA 6 MG/0.6 ML, 6 MG/0.6ML WITH WEARABLE SUBCUTANEOUS INJECTOR **DL** | 4 | PA,QL (1.2 per 28 days) |
| NEUPOGEN 300 MCG/0.5 ML INJECTION SYRINGE **DL** | 4 | PA,QL (7 per 30 days) |
| NEUPOGEN 300 MCG/ML INJECTION SOLUTION **DL** | 4 | PA,QL (14 per 30 days) |
| NEUPOGEN 480 MCG/0.8 ML INJECTION SYRINGE **DL** | 4 | PA,QL (11.2 per 30 days) |
| NEUPOGEN 480 MCG/1.6 ML INJECTION SOLUTION **DL** | 4 | PA,QL (22.4 per 30 days) |
| PRADAXA 110 MG, 150 MG, 75 MG CAPSULE **MO** | 3 | QL (60 per 30 days) |
| PROCRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML INJECTION SOLUTION **MO** | 3 | PA,QL (14 per 30 days) |
| PROCRIT 20,000 UNIT/2 ML INJECTION SOLUTION **MO** | 3 | PA,QL (28 per 30 days) |
| RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML INJECTION SOLUTION **MO** | 3 | PA,QL (14 per 30 days) |
| RETACRIT 40,000 UNIT/ML INJECTION SOLUTION **DL** | 4 | PA,QL (14 per 30 days) |
| *tranexamic acid 1,000 mg/10 ml* **MO** | 1 | PA |
| *tranexamic acid 650 mg tablet* **MO** | 1 | QL (30 per 5 days) |
| UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (1.2 per 28 days) |
| *warfarin sodium 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg tablet* **MO** | 1 | |
| XARELTO 10 MG, 20 MG TABLET **MO** | 2 | QL (30 per 30 days) |
| XARELTO 15 MG (42)-20 MG (9) TABLETS IN A STARTER PACK **MO** | 2 | QL (51 per 30 days) |
| XARELTO 15 MG, 2.5 MG TABLET **MO** | 2 | QL (60 per 30 days) |
| **Cardiovascular Agents** | | |
| *acetazolamide 125 mg, 250 mg tablet* **MO** | 1 | |
| *acetazolamide er 500 mg cap* **MO** | 1 | |
| ALDACTONE 100 MG, 25 MG, 50 MG TABLET **MO** | 3 | |
| *amiodarone hcl 100 mg, 200 mg tablet* **MO** | 1 | |
| *amlodipine besylate 10 mg tab* **MO** | 1 | QL (60 per 30 days) |
| *amlodipine besylate 2.5 mg, 5 mg tab* **MO** | 1 | QL (30 per 30 days) |
| *amlodipine-benazepril 10-20 mg, 2.5-10 mg, 5-10 mg, 5-20 mg; amlodipine-benazepril 2.5-10* **MO** | 1 | QL (60 per 30 days) |
| *atenolol 100 mg, 25 mg, 50 mg tablet* **MO** | 1 | |
| *atorvastatin 10 mg, 20 mg, 40 mg, 80 mg tablet* **MO** | 1 | QL (30 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| BIDIL 20 MG-37.5 MG TABLET MO | 2 | QL (180 per 30 days) |
| *bumetanide 0.5 mg, 1 mg, 2 mg tablet* MO | 1 | |
| BYSTOLIC 10 MG TABLET MO | 2 | QL (120 per 30 days) |
| BYSTOLIC 2.5 MG, 5 MG TABLET MO | 2 | QL (30 per 30 days) |
| BYSTOLIC 20 MG TABLET MO | 2 | QL (60 per 30 days) |
| *cartia xt 120 mg, 180 mg, 240 mg capsule,extended release* MO | 1 | QL (60 per 30 days) |
| *carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg tablet* MO | 1 | |
| CATAPRES 0.1 MG, 0.2 MG, 0.3 MG TABLET MO | 3 | |
| *chlorthalidone 25 mg, 50 mg tablet* MO | 1 | |
| *clonidine 0.1 mg/day patch; clonidine 0.2 mg/day patch; clonidine 0.3 mg/day patch* MO | 1 | QL (4 per 28 days) |
| *clonidine hcl 0.1 mg, 0.2 mg, 0.3 mg tablet* MO | 1 | |
| COREG CR 10 MG, 20 MG, 40 MG, 80 MG CAPSULE, EXTENDED RELEASE MO | 3 | PA,QL (30 per 30 days) |
| CORLANOR 5 MG, 7.5 MG TABLET MO | 3 | PA,QL (60 per 30 days) |
| *digoxin 125 mcg tablet; digoxin 250 mcg tablet* MO | 1 | QL (30 per 30 days) |
| *diltiazem 24h er(cd) 120 mg, 180 mg, 240 mg cp; diltiazem 24hr er 120 mg, 180 mg, 240 mg cap* MO | 1 | QL (60 per 30 days) |
| *dofetilide 125 mcg, 250 mcg, 500 mcg capsule* MO | 1 | |
| *doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg tab* MO | 1 | |
| ENTRESTO 24 MG-26 MG TABLET; ENTRESTO 49 MG-51 MG TABLET; ENTRESTO 97 MG-103 MG TABLET MO | 2 | PA,QL (60 per 30 days) |
| *ezetimibe 10 mg tablet* MO | 1 | QL (30 per 30 days) |
| *fenofibrate 120 mg, 160 mg tablet* MO | 1 | QL (30 per 30 days) |
| *fenofibrate 145 mg, 160 mg tablet* MO | 1 | QL (30 per 30 days) |
| *furosemide 20 mg, 40 mg, 80 mg tablet* MO | 1 | |
| *gemfibrozil 600 mg tablet* MO | 1 | QL (60 per 30 days) |
| *hydralazine 10 mg, 100 mg, 25 mg, 50 mg tablet* MO | 1 | |
| *hydrochlorothiazide 12.5 mg cp* MO | 1 | |
| *hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tb* MO | 1 | |
| HYZAAR 100 MG-12.5 MG TABLET; HYZAAR 100 MG-25 MG TABLET; HYZAAR 50 MG-12.5 MG TABLET MO | 3 | PA,QL (60 per 30 days) |
| *indapamide 1.25 mg, 2.5 mg tablet* MO | 1 | |
| *irbesartan 150 mg, 300 mg, 75 mg tablet* MO | 1 | QL (30 per 30 days) |
| *isosorbide mononit er 120 mg, 30 mg, 60 mg; isosorbide mononit er 120 mg, 30 mg, 60 mg tb* MO | 1 | |
| LANOXIN 125 MCG (0.125 MG), 187.5 MCG (0.1875 MG), 250 MCG (0.25 MG), 62.5 MCG (0.0625 MG) TABLET MO | 3 | QL (30 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| LASIX 20 MG, 40 MG, 80 MG TABLET MO | 3 | |
| LIPITOR 10 MG, 20 MG, 40 MG, 80 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| *lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg tablet* MO | 1 | |
| *losartan potassium 100 mg, 25 mg, 50 mg tab* MO | 1 | QL (60 per 30 days) |
| *metolazone 10 mg, 2.5 mg, 5 mg tablet* MO | 1 | |
| *metoprolol succ er 100 mg, 200 mg, 25 mg, 50 mg tab* MO | 1 | QL (60 per 30 days) |
| *metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg tab; metoprolol tartrate 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg tb* MO | 1 | |
| *mexiletine 150 mg, 200 mg, 250 mg capsule* MO | 1 | |
| *midodrine hcl 10 mg, 2.5 mg, 5 mg tablet* MO | 1 | |
| *moexipril-hctz 15-12.5 mg, 15-25 mg, 7.5-12.5 mg tab; moexipril-hctz 15-12.5 mg, 15-25 mg, 7.5-12.5 mg tablet* MO | 1 | |
| MULTAQ 400 MG TABLET MO | 2 | QL (60 per 30 days) |
| *niacin er 1,000 mg, 500 mg, 750 mg tablet* MO | 1 | |
| *niacor 500 mg tablet* MO | 1 | |
| *nifedipine er 30 mg, 60 mg, 90 mg tablet* MO | 1 | QL (60 per 30 days) |
| NITROSTAT 0.3 MG, 0.4 MG, 0.6 MG SUBLINGUAL TABLET MO | 2 | |
| NORVASC 10 MG TABLET MO | 3 | PA,QL (60 per 30 days) |
| NORVASC 2.5 MG, 5 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| *pacerone 200 mg tablet* MO | 1 | |
| *pentoxifylline er 400 mg tab* MO | 1 | |
| PRALUENT PEN 150 MG/ML, 75 MG/ML SUBCUTANEOUS PEN INJECTOR MO | 3 | PA,QL (2 per 28 days) |
| PRAVACHOL 20 MG, 80 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| *pravastatin sodium 10 mg, 20 mg, 80 mg tab* MO | 1 | QL (30 per 30 days) |
| *pravastatin sodium 40 mg tab* MO | 1 | QL (60 per 30 days) |
| PRINIVIL 10 MG, 20 MG, 5 MG TABLET MO | 3 | |
| *propafenone hcl er 225 mg, 325 mg cap* MO | 1 | QL (60 per 30 days) |
| RANEXA 1,000 MG, 500 MG TABLET,EXTENDED RELEASE MO | 3 | PA,QL (120 per 30 days) |
| REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR MO | 2 | PA,QL (3.5 per 28 days) |
| REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR MO | 2 | PA,QL (3 per 28 days) |
| REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE MO | 2 | PA,QL (3 per 28 days) |
| *rosuvastatin calcium 10 mg, 20 mg, 40 mg, 5 mg tab* MO | 1 | QL (30 per 30 days) |
| *simvastatin 10 mg, 20 mg, 40 mg, 5 mg, 80 mg tablet* MO | 1 | QL (30 per 30 days) |
| *spironolactone-hctz 25-25 tab* MO | 1 | |
| *spironolactone 100 mg, 25 mg, 50 mg tablet* MO | 1 | |
| TEKTURNA 150 MG, 300 MG TABLET MO | 3 | PA,QL (30 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| TEKTURNA HCT 150 MG-12.5 MG TABLET; TEKTURNA HCT 150 MG-25 MG TABLET; TEKTURNA HCT 300 MG-12.5 MG TABLET; TEKTURNA HCT 300 MG-25 MG TABLET MO | 2 | QL (30 per 30 days) |
| *telmisartan 20 mg, 40 mg tablet* MO | 1 | QL (30 per 30 days) |
| *telmisartan-hctz 40-12.5 mg, 80-25 mg tab; telmisartan-hctz 40-12.5 mg, 80-25 mg tb* MO | 1 | ST,QL (30 per 30 days) |
| TENORMIN 100 MG, 25 MG, 50 MG TABLET MO | 3 | |
| *terazosin 1 mg, 10 mg, 2 mg, 5 mg capsule* MO | 1 | |
| TOPROL XL 100 MG, 200 MG, 25 MG, 50 MG TABLET,EXTENDED RELEASE MO | 3 | QL (60 per 30 days) |
| *triamterene-hctz 37.5-25 mg, 50-25 mg cap; triamterene-hctz 37.5-25 mg, 50-25 mg cp* MO | 1 | |
| *triamterene-hctz 37.5-25 mg, 75-50 mg tab; triamterene-hctz 37.5-25 mg, 75-50 mg tb* MO | 1 | |
| *valsartan-hctz 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg tab* MO | 1 | QL (30 per 30 days) |
| VASCEPA 0.5 GRAM CAPSULE MO | 3 | QL (240 per 30 days) |
| VASCEPA 1 GRAM CAPSULE MO | 3 | QL (120 per 30 days) |
| *verapamil er 240 mg tablet* MO | 1 | |
| VYTORIN 10 MG-10 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| WELCHOL 3.75 GRAM ORAL POWDER PACKET MO | 2 | QL (30 per 30 days) |
| WELCHOL 625 MG TABLET MO | 2 | QL (180 per 30 days) |
| ZESTORETIC 10 MG-12.5 MG TABLET; ZESTORETIC 20 MG-12.5 MG TABLET; ZESTORETIC 20 MG-25 MG TABLET MO | 3 | |
| ZESTRIL 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG TABLET MO | 3 | PA |
| ZETIA 10 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| ZOCOR 10 MG, 20 MG, 40 MG, 5 MG, 80 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| **Central Nervous System Agents** | | |
| AMPYRA 10 MG TABLET,EXTENDED RELEASE DL | 4 | PA,QL (60 per 30 days) |
| AUSTEDO 12 MG, 9 MG TABLET DL | 4 | PA,QL (120 per 30 days) |
| AUSTEDO 6 MG TABLET DL | 4 | PA,QL (60 per 30 days) |
| BETASERON 0.3 MG SUBCUTANEOUS KIT DL | 4 | PA,QL (15 per 30 days) |
| COPAXONE 20 MG/ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (30 per 30 days) |
| COPAXONE 40 MG/ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (12 per 28 days) |
| *dexmethylphenidate 10 mg, 2.5 mg, 5 mg tab* MO | 1 | QL (60 per 30 days) |
| *dextroamp-amphet er 10 mg, 15 mg, 5 mg cap* MO | 1 | QL (30 per 30 days) |
| *dextroamp-amphet er 20 mg, 25 mg, 30 mg cap* MO | 1 | QL (60 per 30 days) |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *dextroamp-amphetam 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg tab; dextroamp-amphetamin 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg tab; dextroamp-amphetamine 10 mg, 12.5 mg, 15 mg, 20 mg, 5 mg, 7.5 mg tab* **MO** | 1 | QL (90 per 30 days) |
| *dextroamp-amphetamin 30 mg tab* **MO** | 1 | QL (60 per 30 days) |
| GILENYA 0.25 MG, 0.5 MG CAPSULE **DL** | 4 | PA,QL (30 per 30 days) |
| LYRICA 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG CAPSULE **MO** | 3 | QL (90 per 30 days) |
| LYRICA 20 MG/ML ORAL SOLUTION **MO** | 3 | QL (900 per 30 days) |
| LYRICA 225 MG, 300 MG CAPSULE **MO** | 3 | QL (60 per 30 days) |
| NUEDEXTA 20 MG-10 MG CAPSULE **DL** | 4 | PA,QL (60 per 30 days) |
| REBIF (WITH ALBUMIN) 22 MCG/0.5 ML, 44 MCG/0.5 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (6 per 28 days) |
| REBIF TITRATION PACK 8.8 MCG/0.2 ML-22 MCG/0.5 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (4.2 per 28 days) |
| *riluzole 50 mg tablet* **MO** | 1 | |
| SAVELLA 100 MG, 12.5 MG, 12.5 MG (5)-25 MG(8)-50 MG(42), 25 MG, 50 MG TABLET; SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK **MO** | 2 | QL (60 per 30 days) |
| TECFIDERA 120 MG (14)- 240 MG (46), 240 MG CAPSULE,DELAYED RELEASE; TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE **DL** | 4 | PA,QL (60 per 30 days) |
| TECFIDERA 120 MG CAPSULE,DELAYED RELEASE **DL** | 4 | PA,QL (14 per 30 days) |
| **Dental & Oral Agents** | | |
| *chlorhexidine 0.12% rinse* **MO** | 1 | |
| *periogard 0.12 % mouthwash* **MO** | 1 | |
| *pilocarpine hcl 5 mg, 7.5 mg tablet* **MO** | 1 | |
| *triamcinolone 0.1% paste* **MO** | 1 | |
| **Dermatological Agents** | | |
| *ammonium lactate 12% cream* **MO** | 1 | |
| *ammonium lactate 12% lotion* **MO** | 1 | |
| COSENTYX 150 MG/ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (34 per 365 days) |
| COSENTYX 300 MG/2 SYRINGES (150 MG/ML) SUBCUTANEOUS **DL** | 4 | PA,QL (34 per 365 days) |
| COSENTYX PEN 150 MG/ML SUBCUTANEOUS **DL** | 4 | PA,QL (34 per 365 days) |
| COSENTYX PEN 300 MG/2 PENS (150 MG/ML) SUBCUTANEOUS **DL** | 4 | PA,QL (34 per 365 days) |
| ELIDEL 1 % TOPICAL CREAM **MO** | 3 | PA |
| ENSTILAR 0.005 %-0.064 % TOPICAL FOAM **MO** | 3 | QL (120 per 30 days) |
| *fluorouracil 2% topical soln; fluorouracil 5% topical soln* **MO** | 1 | |
| *methoxsalen 10 mg capsule* **DL** | 4 | |
| PICATO 0.015 % TOPICAL GEL **MO** | 3 | QL (3 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| PICATO 0.05 % TOPICAL GEL MO | 3 | QL (2 per 30 days) |
| RECTIV 0.4 % (W/W) OINTMENT MO | 3 | QL (30 per 30 days) |
| REGRANEX 0.01 % TOPICAL GEL DL | 4 | |
| SANTYL 250 UNIT/GRAM TOPICAL OINTMENT MO | 2 | |
| STELARA 130 MG/26 ML INTRAVENOUS SOLUTION DL | 4 | PA,QL (104 per 30 days) |
| STELARA 45 MG/0.5 ML SUBCUTANEOUS SOLUTION DL | 4 | PA,QL (1.5 per 84 days) |
| STELARA 45 MG/0.5 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (1.5 per 84 days) |
| STELARA 90 MG/ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (3 per 84 days) |
| TACLONEX 0.005 %-0.064 % TOPICAL OINTMENT DL | 4 | PA,QL (60 per 30 days) |
| TACLONEX 0.005 %-0.064 % TOPICAL SUSPENSION MO | 2 | QL (420 per 30 days) |
| TOLAK 4 % TOPICAL CREAM MO | 2 | |
| *tretinoin 0.01% gel; tretinoin 0.025% gel; tretinoin 0.05% gel* MO | 1 | PA |
| *tretinoin 0.025% cream; tretinoin 0.05% cream; tretinoin 0.1% cream* MO | 1 | PA |
| ZYCLARA 3.75 % TOPICAL CREAM PACKET MO | 3 | ST |
| **Electrolytes/Minerals/Metals/Vitamins** | | |
| AURYXIA 210 MG IRON TABLET MO | 3 | PA,QL (360 per 30 days) |
| *calcium acetate 667 mg gelcap* MO | 1 | |
| CLINIMIX 5 % IN 20 % DEXTROSE (SULFITE-FREE) INTRAVENOUS SOLUTION MO | 3 | B vs D |
| CLINIMIX E 2.75%-10% SOLUTION MO | 3 | B vs D |
| CUPRIMINE 250 MG CAPSULE DL | 4 | QL (600 per 30 days) |
| EXJADE 125 MG, 250 MG, 500 MG DISPERSIBLE TABLET DL | 4 | PA |
| *kionex powder* MO | 1 | |
| KLOR-CON 10 MEQ TABLET,EXTENDED RELEASE MO | 1 | |
| *klor-con m10 meq tablet,extended release* MO | 1 | |
| *potassium cl er 10 meq, 20 meq tablet* MO | 1 | |
| *potassium cl er 10 meq, 8 meq capsule* MO | 1 | |
| *potassium citrate er 10 meq (1,080 mg), 15 meq, 5 meq (540 mg) tb; potassium citrate er 10 meq tb; potassium citrate er 5 meq tab* MO | 1 | |
| *pr natal 400 ec 29 mg-1 mg-400 mg tablet-capsule,delayed release* MO | 1 | |
| PRENATABS FA 29 MG-1 MG TABLET MO | 1 | |
| RENVELA 0.8 GRAM ORAL POWDER PACKET MO | 2 | QL (540 per 30 days) |
| RENVELA 2.4 GRAM ORAL POWDER PACKET MO | 2 | QL (180 per 30 days) |
| RENVELA 800 MG TABLET MO | 2 | QL (540 per 30 days) |
| SAMSCA 15 MG, 30 MG TABLET DL | 4 | QL (60 per 30 days) |
| *sodium lactate 50 meq/10 ml vl* MO | 1 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| SPS (WITH SORBITOL) 15 GRAM-20 GRAM/60 ML ORAL SUSPENSION MO | 1 | |
| SYPRINE 250 MG CAPSULE DL | 4 | PA,QL (240 per 30 days) |
| **Gastrointestinal Agents** | | |
| AMITIZA 24 MCG, 8 MCG CAPSULE MO | 3 | PA,QL (60 per 30 days) |
| CARAFATE 100 MG/ML ORAL SUSPENSION MO | 3 | |
| *cimetidine 200 mg, 300 mg, 400 mg, 800 mg tablet* MO | 1 | |
| DEXILANT 30 MG, 60 MG CAPSULE, DELAYED RELEASE MO | 3 | QL (30 per 30 days) |
| *dicyclomine 10 mg capsule* MO | 1 | |
| *dicyclomine 20 mg tablet* MO | 1 | |
| *diphenoxylat-atrop 2.5-0.025/5* MO | 1 | |
| *diphenoxylate-atrop 2.5-0.025* MO | 1 | |
| *generlac 10 gram/15 ml oral solution* MO | 1 | |
| *lactulose 10 gm/15 ml solution; lactulose 20 gm/30 ml solution* MO | 1 | |
| *lansoprazole dr 30 mg capsule* MO | 1 | QL (30 per 30 days) |
| LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE MO | 2 | QL (30 per 30 days) |
| *misoprostol 100 mcg, 200 mcg tablet* MO | 1 | |
| MOVANTIK 12.5 MG, 25 MG TABLET MO | 2 | QL (30 per 30 days) |
| MYALEPT 5 MG/ML (FINAL CONCENTRATION) SUBCUTANEOUS SOLUTION DL | 4 | PA,QL (30 per 30 days) |
| NEXIUM 20 MG, 40 MG CAPSULE,DELAYED RELEASE MO | 3 | PA,QL (30 per 30 days) |
| *omeprazole dr 10 mg, 20 mg, 40 mg capsule* MO | 1 | QL (60 per 30 days) |
| *pantoprazole sod dr 20 mg, 40 mg tab* MO | 1 | QL (60 per 30 days) |
| *pepcid 20 mg, 40 mg tablet* MO | 3 | PA |
| PROTONIX 20 MG, 40 MG TABLET,DELAYED RELEASE MO | 3 | PA,QL (60 per 30 days) |
| PYLERA 140 MG-125 MG-125 MG CAPSULE MO | 3 | QL (144 per 30 days) |
| *ranitidine 150 mg, 300 mg tablet* MO | 1 | |
| RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SOLUTION MO | 3 | QL (36 per 30 days) |
| RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SYRINGE MO | 3 | QL (36 per 28 days) |
| RELISTOR 150 MG TABLET MO | 3 | QL (90 per 30 days) |
| RELISTOR 8 MG/0.4 ML SUBCUTANEOUS SYRINGE MO | 3 | QL (12 per 30 days) |
| *sucralfate 1 gm tablet* MO | 1 | |
| SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION MO | 2 | |
| *trilyte with flavor packets 420 gram oral solution* MO | 1 | |
| *ursodiol 250 mg, 500 mg tablet* MO | 1 | |
| VIBERZI 100 MG, 75 MG TABLET DL | 4 | PA,QL (60 per 30 days) |
| XIFAXAN 200 MG TABLET DL | 4 | PA,QL (9 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| XIFAXAN 550 MG TABLET DL | 4 | PA,QL (84 per 28 days) |
| ZANTAC 300 MG TABLET MO | 3 | PA |
| **Genetic/Enzyme Disorder: Replacement, Modifiers, Treatment** | | |
| ARALAST NP 1,000 MG, 500 MG INTRAVENOUS SOLUTION DL | 4 | PA |
| CERDELGA 84 MG CAPSULE DL | 4 | PA |
| CEREZYME 400 UNIT INTRAVENOUS SOLUTION DL | 4 | PA |
| CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE; CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE; CREON 3,000 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000 UNIT-114,000 UNIT-180,000 UNIT CAPSULE,DELAYED RELEASE; CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE MO | 2 | |
| ELELYSO 200 UNIT INTRAVENOUS SOLUTION DL | 4 | PA |
| GLASSIA 1 GRAM/50 ML (2 %) INTRAVENOUS SOLUTION DL | 4 | PA |
| STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML SUBCUTANEOUS SOLUTION DL | 4 | PA |
| ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP DR 10,000 UNIT CAPSULE; ZENPEP DR 15,000 UNIT CAPSULE; ZENPEP DR 25,000 UNIT CAPSULE; ZENPEP DR 3,000 UNIT CAPSULE; ZENPEP DR 40,000 UNIT CAPSULE; ZENPEP DR 5,000 UNIT CAPSULE MO | 3 | |
| **Genitourinary Agents** | | |
| *alfuzosin hcl er 10 mg tablet* MO | 1 | QL (30 per 30 days) |
| AVODART 0.5 MG CAPSULE MO | 3 | PA,QL (30 per 30 days) |
| *bethanechol 10 mg, 25 mg, 5 mg, 50 mg tablet* MO | 1 | |
| *dutasteride 0.5 mg capsule* MO | 1 | QL (30 per 30 days) |
| ELMIRON 100 MG CAPSULE DL | 4 | QL (90 per 30 days) |
| *finasteride 5 mg tablet* MO | 1 | QL (30 per 30 days) |
| FLOMAX 0.4 MG CAPSULE MO | 3 | QL (60 per 30 days) |
| MYRBETRIQ 25 MG, 50 MG TABLET,EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| *oxybutynin 5 mg tablet* MO | 1 | |
| *oxybutynin cl er 10 mg, 15 mg, 5 mg tablet* MO | 1 | QL (60 per 30 days) |
| RAPAFLO 4 MG, 8 MG CAPSULE MO | 3 | PA,QL (30 per 30 days) |
| *tamsulosin hcl 0.4 mg capsule* MO | 1 | QL (60 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| TOVIAZ 4 MG, 8 MG TABLET,EXTENDED RELEASE MO | 2 | QL (30 per 30 days) |
| VESICARE 10 MG, 5 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)** | | |
| ACTHAR 80 UNIT/ML INJECTION GEL DL | 4 | PA,QL (30 per 30 days) |
| *desonide 0.05% cream* MO | 1 | |
| *desoximetasone 0.05% cream; desoximetasone 0.25% cream* MO | 1 | |
| *methylprednisolone 4 mg dosepk* MO | 1 | |
| *prednisone 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg tablet* MO | 1 | B vs D |
| *triderm 0.1 %, 0.5 % topical cream* MO | 1 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)** | | |
| *chorionic gonad 10,000 unit vl* DL | 4 | PA |
| *desmopressin acetate 0.1 mg tb* MO | 1 | QL (180 per 30 days) |
| *desmopressin acetate 0.2 mg tb* MO | 1 | |
| EGRIFTA 1 MG SUBCUTANEOUS SOLUTION DL | 4 | PA,QL (60 per 30 days) |
| INCRELEX 10 MG/ML SUBCUTANEOUS SOLUTION DL | 4 | PA |
| OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) SUBCUTANEOUS CARTRIDGE DL | 4 | PA |
| OMNITROPE 5.8 MG SUBCUTANEOUS SOLUTION DL | 4 | PA |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)** | | |
| HEMABATE 250 MCG/ML INTRAMUSCULAR SOLUTION MO | 3 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)** | | |
| ANDROGEL 1 % (25 MG/2.5 GRAM) TRANSDERMAL GEL PACKET; ANDROGEL 1 % (25 MG/2.5GRAM), 1 % (50 MG/5 GRAM) TRANSDERMAL GEL PACKET MO | 3 | PA,QL (300 per 30 days) |
| ANDROGEL 1.62 % (20.25 MG/1.25 GRAM) TRANSDERMAL GEL PACKET MO | 3 | PA,QL (37.5 per 30 days) |
| ANDROGEL 1.62 % (40.5 MG/2.5 GRAM), 20.25 MG/1.25 GRAM (1.62 %) TRANSDERMAL GEL PACKET; ANDROGEL 1.62 % (40.5 MG/2.5 GRAM), 20.25 MG/1.25 GRAM (1.62 %) TRANSDERMAL GEL PUMP MO | 3 | PA,QL (150 per 30 days) |
| *danazol 100 mg, 200 mg, 50 mg capsule* MO | 1 | |
| DUAVEE 0.45 MG-20 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| ELLA 30 MG TABLET MO | 2 | QL (1 per 30 days) |
| ESTRACE 0.01% (0.1 MG/GRAM) VAGINAL CREAM MO | 3 | PA |
| ESTRACE 0.5 MG, 1 MG, 2 MG TABLET MO | 1 | |
| *estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg tablet; estradiol 0.5 mg, 1 mg, 10 mcg, 2 mg vaginal insrt* MO | 1 | |
| ESTRING 2 MG (7.5 MCG/24 HOUR) VAGINAL RING MO | 3 | QL (1 per 90 days) |
| EVISTA 60 MG TABLET MO | 3 | PA,QL (30 per 30 days) |
| *medroxyprogesterone 10 mg, 2.5 mg, 5 mg tab* MO | 1 | |

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|---|---|---|
| MENEST 0.3 MG, 0.625 MG, 1.25 MG TABLET MO | 1 | |
| METHITEST 10 MG TABLET DL | 4 | |
| *norg-ee 0.18-0.215-0.25/0.025; norg-ee 0.18-0.215-0.25/0.035; norg-ethin estra 0.25-0.035 mg* MO | 1 | |
| *nortrel 1/35 (21) 1 mg-35 mcg tablet* MO | 1 | |
| ORTHO-NOVUM 7/7/7 (28) 0.5 MG/0.75 MG/1 MG-35 MCG TABLET MO | 3 | |
| *oxandrolone 10 mg tablet* DL | 4 | PA,QL (60 per 30 days) |
| *oxandrolone 2.5 mg tablet* MO | 1 | PA,QL (120 per 30 days) |
| PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET MO | 3 | |
| PREMARIN 0.625 MG/GRAM VAGINAL CREAM MO | 2 | |
| PREMARIN 25 MG SOLUTION FOR INJECTION MO | 3 | |
| *raloxifene hcl 60 mg tablet* MO | 1 | QL (30 per 30 days) |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)** | | |
| *levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg tablet* MO | 1 | |
| SYNTHROID 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG TABLET MO | 2 | |
| UNITHROID 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG TABLET MO | 3 | |
| **Hormonal Agents, Suppressant (Adrenal)** | | |
| LYSODREN 500 MG TABLET DL | 4 | |
| **Hormonal Agents, Suppressant (Pituitary)** | | |
| *octreotide 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml vial; octreotide acet 0.05 mg/ml vl; octreotide acet 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml vl* MO | 1 | PA |
| SOMATULINE DEPOT 120 MG/0.5 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (0.5 per 28 days) |
| SOMATULINE DEPOT 60 MG/0.2 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (0.2 per 28 days) |
| SOMATULINE DEPOT 90 MG/0.3 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (0.3 per 28 days) |
| SOMAVERT 10 MG, 15 MG, 20 MG SUBCUTANEOUS SOLUTION DL | 4 | PA,QL (60 per 30 days) |
| SYNAREL 2 MG/ML NASAL SPRAY DL | 4 | |
| **Hormonal Agents, Suppressant (Thyroid)** | | |
| *methimazole 10 mg, 5 mg tablet* MO | 1 | |
| *propylthiouracil 50 mg tablet* MO | 1 | |
| **Immunological Agents** | | |
| ACTIMMUNE 100 MCG (2 MILLION UNIT)/0.5 ML SUBCUTANEOUS SOLUTION DL | 4 | PA |
| BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION MO | 2 | |

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|---|---|---|
| CINRYZE 500 UNIT (5 ML) INTRAVENOUS SOLUTION **DL** | 4 | PA,QL (20 per 30 days) |
| *cyclosporine modified 100 mg, 25 mg, 50 mg* **MO** | 1 | B vs D |
| ENBREL 25 MG (1 ML) SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (8 per 28 days) |
| ENBREL 25 MG/0.5 ML (0.5 ML) SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (8.16 per 28 days) |
| ENBREL 50 MG/ML (1 ML) SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (78 per 365 days) |
| ENBREL MINI 50 MG/ML (1 ML) SUBCUTANEOUS CARTRIDGE **DL** | 4 | PA,QL (8 per 28 days) |
| ENBREL SURECLICK 50 MG/ML (1 ML) SUBCUTANEOUS PEN INJECTOR **DL** | 4 | PA,QL (78 per 365 days) |
| FIRAZYR 30 MG/3 ML SUBCUTANEOUS SYRINGE **DL** | 4 | PA,QL (9 per 30 days) |
| GAMUNEX-C 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 %) INJECTION SOLUTION **DL** | 4 | PA |
| HAEGARDA 2,000 UNIT, 3,000 UNIT SUBCUTANEOUS SOLUTION **DL** | 4 | PA,QL (24 per 28 days) |
| HIZENTRA 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) SUBCUTANEOUS SOLUTION **DL** | 4 | PA |
| HUMIRA 10 MG/0.2 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (2 per 28 days) |
| HUMIRA 20 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (31 per 365 days) |
| HUMIRA PEDIATRIC CROHN'S STARTER 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (31 per 365 days) |
| HUMIRA PEN 40 MG/0.8 ML SUBCUTANEOUS KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML SUBCUT KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML SUBCUT KT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) 10 MG/0.1 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (2 per 28 days) |
| HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SUBCUT SYR KIT; HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SUBCUT SYRINGE KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN 40 MG/0.4 ML SUBCUTANEOUS KIT **DL** | 4 | PA,QL (31 per 365 days) |
| HUMIRA(CF) PEN 80 MG/0.8 ML SUBCUTANEOUS KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML SUBCUT KT **DL** | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT **DL** | 4 | PA,QL (6 per 28 days) |
| HYPERRAB S/D (PF) 150 UNIT/ML INTRAMUSCULAR SOLUTION **DL** | 4 | B vs D |
| IMOGAM RABIES-HT (PF) 150 UNIT/ML INTRAMUSCULAR SOLUTION **MO** | 3 | B vs D |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| INFANRIX (DTAP) (PF) 25 LF UNIT-58 MCG-10 LF/0.5ML INTRAMUSCULAR SUSP MO | 3 | |
| INFLECTRA 100 MG INTRAVENOUS SOLUTION DL | 4 | PA |
| IPOL 40 UNIT-8 UNIT-32 UNIT/0.5 ML SUSPENSION FOR INJECTION MO | 3 | |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML SUBCUTANEOUS PEN INJECTOR DL | 4 | PA,QL (2.28 per 28 days) |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (2.28 per 28 days) |
| *leflunomide 10 mg, 20 mg tablet* MO | 1 | QL (30 per 30 days) |
| *methotrexate 2.5 mg tablet* MO | 1 | B vs D |
| *mycophenolate 250 mg capsule* MO | 1 | B vs D |
| REMICADE 100 MG INTRAVENOUS SOLUTION DL | 4 | PA |
| RIDAURA 3 MG CAPSULE DL | 4 | |
| RUCONEST 2,100 UNIT INTRAVENOUS SOLUTION DL | 4 | PA,QL (8 per 28 days) |
| SHINGRIX (PF) 50 MCG/0.5 ML INTRAMUSCULAR SUSPENSION, KIT MO | 2 | QL (2 per 365 days) |
| SIMPONI 100 MG/ML SUBCUTANEOUS PEN INJECTOR DL | 4 | PA,QL (16 per 365 days) |
| SIMPONI 100 MG/ML SUBCUTANEOUS SYRINGE DL | 4 | PA,QL (16 per 365 days) |
| SIMPONI ARIA 12.5 MG/ML INTRAVENOUS SOLUTION DL | 4 | PA,QL (20 per 28 days) |
| SYNAGIS 100 MG/ML, 50 MG/0.5 ML INTRAMUSCULAR SOLUTION DL | 4 | PA |
| TYPHIM VI 25 MCG/0.5 ML INTRAMUSCULAR SOLUTION MO | 3 | |
| ZOSTAVAX (PF) 19,400 UNIT/0.65 ML SUBCUTANEOUS SUSPENSION MO | 3 | QL (1 per 365 days) |
| **Inflammatory Bowel Disease Agents** | | |
| APRISO 0.375 GRAM CAPSULE,EXTENDED RELEASE MO | 3 | ST,QL (120 per 30 days) |
| *balsalazide disodium 750 mg cp* MO | 1 | |
| *budesonide ec 3 mg capsule* MO | 1 | |
| CANASA 1,000 MG RECTAL SUPPOSITORY DL | 4 | ST,QL (30 per 30 days) |
| *hydrocortisone 100 mg/60 ml* MO | 1 | |
| LIALDA 1.2 GRAM TABLET,DELAYED RELEASE MO | 3 | ST,QL (120 per 30 days) |
| PENTASA 250 MG CAPSULE,CONTROLLED RELEASE DL | 4 | ST,QL (150 per 30 days) |
| **Metabolic Bone Disease Agents** | | |
| *alendronate sodium 10 mg, 40 mg, 5 mg tab; alendronate sodium 10 mg, 40 mg, 5 mg tablet* MO | 1 | QL (30 per 30 days) |
| *alendronate sodium 35 mg, 70 mg tab* MO | 1 | QL (4 per 28 days) |
| BINOSTO 70 MG EFFERVESCENT TABLET MO | 3 | QL (4 per 28 days) |
| *calcitonin-salmon 200 units sp* MO | 1 | QL (3.7 per 28 days) |
| *calcitriol 0.25 mcg, 0.5 mcg capsule* MO | 1 | |
| *doxercalciferol 0.5 mcg, 1 mcg, 2.5 mcg cap; doxercalciferol 0.5 mcg, 1 mcg, 2.5 mcg capsule* MO | 1 | |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUBCUTANEOUS PEN INJECTOR MO | 3 | PA,QL (2.4 per 28 days) |
| FOSAMAX 70 MG TABLET MO | 3 | PA,QL (4 per 28 days) |
| PROLIA 60 MG/ML SUBCUTANEOUS SYRINGE MO | 3 | B vs D,QL (1 per 180 days) |
| RAYALDEE 30 MCG CAPSULE,EXTENDED RELEASE DL | 4 | QL (60 per 30 days) |
| SENSIPAR 30 MG, 60 MG TABLET DL | 4 | PA,QL (60 per 30 days) |
| SENSIPAR 90 MG TABLET DL | 4 | PA,QL (120 per 30 days) |
| **Miscellaneous Therapeutic Agents** | | |
| AIMOVIG AUTOINJECTOR 140 MG/ML SUBCUTANEOUS AUTO-INJECTOR MO | 3 | PA,QL (1 per 30 days) |
| AIMOVIG AUTOINJECTOR 70 MG/ML SUBCUTANEOUS AUTO-INJECTOR MO | 3 | PA,QL (2 per 30 days) |
| AIMOVIG 140 MG DOSE-2 AUTOINJ MO | 3 | PA,QL (2 per 30 days) |
| ALCOHOL SWAB MO | 1 | |
| BD SAFETYGLIDE INSULIN 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", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64" MO | 1 | |
| BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2" MO | 1 | |
| EMGALITY PEN 120 MG/ML SUBCUTANEOUS PEN INJECTOR MO | 3 | PA,QL (2 per 30 days) |
| EMGALITY 120 MG/ML SUBCUTANEOUS SYRINGE MO | 3 | PA,QL (2 per 30 days) |
| EMGALITY 300 MG/3 ML (100 MG/ML X 3) SUBCUTANEOUS SYRINGE MO | 3 | PA,QL (3 per 30 days) |
| NOVOFINE 30G X 1/3" NEEDLES MO | 1 | |
| NOVOFINE 32 32 GAUGE X 1/4" NEEDLE MO | 1 | |
| NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE MO | 1 | |
| NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE MO | 1 | |
| NOVOTWIST 32 GAUGE X 1/5" NEEDLE MO | 1 | |
| OMNIPOD DASH INSULIN POD SUBCUTANEOUS CARTRIDGE MO | 2 | |
| OMNIPOD INSULIN MANAGEMENT MO | 2 | |
| OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE MO | 2 | |
| PHYSIOLYTE 140 MEQ-5 MEQ-3 MEQ-98 MEQ/L IRRIGATION SOLUTION MO | 1 | |
| V-GO 20 DEVICE MO | 2 | |
| V-GO 30 DEVICE MO | 2 | |
| V-GO 40 DEVICE MO | 2 | |
| **Ophthalmic Agents** | | |
| ALPHAGAN P 0.1 % EYE DROPS MO | 2 | |
| ALPHAGAN P 0.15 % EYE DROPS MO | 3 | PA |
| *atropine 1% eye drops* MO | 1 | |
| *azelastine hcl 0.05% drops* MO | 1 | |
| AZOPT 1 % EYE DROPS,SUSPENSION MO | 3 | ST,QL (10 per 28 days) |
| BEPREVE 1.5 % EYE DROPS MO | 3 | ST,QL (5 per 25 days) |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| *brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp* MO | 1 | |
| COMBIGAN 0.2 %-0.5 % EYE DROPS MO | 2 | QL (5 per 25 days) |
| *dorzolamide hcl 2% eye drops* MO | 1 | QL (10 per 30 days) |
| DUREZOL 0.05 % EYE DROPS MO | 2 | |
| *epinastine hcl 0.05% eye drops* MO | 1 | ST,QL (5 per 25 days) |
| ILEVRO 0.3 % EYE DROPS,SUSPENSION MO | 2 | QL (3 per 30 days) |
| *ketorolac 0.4% ophth solution; ketorolac 0.5% ophth solution* MO | 1 | |
| *latanoprost 0.005% eye drops* MO | 1 | QL (5 per 25 days) |
| LOTEMAX 0.5 % EYE DROPS,SUSPENSION; LOTEMAX 0.5 % EYE GEL DROPS MO | 3 | ST |
| LOTEMAX 0.5 % EYE OINTMENT MO | 3 | ST |
| LUMIGAN 0.01 % EYE DROPS MO | 2 | QL (2.5 per 25 days) |
| NEVANAC 0.1 % EYE DROPS,SUSPENSION MO | 3 | ST |
| *olopatadine hcl 0.1% eye drops* MO | 1 | ST |
| *olopatadine hcl 0.2% eye drop* MO | 1 | |
| PATADAY 0.2 % EYE DROPS MO | 3 | ST |
| PAZEO 0.7 % EYE DROPS MO | 2 | QL (2.5 per 25 days) |
| PHOSPHOLINE IODIDE 0.125 % EYE DROPS MO | 3 | |
| *pilocarpine 1% eye drops; pilocarpine 2% eye drops; pilocarpine 4% eye drops* MO | 1 | |
| *prednisolone ac 1% eye drop* MO | 1 | |
| *proparacaine 0.5% eye drops* MO | 1 | |
| RESTASIS 0.05 % EYE DROPS IN A DROPPERETTE MO | 2 | QL (60 per 30 days) |
| RESTASIS MULTIDOSE 0.05 % EYE DROPS MO | 2 | QL (5.5 per 25 days) |
| *timolol 0.5% eye drop; timolol maleate 0.25% eye drop; timolol maleate 0.5% eye drops* MO | 1 | |
| *tobramycin-dexameth ophth susp* MO | 1 | |
| TRAVATAN Z 0.004 % EYE DROPS MO | 2 | QL (2.5 per 25 days) |
| XIIDRA 5 % EYE DROPS IN A DROPPERETTE MO | 3 | PA,QL (60 per 30 days) |
| **Otic Agents** | | |
| *neomycin-polymyxin-hc ear soln* MO | 1 | |
| *neomycin-polymyxin-hc ear susp* MO | 1 | |
| **Respiratory Tract/Pulmonary Agents** | | |
| *acetylcysteine 10% vial; acetylcysteine 20% vial* MO | 1 | B vs D |
| ADCIRCA 20 MG TABLET DL | 4 | PA,QL (60 per 30 days) |
| ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL | 4 | PA,QL (90 per 30 days) |

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER **MO** | 2 | QL (12 per 30 days) |
| *albuterol 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml sol; albuterol 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml solution; albuterol sul 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml sol; albuterol sul 2.5 mg/3 ml soln* **MO** | 1 | B vs D |
| ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION **MO** | 2 | QL (30 per 30 days) |
| *azelastine 0.1% (137 mcg) spry* **MO** | 1 | QL (30 per 25 days) |
| BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER **MO** | 3 | QL (10.7 per 30 days) |
| BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| BROVANA 15 MCG/2 ML SOLUTION FOR NEBULIZATION **MO** | 3 | PA,QL (120 per 30 days) |
| CAYSTON 75 MG/ML SOLUTION FOR NEBULIZATION **DL** | 4 | PA,QL (84 per 28 days) |
| *cetirizine hcl 1 mg/ml soln* **MO** | 1 | QL (300 per 30 days) |
| *clemastine fum 2.68 mg tab* **MO** | 1 | |
| COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 3 | QL (4 per 20 days) |
| *cromolyn 100 mg/5 ml oral conc* **MO** | 1 | |
| *cromolyn 20 mg/2 ml neb soln* **DL** | 4 | B vs D |
| *cyproheptadine 2 mg/5 ml syrup* **MO** | 1 | |
| *cyproheptadine 4 mg tablet* **MO** | 1 | |
| DALIRESP 250 MCG TABLET **MO** | 2 | QL (28 per 365 days) |
| DALIRESP 500 MCG TABLET **MO** | 2 | QL (30 per 30 days) |
| *epinephrine 0.15 mg auto-injct; epinephrine 0.3 mg auto-inject* **MO** | 1 | QL (4 per 30 days) |
| EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR **MO** | 3 | PA,QL (4 per 30 days) |
| EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR **MO** | 3 | PA,QL (4 per 30 days) |
| ESBRIET 267 MG CAPSULE **DL** | 4 | PA,QL (270 per 30 days) |
| ESBRIET 267 MG TABLET **DL** | 4 | PA,QL (270 per 30 days) |
| ESBRIET 801 MG TABLET **DL** | 4 | PA,QL (90 per 30 days) |
| FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION AEROSOL INHALER **MO** | 2 | QL (24 per 30 days) |
| FLOVENT HFA 44 MCG/ACTUATION AEROSOL INHALER **MO** | 2 | QL (10.6 per 30 days) |
| *fluticasone prop 50 mcg spray* **MO** | 1 | QL (16 per 30 days) |
| GRASTEK 2,800 BAU SUBLINGUAL TABLET **MO** | 3 | PA,QL (30 per 30 days) |
| INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION **MO** | 2 | QL (30 per 30 days) |
| *ipratropium 0.03% spray* **MO** | 1 | QL (30 per 30 days) |
| *ipratropium 0.06% spray* **MO** | 1 | QL (45 per 30 days) |
| *iprat-albut 0.5-3(2.5) mg/3 ml* **MO** | 1 | B vs D |
| KALYDECO 150 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |
| KALYDECO 25 MG, 50 MG, 75 MG ORAL GRANULES IN PACKET **DL** | 4 | PA,QL (56 per 28 days) |
| LETAIRIS 10 MG, 5 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| *levocetirizine 5 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *montelukast sod 10 mg tablet* **MO** | 1 | QL (30 per 30 days) |
| *montelukast sod 4 mg, 5 mg tab chew* **MO** | 1 | QL (30 per 30 days) |
| OFEV 100 MG, 150 MG CAPSULE **DL** | 4 | PA,QL (60 per 30 days) |
| OPSUMIT 10 MG TABLET **DL** | 4 | PA,QL (30 per 30 days) |
| ORALAIR 100 INDEX OF REACTIVITY SUBLINGUAL TABLET; ORALAIR 100 INDEX OF REACTIVITY(3)/300 IDX REACT.(6) SUBLINGUAL TABLET; ORALAIR 300 IR SUBLINGUAL TABLET **MO** | 3 | PA,QL (30 per 30 days) |
| PERFOROMIST 20 MCG/2 ML SOLUTION FOR NEBULIZATION **MO** | 3 | PA,QL (120 per 30 days) |
| PULMOZYME 1 MG/ML SOLUTION FOR INHALATION **DL** | 4 | B vs D |
| QVAR 40 MCG ORAL INHALER; QVAR 80 MCG ORAL INHALER **MO** | 3 | ST,QL (17.4 per 30 days) |
| SEREVENT DISKUS 50 MCG/DOSE POWDER FOR INHALATION **MO** | 2 | QL (60 per 30 days) |
| *sildenafil 20 mg tablet* **MO** | 1 | PA,QL (90 per 30 days) |
| SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 2 | QL (4 per 28 days) |
| SPIRIVA WITH HANDIHALER 18 MCG AND INHALATION CAPSULES **MO** | 2 | QL (30 per 30 days) |
| STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 2 | QL (4 per 28 days) |
| STRIVERDI RESPIMAT 2.5 MCG/ACTUATION SOLUTION FOR INHALATION **MO** | 2 | QL (4 per 30 days) |
| SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO** | 2 | QL (10.2 per 30 days) |
| *theophylline er 100 mg, 200 mg, 300 mg tab; theophylline er 100 mg, 200 mg, 300 mg tablet* **MO** | 1 | |
| TOBI PODHALER 28 MG CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG CAPSULES FOR INHALATION **DL** | 4 | PA,QL (224 per 28 days) |
| TRACLEER 125 MG, 62.5 MG TABLET **DL** | 4 | PA,QL (60 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION MO | 2 | QL (60 per 30 days) |
| TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED MO | 3 | PA,QL (1 per 30 days) |
| VENTAVIS 10 MCG/ML SOLUTION FOR NEBULIZATION DL | 4 | PA,QL (150 per 30 days) |
| VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER MO | 2 | QL (36 per 30 days) |
| *zafirlukast 10 mg, 20 mg tablet* MO | 1 | QL (60 per 30 days) |
| **Skeletal Muscle Relaxants** | | |
| *carisoprodol 250 mg, 350 mg tablet* MO | 1 | QL (120 per 30 days) |
| *cyclobenzaprine 10 mg, 5 mg tablet* MO | 1 | PA |
| *methocarbamol 500 mg, 750 mg tablet* MO | 1 | |
| *orphenadrine 30 mg/ml vial* MO | 1 | |
| *orphenadrine er 100 mg tablet* MO | 1 | |
| SOMA 350 MG TABLET MO | 3 | PA,QL (120 per 30 days) |
| **Sleep Disorder Agents** | | |
| BELSOMRA 10 MG TABLET MO | 2 | QL (60 per 30 days) |
| BELSOMRA 15 MG, 20 MG TABLET MO | 2 | QL (30 per 30 days) |
| BELSOMRA 5 MG TABLET MO | 2 | QL (120 per 30 days) |
| *modafinil 100 mg, 200 mg tablet* MO | 1 | PA,QL (60 per 30 days) |
| *zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tab sl; zolpidem tart 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tablet sl; zolpidem tart er 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tab; zolpidem tartrate 1.75 mg, 10 mg, 12.5 mg, 3.5 mg, 5 mg, 6.25 mg tablet* MO | 1 | QL (30 per 30 days) |

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# Important!

## At Humana, it is important you are treated fairly.

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- You may file a complaint, also known as a grievance:
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  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights 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, **1-800-368-1019, 800-537-7697 (TDD).**

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

## Auxiliary aids and services, free of charge, are available to you.

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## Language assistance services, free of charge, are available to you.

1-866-396-8810 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

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**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ę́ niká'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

# Notes

# Notes

This abridged formulary was updated on 11/13/2019 and is not a complete list of drugs covered by our plan. For a complete listing, more recent information or other questions, please contact Humana Medicare Employer Plan at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m. Eastern Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit Humana.com.

Humana®

Humana.com

St. Tammany Parish School Board

Humana offers a plan for your future

# Time changes everything except who you are

## Group Medicare HMO

Humana®

Y0040_GHHJMNXEN_20_M

HMO

HUMANA GROUP MEDICARE EMPLOYER HEALTH MAINTENANCE ORGANIZATION (HMO)

Humana®

Humana®

[1]Humana Inc. 2018 Annual Report, February 2019

Humana is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Call **1-866-396-8810 (TTY: 711)** for more information.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Y0040_GHHJMNXEN_20_M

## We're here for you

Humana Group Medicare Customer Care
**1-866-396-8810 (TTY: 711)**
Monday – Friday, 8 a.m. – 9 p.m., Eastern time

Humana®

## What's inside

- How to enroll
- Summary of Benefits
- Introduction to Medicare
- Details about your plan
- Tools and programs to manage your health
- Frequently asked questions

## What to expect after you enroll

### Enrollment confirmation

You'll receive a letter from Humana once the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment.

### Humana member ID card

Your Humana member ID card will arrive in the mail shortly after you enroll.

### Evidence of Coverage (EOC)

This detailed booklet about your healthcare coverage with your plan will arrive in the mail. This will also include your privacy notice.

### Medicare health survey

CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment. Be on the lookout for information on how to access the survey. Your answers will help us better serve your health needs.

## Why choose Humana?

We've earned the trust of millions of members since we offered our first Medicare plan in 1987. More than 8.8 million[1] Medicare customers have chosen us to be their healthcare partner.

Humana

2020 GROUP MEDICARE EMPLOYER HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN

# Time changes everything except who you are

Humana offers a plan for your future

Humana

MAPD HMO

Y0040_GHHKF68EN_20_M

## Start here

You'll see how this Medicare Advantage HMO with prescription drug plan may give you the value you deserve. After you enroll, Humana will mail you an Evidence of Coverage booklet that will have all the plan information and details, including a full list of benefits.

## What is Medicare?

Medicare is a federal health insurance program for U.S. citizens and legal residents who are 65 and older or qualify due to a disability. You can receive your Medicare Part A and Part B benefits through the federal government or a private insurance company.

## Humana offers you a Medicare Advantage HMO

### A HMO offers

- **All the benefits of Original Medicare, plus extra benefits**
- Maximum out-of-pocket protections
- Worldwide emergency coverage
- Programs to help improve health and well-being

### Dedicated team and more

- Your choice of an in-network provider to manage your care
- Large network of doctors, specialists and hospitals to pick from
- Coverage for office visits, including routine physical exams
- Coverage for medically necessary stays in the hospital
- Almost no claim forms to fill out or mail—we take care of that for you
- Predictable costs, so you'll know how much your copayments and coinsurance percentages are
- Dedicated Customer Care specialists who serve only our Group Medicare members

## Humana offers you a Medicare Advantage HMO with prescription drug plan, which offers:

### A large network

There are more than 66,000 participating pharmacies in our network.

### Almost no claims paperwork

The plan works with your pharmacist to handle claims for you.

### Maximize Your Benefit® Rx

Humana keeps in touch by telephone and mail to let you know about ways to save on prescription drugs by switching to ones that cost less.

### Pharmacy finder

An online tool that helps you find pharmacies. It also tells you how far they are from you, the hours they're open, if they have a drive-through available, if they offer emergency Rx, delivery options and if they have bilingual employees.

## Total well-being starts with a complete approach to health

### Support your health and your finances

Humana offers solid insurance products that help you support your healthcare needs, all provided by a Fortune 100 company with over 30 years of experience providing Medicare member plans.

### Maximize your well-being

Our health and well-being tools and resources make it easy to set health goals, chart your progress, strengthen your mind and body, and build connections with others. The power to help you live a full, vibrant life is in your hands.

### Manage your health

Complex or chronic health conditions often demand personal attention. A Humana nurse can meet you at home, in the hospital, by phone or email to help you manage your condition and minimize complications.

## Medicare Part A

HOSPITAL INSURANCE

It helps cover medically necessary inpatient care in a hospital or skilled nursing facility. It also helps cover some home healthcare and hospice care.

## Medicare Part B

MEDICAL INSURANCE

It helps cover medically necessary doctors' services, outpatient care and other medical services and supplies. Part B also helps cover some preventive services.

## Medicare Part C

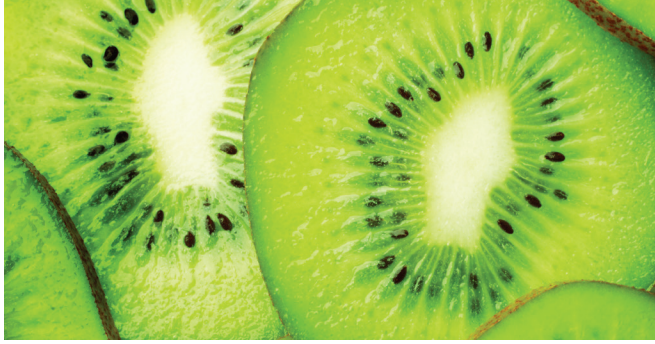
MEDICARE ADVANTAGE PLANS

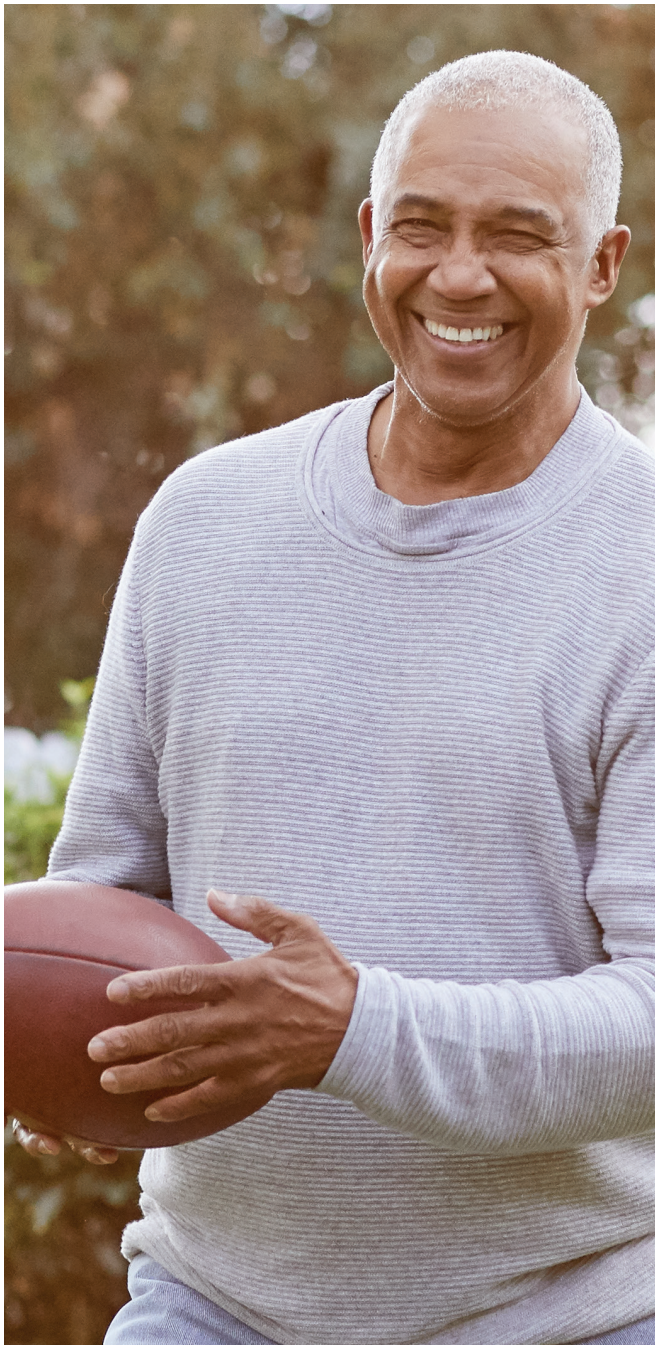
These are available through private insurance companies, such as Humana. Medicare Part C helps cover everything medically necessary that Part A and Part B cover, including hospital and medical services. You still have Medicare if you elect Medicare Part C coverage. You must be entitled to Medicare Part A and enrolled in Part B to be eligible for a Medicare Part C plan.

## Medicare Part D

PRESCRIPTION DRUG COVERAGE

Like Part C Medicare Advantage plans, Part D is only available through private companies, such as Humana. Many Part C Medicare Advantage plans include Medicare Part D prescription drug coverage. Part D helps pay for the medications your doctor prescribes. You can only join a Medicare Part D prescription drug plan if you are entitled to Medicare Part A and/or enrolled in Part B.





# Humana Pharmacy

More and more Humana members are finding Humana Pharmacy® to be their choice for value, experience, safety, accuracy, convenience and service.

## Why choose Humana pharmacy?

- **Savings**. Many Humana plans provide cost savings if you fill a 90-day supply* of your maintenance medicine through a mail-delivery pharmacy, instead of a retail pharmacy. Plus, the pharmacy team works with you and your doctor to find medicine that costs less.
- **Experienced pharmacy team**. Pharmacists are available to answer questions about your medicine and our services.
- **Safe and accurate**. Two pharmacists check your new prescriptions to make sure they're safe to take with your other medications. The dispensing equipment and heat–sealed bottles with tamper-resistant foil help ensure quality and safety. Plus, your order comes in plain packaging for additional security.
- **Timely reminders**. To help make sure you have the medicine and supplies you need when you need them, we can remind you when it's time to refill your medicine. Just set your preferences when you sign up at **HumanaPharmacy.com**.
- **Time-saving mail delivery**. No driving to the pharmacy and waiting in line. You may be able to order just four times a year and have more time to do the things you enjoy.

## Make Humana Pharmacy your one source

**Maintenance medicine.** Medicine you take all the time for conditions like high cholesterol, high blood pressure and asthma.

**Specialty medicine.** Specialized therapies to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

*Some prescriptions are only available in a 30-day supply.

## Visit HumanaPharmacy.com

After you become a Humana member, you can sign in with your MyHumana identification number or register to get started. You can also sign up by calling **1-888-538-3518 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

## Online

**HumanaPharmacy.com.** Start a new prescription, order refills, check on your order and get information about how to get started.

## Doctor

Let your doctor know you would like to use our pharmacy and he or she can send prescriptions through e-prescribe. Healthcare providers can also fill out the fax form by downloading it from **HumanaPharmacy.com/forms** and faxing the prescription to **1-800-379-7617**.

## Mail

Download the "Registration & Prescription Order Form" from **HumanaPharmacy.com/forms** and mail your paper prescriptions to:
Humana Pharmacy
P.O. Box 745099
Cincinnati, OH 45274-5099

## Phone

For maintenance medicine, you can call **1-888-538-3518 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

For specialty medicine, you can call Humana Specialty Pharmacy® directly at **1-800-833-1642 (TTY: 711)**, Monday – Friday, 8 a.m. – 11 p.m., and Saturday, 8 a.m. – 6:30 p.m., Eastern time.

## Humana Pharmacy Mobile app

Place new orders and refills for your medicine, check order status and gain access to a secure site 24 hours a day, seven days a week.

Text "**HPAPP**" to **239355** (Be Well) to download. Message and data rates apply. Reply STOP to cancel, HELP for help.

# Drug categories

## Preferred generic and generic drugs

**Essentially the same drugs, usually priced differently**

Have the same active ingredients as brand-name drugs and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as brand-name drugs. Your cost for generic drugs is usually lower than your cost for brand-name drugs.

## Preferred drug

**A medicine available to you for less than nonpreferred**

Generic or brand-name drugs that Humana offers at a lower cost to you than nonpreferred drugs.

## Nonpreferred drug

**A more expensive drug than preferred**

More expensive generic or brand-name prescription drugs that Humana offers at a higher cost to you than preferred drugs.

## Specialty

**Drugs for specific uses**

Some injectable and other high-cost drugs.

# Medication Therapy Management

As part of your Medicare Part D coverage with Humana, you might be able to take part in a program called Medication Therapy Management (MTM) at no extra cost. MTM may help you to:

- Know more about getting the greatest benefit from your medications
- Reduce risk by learning how to avoid harmful side effects
- Possibly save money by finding lower-cost alternatives to prescribed medications

## Who's eligible?

Members are chosen for MTM using the following Centers for Medicare & Medicaid Services (CMS) and Humana criteria:

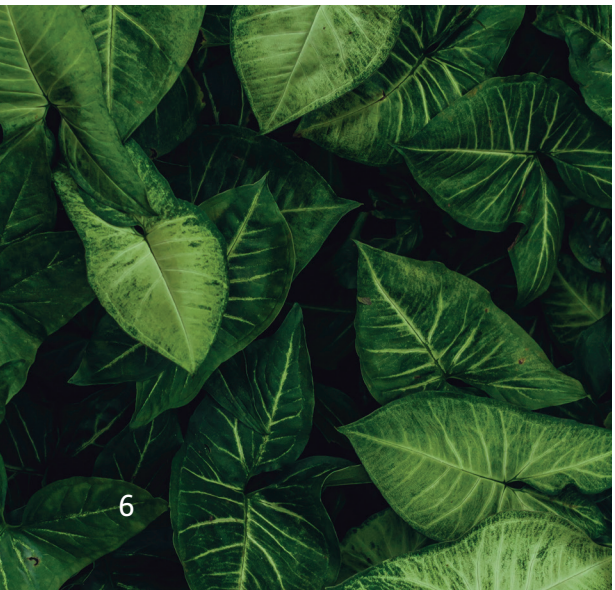
- Have three of the five multiple chronic conditions:
  - Congestive heart failure (CHF)
  - Dyslipidemia (high or low LDL cholesterol)
  - Diabetes
  - Chronic obstructive pulmonary disease (COPD)
  - Osteoporosis
- Take at least eight chronic/maintenance Part D drugs
- Spend more than $4,255 on prescription drugs per calendar year

## How does the program work?

MTM offers additional information in the SmartSummary Rx that can help to manage medications and drug costs. Members also get a face-to-face or phone consultation with a healthcare professional to talk about their medications.

## Scheduling a consultation

If you qualify for MTM, you will receive an invitation letter or see a note in your SmartSummary Rx to call the MTM call center. If you think you qualify but don't see the note, please call the group Medicare Customer Care phone number. Although the MTM program is a special service offered at no cost to Medicare members, it is not considered a benefit.



## Medical preauthorization

For certain services and procedures, your doctor or hospital may need to get advance approval from Humana before your plan will cover any costs. This is called prior authorization or preauthorization. Doctors or hospitals will submit the preauthorization request to Humana. If your doctor hasn't done this, please call our Customer Care team, as Humana may not be able to pay for these services.

## Part B vs. Part D

Knowing how your coverage works can save you from paying out of your pocket for vaccines. The Medicare Part D portion of your plan covers all commercially available vaccines—except for those covered by Part B—as long as the vaccine is reasonable and necessary to prevent illness.

**Get vaccines like the ones listed below at a network pharmacy.**
If you get them at your doctor's office, you'll pay the full cost of the vaccine out of pocket. Some common vaccines that you should get at your pharmacy, not from your doctor are Shingles, Tdap and Hepatitis A.

## Understanding your diabetes coverage

At Humana, we are here to help. We want you to have an easy experience when getting your diabetic supplies and prescriptions.

Your Humana Medicare Advantage Plan helps cover a variety of diabetic glucose testing supplies. Humana Pharmacy is the preferred durable medical equipment (DME) vendor for the products, and offers the meters listed below and their test strips and lancets: Roche Accu-Chek Nano®, Roche Accu-Chek Guide, Roche Accu-Chek Aviva Plus® and HP® True Metrix® AIR by Trividia. To order a meter and supplies from Humana Pharmacy, call **1-877-222-5084 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

Your doctor can also send prescriptions for meters and other testing supplies by fax or e-prescribe.

You can also request a no-cost meter from the manufacturer by calling Roche at **1-888-355-4242 (TTY: 711)**, or Trividia Health at **1-866-788-9618 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

**"With its large pharmacy network, nearly paperless claims process and suggestions for saving money, Humana brings a thoughtful, 'you-in-mind' approach to prescription drug coverage."**

# Important information about your prescription drug coverage

Some drugs covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, step therapy or quantity limits. You can visit **Humana.com** to register or sign in and select Pharmacy or call Humana's Group Medicare Customer Care team to check coverage on the medications you take.

## Prior authorization

The Humana Medicare Employer Plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. The reason a prior authorization is required can vary depending on the medication. Humana will work with your doctor when a prior authorization is required. If your doctor prescribes a drug that needs prior authorization, please be sure the prior authorization has been submitted to Humana before the prescription is filled. The Centers for Medicare & Medicaid Services (CMS) requires a turnaround time of 72 hours for a prior authorization. However, an expedited review can be requested by your provider if waiting 72 hours may be harmful to you.

## Step therapy

In some cases, the Humana Medicare Employer Plan requires that you first try certain drugs to treat your medical condition before coverage is available for a more expensive drug prescribed to treat your medical condition. For example, if Drug A and Drug B both treat your medical condition, the Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan can then cover Drug B. A step therapy prescription can be filled once the necessary requirements are met.

## Quantity limits

For some drugs, the Humana Medicare Employer Plan limits the quantity of the drug that is covered. The Humana Medicare Employer Plan might limit how many refills you can get or quantity of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Specialty drugs are limited to a 30-day supply regardless of tier placement.

## One-time transition fill

For certain drugs typically requiring prior authorization or step therapy, Humana will cover a one-time, 30-day supply of your Part D covered drug during the first 90 days of your enrollment. Once you have received the transition fill for your prescription requiring a prior authorization or step therapy, you'll receive a letter from Humana telling you about the requirements or limits on the prescription. The letter will also advise that you will need to get approval before future refills will be covered. A prior authorization will need to be approved or other alternative medicines should be tried if the medication requires step therapy.

## Next steps for you

1. Visit **Humana.com/Pharmacy** or call the Customer Care number on the back of your Humana member ID card to see if your medications have quantity limits, or require a prior authorization or step therapy.
2. Talk to your doctor about your drugs if they require prior authorization, step therapy is needed or has quantity limits.
3. If you have questions about your prescription drug benefits, please call our Customer Care number on the back of your Humana member ID card.

## What should your doctor do if there are quantity limits, prior authorization is needed or requirements have been met for a step therapy drug?

- Go online to **Humana.com/Provider** and visit our provider prior authorization page. This page has a printable form that can be mailed or faxed to Humana.
- Call **1-800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team. They are available Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

Remember: Before making a change, you should always talk about treatment options with your doctor.

**“It’s about getting you the information you need, it’s about respecting your budget, it’s about encouraging you to use your insurance and really helping you take care of your health.”**

# Extra benefits

## SilverSneakers fitness*

This program gives you access to fitness locations nationwide where you can:

**Work out indoors**
You receive a basic fitness membership and SilverSneakers® group exercise classes (where available).

**Go outside with SilverSneakers FLEX®**
Try tai chi, yoga, walking groups and more. Available at local parks and recreation centers (where available).

**Get SilverSneakers Steps®**
At home or on the go—receive your choice of a kit for general fitness, strength, walking or yoga (one per member per year).

Visit www.SilverSneakers.com to find a convenient location near you at no additional cost. Call **1-888-423-4632 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

*Equipment and classes may vary by location.

## Humana At Home℠

Supports qualifying members with both short-term and long-term services that can help them remain independent at home. Humana At Home care managers support members by providing education about chronic conditions and medication adherence, helping with discharge instructions, accessing community resources, finding social support and more, all included in the plan at no additional cost.
**Humana.com/caremgmt**
**1-800-432-4803 (TTY: 711)**
Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time

## Humana Well Dine® meal program

After your inpatient stay in a hospital or nursing facility, you're eligible for 10 nutritious meals delivered to your door at no additional cost to you.
For more information, please contact the number on the back of your Humana member ID card.

## Communication counts

As soon as you receive your Humana member ID card, go to **Humana.com** and register for MyHumana. This is your personal, secure online account that allows you to access your specific plan details from your computer or smartphone.

## The MyHumana Mobile app

If you have an iPhone or Android, download the MyHumana Mobile app.* You'll have your plan details with you at all times.

Visit **Humana.com/mobile-apps** to learn about our many mobile apps, the app features and how to use them.

With MyHumana and the MyHumana Mobile app, you can:

- Review your plan benefits and claims
- Find pharmacies in your network
- Find providers in your network
- Compare drug prices
- Access digital ID cards

### Connect with us on Facebook

Find healthcare information for Medicare members and caregivers to help in your pursuit of lifelong well-being at **facebook.com/Humana**.

*Standard data rates may apply.

**"Humana makes technology a user-friendly tool, and that helps make using your coverage easier. Your plan information is right there, online, available at the touch of your finger."**

## Build healthy provider relationships

Your relationship with your provider is important in helping you protect and manage your health. With the Humana Medicare Employer HMO plan, you'll have a primary care provider who will help you manage your care, who knows your medical history and the medicines you take. You can pick any provider from our network who is taking new patients, or you can change to another network provider if you choose. If you need to see a specialist, your provider will help you find one.

When you need hospital or outpatient care, you'll need a referral. Ask your provider to contact us whenever you're admitted to the hospital. We may have advice and special programs your doctor can use to help you heal faster.

### Is your provider in Humana's provider network?

Humana respects your relationship with your provider. We want you to be able to select a provider who's close to home and who can focus on your specific needs. If you need help finding a provider, call our Group Medicare Customer Care team or use our online directory. Humana's online provider lookup is an easy way to find doctors, hospitals and other healthcare providers in Humana's network:

- Go to **Humana.com** and select "Find a doctor"
- Get provider phone numbers, addresses and directions
- Customize your search by specialty, location and name

### Is your pharmacy in Humana's network?

Your relationship with your pharmacist is important in protecting and managing your health. You must use network pharmacies to enjoy the benefits of our plan except in an emergency. Pharmacies in the network have agreed to work with Humana to fill prescriptions for our members. If you use a pharmacy outside the network, your costs may be higher.

Our pharmacy network includes mail delivery, specialty, retail, long-term care, home infusion, and Indian, tribal and urban pharmacies.

You can find a complete list of network pharmacies at MyHumana, your personal, secure online account at **Humana.com**, and the MyHumana Mobile app.* Get printable maps and directions, along with many more details to find a pharmacy that fits your needs. Other information at **Humana.com/pharmacy/medicare/tools** includes:

- Printable Drug Lists
- Prior authorization information
- Maximize Your Benefit Rx

*Standard data rates may apply.

## Allies in well-being

### Consent forms

Everyone needs a little help now and then. We're happy to work with you and whomever you designate as a helper. Many people trust a family member or close friend to help them with their healthcare—someone who may help you talk with us about your insurance plan, keep track of your benefits and claims, or answer healthcare questions.

We need your permission to share your personal information with someone else. To give your permission, you'll need to read and sign a consent form.

### Here are the ways you can do that:

- Fill out and submit the form online once you have registered on MyHumana
- Print the form from **Humana.com/PHI** and return it by following the instructions on the form
- Call us and we'll mail the form to you to complete and return

A signed consent form allows insurers to share health plan information and protected health information with your designated helper. It's different from granting medical power of attorney, which allows someone to make decisions about your care.

**"Humana focuses on meeting your changing needs and smoothing your move to Medicare, so you can focus on work and play and living your life."**

## SmartSummary and SmartSummary Rx are your personalized benefits statements

Humana believes Medicare members deserve a better way to understand, track, manage and possibly save money on their healthcare. Your SmartSummary® and SmartSummary Rx® help you do just that. You'll receive these statements after each month in which you've had a medical and/or prescription claim. You can also sign in to MyHumana and see your past SmartSummary and SmartSummary Rx statements anytime.

### SmartSummary helps you:

- Understand your total healthcare picture
- Manage your monthly and yearly healthcare costs
- Engage with your providers by having a list of the healthcare services you receive
- Learn about preventive care, health conditions, treatment options and ways to help reduce health expenses

### SmartSummary Rx includes:

- Numbers to watch – SmartSummary Rx shows your total drug costs for the month and year-to-date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- Personalized messages – SmartSummary Rx gives you tips on saving money on the prescription drugs you take, information about changes in prescription copayments and how to plan ahead.
- Your Rx record – A personalized prescription manager tells you more about your prescription medications, including information about dosage and the prescribing doctor. It also has a refill calendar that helps you know the date of your next refill. This page can be useful to take to your doctor appointments or to your pharmacist.
- Healthcare news relevant for you – SmartSummary Rx personalizes a news section to let you know about things you can do for your health, including medicines and treatments for health problems.

# Time to ask

Understanding is the key to good decisions. Below are some common Medicare questions. Ask any others you may have. Humana has answers.

### Do I need to show my red, white and blue Medicare card when I visit the doctor?

No. You'll get a Humana member ID card that will take its place. Keep your Medicare ID card in a safe place—or use it only when it's needed for discounts and other offers from retailers.

### What should I do if I move or have a temporary address change?

If you move to another area or state, it may affect your plan. It's important to contact your group benefits administrator for details and call to notify Humana of the move.

### What should I do if I have to file a claim?

Call Humana Group Medicare Customer Care for more information and assistance. To request reimbursement for a charge you paid for a service, send the provider's itemized receipt and the Health Benefits Claim Form (also available at **Humana.com**) to the claims address on the back of your Humana member ID card. Make sure the receipt includes your name and Humana member ID number.

### What if I have other health insurance coverage?

If you have other health insurance, show your Humana member ID card and your other insurance cards when you see a healthcare provider. The Humana Medicare Employer plan may be eligible in combination with other types of health insurance coverage you may have. This is called coordination of benefits. Please notify Humana if you have any other medical coverage.

### When does my coverage begin?

Your former employer or union decides how and when you enroll. Check with your benefits administrator for the proposed effective date of your enrollment. Be sure to keep your current healthcare coverage until your Humana Medicare Employer HMO plan enrollment is confirmed.

### What if my service needs a prior authorization?

If your medical service or medication requires a prior authorization, your provider can contact Humana to request it. You can call Customer Care if you have questions regarding what medical services and medications require prior authorization.

### What should I do if I need prescriptions filled before I receive my Humana member ID card?

If you need to fill a prescription after your coverage begins but before you receive your Humana member ID card, take a copy of your temporary proof of membership to any in-network pharmacy.

### How can I get help with my drug plan costs?

People with limited incomes may qualify for assistance from the Extra Help program to pay for their prescription drug costs. To see if you qualify for Extra Help, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **1-877-486-2048**. You can also call the Social Security Administration at **1-800-772-1213**. If you use a TTY, call **1-800-325-0778**. Your state's Medical Assistance (Medicaid) Office may also be able to help, or you can apply for Extra Help online at **www.socialsecurity.gov**.

# Medical common terms and definitions

## Coinsurance

**Your share of the cost after deductible**
A percentage of your medical and drug costs that you may pay out of your pocket for services after you pay any plan deductible.

## Copayment

**What you pay at the provider's office for medical services**
The set dollar amount you pay when you receive medical services or have a prescription filled.

## Deductible

**What you pay up front**
The amount you pay for healthcare before your plan begins to pay for your benefits.

## Exclusions and limitations

**Anything not covered or covered under limited situations or conditions**
Specific conditions or circumstances that aren't covered under a plan.

## Maximum out-of-pocket

**The most you'll spend before your plan pays 100% of the cost**
The most you would have to pay for services covered by a health plan, including deductibles, copays and coinsurance. If and when you reach your annual out-of-pocket limit, the Humana Medicare Employer plan pays 100% of the Medicare-approved amount for most covered medical charges.

## Network

**Your plan's contracted medical providers**
A group of healthcare providers contracted to provide medical services at discounted rates. The providers include doctors, hospitals and other healthcare professionals and facilities.

## Plan discount

**A way Humana helps you save money**
Amount you are not responsible for due to Humana's negotiated rate with provider.

## Premium

**The regular monthly payment for your plan**
The amount you and/or your employer regularly pay for Medicare or Medicare Advantage coverage.

# Pharmacy common terms and definitions

## Catastrophic coverage

**What you pay for covered drugs after reaching $6,350**
Once your out-of-pocket costs reach the $6,350 maximum, you pay a small coinsurance or a small copayment for covered drug costs until the end of the plan year.

## Coinsurance

**Your share of your prescription's cost**
This is a percentage of the total cost of a drug you pay each time you fill a prescription.

## Copayment

**What you pay at the pharmacy for your prescription**
The set dollar amount you pay when you fill a prescription.

## Deductible

**Your cost for Part D prescription drugs before the plan pays**
The amount you pay for Part D prescription drugs before the plan begins to pay its share.

## Exclusions and limitations

**Anything not covered**
Specific conditions or circumstances that aren't covered under a plan.

## Formulary

**Drugs covered under your plan**
A list of drugs approved for coverage under the plan. Also called a Drug List.

## Out-of-pocket

**Portion of costs you pay**
Amount you may have to pay for most plans, including deductibles, copays and coinsurance.

## Notes

## Notes


Humana®

CHOOSE WELLNESS—AND GIFT CARDS

# EARN GIFT CARDS FOR HEALTHY ACTIONS

## Go365 by Humana rewards you for making healthy choices

go365™ by Humana®

## Improve your well-being and earn rewards along the way.

- Go365® by Humana is a wellness and rewards program available on many Humana plans
- It rewards you for completing your preventive screenings, getting your steps in, and participating in other healthy activities that can help keep you on the right track
- When you've completed qualified activities, you'll earn rewards that you can redeem for gift cards from the following retailers:

amazon.com gift card | Walmart Gift Card | Gift Card | GiftCard | T.J.maxx Marshalls HomeGoods | KOHL'S expect great things

## Learn more

**Humana.com/Go365**

Humana is a Medicare Advantage HMO and PPO organization with a Medicare contract. Enrollment in any Humana plan depends on contract renewal. In accordance with the federal requirements of the Centers for Medicare & Medicaid Services, no amounts on the gift cards shall be used to purchase covered medical supplies or prescription drugs, nor are they redeemable for cash Gift card amounts vary based on the qualifying activity. Rewards must be earned and redeemed within the same plan year. Rewards not redeemed by December 31 will expire. The merchants represented are not sponsors of Go365 or otherwise affiliated with Go365. The logos and other identifying marks attached are trademarks of and owned by each represented company and/or its affiliates. Please visit each company's website for additional terms and conditions.

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## Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion.

Humana Inc. and its subsidiaries provide: (1) free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate; and, (2) free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call the number on your ID card or if you use a **TTY**, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call the number on your ID card or if you use a **TTY**, call **711**.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights 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, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

## Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call the number on your ID card **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación **(TTY: 711)**... 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。 請致電會員卡上的電話號碼 **(TTY : 711)**。 CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số điện thoại ghi trên thẻ ID của quý vị **(TTY: 711)**... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . ID 카드에 적혀 있는 번호로 전화해 주십시오 **(TTY: 711)**... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero na nasa iyong ID card **(TTY: 711)**... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Наберите номер, указанный на вашей карточке-удостоверении **(телетайп: 711)...** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki sou kat idantite manm ou **(TTY: 711)**... ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro figurant sur votre carte de membre **(ATS: 711)**...UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Proszę zadzwonić pod numer podany na karcie identyfikacyjnej **(TTY: 711)**... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número presente em seu cartão de identificação **(TTY: 711)**... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero che appare sulla tessera identificativa **(TTY: 711)**... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wählen Sie die Nummer, die sich auf Ihrer Versicherungskarte befindet **(TTY: 711)**... 注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。お手持ちの ID カードに記載されている電話番号までご連絡ください **(TTY: 711)**...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره تلفن روی کارت شناسایی تان تماس بگیرید **(TTY: 711)...**

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, námboo ninaaltsoos yézhí, bee nééh ho'dólzin bikáá'ígíí bee hólne' **(TTY: 711)**...

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الهاتف الموجود على بطاقة الهوية الخاصة بك. **(رقم هاتف الصم والبكم: 711)...**