2024

Prescription Drug Guide

Humana Abbreviated Formulary

Partial List of covered drugs

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

Humana Premier Rx Plan (PDP)

This abridged formulary was updated on 10/11/2023 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana with any questions at 1-800-281-6918 or for TTY users, 711, five days a week April 1 – September 30 or seven days a week October 1 – March 31 from 8 a.m. - 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting **Humana.com**.

Instructions for getting information about all covered drugs are inside.

For a complete list of Contract/PBP numbers this document relates to, please see the final page of this document.

Humana®

Welcome to Humana!

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 Humana. This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2024. For a complete, updated formulary, please contact us on our website at **Humana.com/PlanDocuments** or you can call the number below to request a paper copy. 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 formulary?

A formulary is the entire list of covered drugs or medicines selected by Humana. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. Humana 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. Humana will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana 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 Humana. To search the complete list of all prescription drugs Humana covers, you can visit **Humana.com/medicaredruglist**.

For help or a complete list of covered drugs, please contact Humana Customer Care with any questions at 1-800-281-6918 **(TTY: 711)**. five days a week April 1 – September 30 or seven days a week October 1 – March 31 from 8 a.m. - 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting **Humana.com**.

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: In the below cases, you will be affected by coverage changes during the 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 titled "How do I request an exception to the Humana 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 both. 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 will 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 titled "How do I request an exception to the Humana formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 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. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

What if you are affected by a Drug List change?

We will 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, 2024. We will update the printed formularies each month and they will be available on **Humana.com/medicaredruglist**.

To get updated information about the drugs that Humana covers, please visit **Humana.com/medicaredruglist**.

Please contact Humana Customer Care with any questions at **1-800-281-6918 (TTY: 711)**, five days a week April 1- September 30 or seven days a week October 1 – March 31 from 8 a.m. – 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting **Humana.com**.

How do I use the formulary?

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

Medical condition

The formulary starts on page 11. We have put the drugs into groups depending on the type of medical conditions that they are 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 11. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 6 for more information on Utilization Management Requirements).

Alphabetical listing

If you are not sure about your drug's group, you should look for your drug in the Index that begins on page 28. 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 will 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 six tiers.
Humana 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 - Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for the plan
- **Tier 2 - Generic:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Preferred Generic drugs
- **Tier 3 - Preferred Brand:** Generic or brand drugs that the plan offers at a lower cost to you than Tier 4 Non-Preferred drugs
- **Tier 4 - Non-Preferred Drug:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 3 Preferred Brand drugs
- **Tier 5 - Specialty Tier:** Some injectables and other high-cost drugs
- **Tier 6 - Select Care Drugs:** Select generic and brand drugs used to treat certain chronic conditions

How much will I pay for covered drugs?

Humana 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 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):** Humana requires you to get prior authorization for certain drugs to be covered under your plan. This means that you will need to get approval from Humana before you fill your prescriptions. If you do not get approval, Humana may not cover the drug.

- **Quantity Limits (QL):** For some drugs, Humana limits the amount of the drug that is covered. Humana 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 is 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, Humana 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, Humana may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Humana 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 Humana 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 Humana at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m. (EST).

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 11.

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

You can ask Humana to make an exception to these restrictions or limits. See the section "**How do I request an exception to the Humana formulary?**" on page 7 for information about how to request an exception.

What if my drug is not on the formulary?

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

If Humana does not cover your drug, you have two options:

- You can ask Customer Care for a list of similar drugs that Humana covers. Show the list to your doctor and ask them to prescribe a similar drug that is covered by Humana.
- You can ask Humana 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.

What is a compounded drug?

A compounded drug is used to provide drug therapies that are not commercially available as FDA-approved finished products in the same dose, formulation, and/or combination of ingredients, but are instead created by a pharmacist by combining or mixing ingredients to create a prescription medication customized to the needs of an individual patient. While some compounded drugs may be Part D eligible, most compounded drugs are non-formulary drugs (not covered) by your plan. You may need to ask for and receive an approved coverage determination from us to have your compounded drug covered.

How do I request an exception to the Humana formulary?

You can ask Humana 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 is not on the formulary. If approved, this drug will be covered at a pre-determined cost sharing level, and you would not be able to ask us to provide the drug at a lower cost sharing level.
- **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. *You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.*

Generally, Humana 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 would not 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 fast, 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. If your request to expedite is granted, we must give you a decision no later than 24 hours after we receive 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 does not 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 are a member of the plan.

Here is what we will do for each of your current Part D drugs that are not on the formulary, or if you have limited ability to get your drugs:

- We will 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 have been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you are a resident of a long-term care facility and you take Part D drugs that are not on the formulary, we will cover a 31-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 31 days of a drug) during the first 90 days you are a member of our plan. We will 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 is not on the formulary *or*
- You have limited ability to get your drugs *and*
- You are 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, Humana will cover as much as a 31-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. Humana will review requests for continuation of therapy on a case-by-case basis understanding when you are on a stabilized drug regimen that, if changed, is known to have risks.

Transition extension

Humana will consider on a case-by-case basis an extension of the transition period if your exception request or appeal has not been processed by the end of your initial transition period. We will 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.

CenterWell Pharmacy™

You may fill your medicines at any network pharmacy. CenterWell Pharmacy – Humana's mail-delivery pharmacy is one option. CenterWell Pharmacy is the preferred cost-sharing mail order pharmacy for many Humana MAPD and prescription drug plans (PDP). You can have your maintenance medicines, specialty medicines, or supplies mailed to a place that is most convenient for you. You should get your new prescription by mail in 7 – 10 days after CenterWell Pharmacy has received your prescription and all the necessary information. Refills should arrive within 5 – 7 days. To get started or learn more, visit **CenterWellPharmacy.com**. You can also call CenterWell Pharmacy at **1-844-222-2151** (**TTY: 711**) Monday – Friday, 8 a.m. to 11 p.m. (EST), and Saturday, 8 a.m. to 6:30 p.m. (EST).

Other pharmacies are available in our network.

For More Information

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

Please contact Humana Customer Care with any questions at **1-800-281-6918 (TTY: 711)**, five days a week April 1 – September 30 or seven days a week October 1 – March 31 from 8 a.m. – 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting **Humana.com**.

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 Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by Humana. If you have trouble finding your drug in the list, turn to the Index that begins on page 28.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug is not listed in this partial formulary, please visit our website at **Humana.com**.

Your Humana plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D and are not subject to the Medicare appeals process. These drugs are listed separately on page 27.

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 or Utilization Management column, you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:

GC - Tier 1 or Tier 2 drugs that are covered in the gap
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.
LA - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.
AV - Advisory Committee on Immunization Practices (ACIP) Covered Part D vaccines; Part D vaccines recommended by ACIP for adults that may be available at no cost to you; additional restrictions may apply. For more information, please refer to your Evidence of Coverage.
CI - Covered insulin products; Part D insulin products covered by your plan. For more information on cost sharing for your covered insulin products, please refer to your Evidence of Coverage.
PDS – Preferred Diabetic Supplies; BD and HTL-Droplet are the preferred diabetic syringe and pen needle brands for the plan.

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. Humana 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 6 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANALGESICS		
acetaminophen-codeine 300-30 mg TABLET **DL**	3	QL(360 per 30 days)
BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG FILM **DL**	4	QL(60 per 30 days)
celecoxib 100 mg, 200 mg CAPSULE **GC,MO**	2	QL(60 per 30 days)
diclofenac sodium 1 % GEL **MO**	3	QL(1000 per 30 days)
diclofenac sodium 75 mg TABLET, DR/EC **GC,MO**	2	
hydrocodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET **DL**	3	QL(360 per 30 days)
ibuprofen 600 mg, 800 mg TABLET **GC,MO**	1	
meloxicam 15 mg TABLET **GC,MO**	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET **GC,MO**	1	QL(60 per 30 days)
morphine 15 mg TABLET ER **DL**	3	QL(120 per 30 days)
naproxen 500 mg TABLET **GC,MO**	1	
oxycodone 10 mg, 15 mg, 5 mg TABLET **DL**	3	QL(360 per 30 days)
oxycodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET **DL**	3	QL(360 per 30 days)
tramadol 50 mg TABLET **DL,GC**	2	QL(240 per 30 days)
XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG CAPSULE ER SPRINKLE 12 HR. **DL**	3	QL(60 per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
acamprosate 333 mg TABLET, DR/EC **MO**	4	
ZUBSOLV 0.7-0.18 MG, 1.4-0.36 MG SUBLINGUAL TABLET **GC,MO**	2	QL(90 per 30 days)
ZUBSOLV 11.4-2.9 MG SUBLINGUAL TABLET **GC,MO**	2	QL(30 per 30 days)
ANTIBACTERIALS		
amoxicillin 500 mg CAPSULE **GC,MO**	1	
amoxicillin 500 mg TABLET **GC,MO**	1	
amoxicillin-pot clavulanate 875-125 mg TABLET **GC,MO**	2	
azithromycin 250 mg TABLET **GC,MO**	2	
cefdinir 300 mg CAPSULE **GC,MO**	2	
cephalexin 500 mg CAPSULE **GC,MO**	1	
ciprofloxacin hcl 500 mg TABLET **GC,MO**	1	
clarithromycin 125 mg/5 ml SUSPENSION FOR RECONSTITUTION **MO**	4	
clindamycin hcl 300 mg CAPSULE **GC,MO**	2	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
daptomycin 500 mg RECON SOLUTION **DL**	5	
doxycycline hyclate 100 mg CAPSULE **MO**	3	
doxycycline hyclate 100 mg TABLET **MO**	3	
levofloxacin 500 mg TABLET **GC,MO**	2	
metronidazole 500 mg TABLET **GC,MO**	2	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE **MO**	3	
sulfacetamide sodium 10 % OINTMENT **MO**	3	
sulfamethoxazole-trimethoprim 800-160 mg TABLET **GC,MO**	1	
ANTICONVULSANTS		
EPIDIOLEX 100 MG/ML SOLUTION **DL**	5	PA
gabapentin 100 mg, 300 mg, 400 mg CAPSULE **GC,MO**	2	QL(270 per 30 days)
gabapentin 600 mg, 800 mg TABLET **GC,MO**	2	QL(180 per 30 days)
lamotrigine 100 mg, 200 mg TABLET **GC,MO**	1	
levetiracetam 500 mg TABLET **GC,MO**	2	
primidone 50 mg TABLET **GC,MO**	2	
XCOPRI 100 MG, 50 MG TABLET **DL**	4	QL(30 per 30 days)
XCOPRI 150 MG, 200 MG TABLET **DL**	4	QL(60 per 30 days)
XCOPRI MAINTENANCE PACK 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1) TABLET **DL**	4	QL(56 per 28 days)
XCOPRI TITRATION PACK 12.5 MG (14)- 25 MG (14) TABLET, DOSE PACK **MO**	4	QL(28 per 28 days)
XCOPRI TITRATION PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14) TABLET, DOSE PACK **DL**	4	QL(28 per 28 days)
ANTIDEMENTIA AGENTS		
donepezil 10 mg TABLET **GC,MO**	1	QL(60 per 30 days)
donepezil 5 mg TABLET **GC,MO**	1	QL(30 per 30 days)
memantine 10 mg, 5 mg TABLET **GC,MO**	2	PA,QL(60 per 30 days)
NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. **MO**	3	QL(30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE ER SPRINKLE 24 HR. **MO**	3	QL(28 per 28 days)
ANTIDEPRESSANTS		
amitriptyline 25 mg TABLET **GC,MO**	2	
bupropion hcl 150 mg TABLET, ER 24 HR. **MO**	3	QL(90 per 30 days)
bupropion hcl 150 mg TABLET, SR 12 HR. **MO**	3	QL(90 per 30 days)
bupropion hcl 300 mg TABLET, ER 24 HR. **MO**	3	QL(60 per 30 days)
citalopram 10 mg, 40 mg TABLET **GC,MO**	1	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
citalopram 20 mg TABLET **GC,MO**	1	QL(60 per 30 days)
duloxetine 20 mg CAPSULE, DR/EC **GC,MO**	2	QL(120 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC **GC,MO**	2	QL(90 per 30 days)
duloxetine 60 mg CAPSULE, DR/EC **GC,MO**	2	QL(60 per 30 days)
escitalopram oxalate 10 mg TABLET **GC,MO**	1	QL(45 per 30 days)
escitalopram oxalate 20 mg, 5 mg TABLET **GC,MO**	1	QL(30 per 30 days)
fluoxetine 20 mg CAPSULE **GC,MO**	1	QL(120 per 30 days)
fluoxetine 40 mg CAPSULE **GC,MO**	1	QL(60 per 30 days)
imipramine hcl 10 mg TABLET **GC,MO**	2	
mirtazapine 15 mg, 30 mg, 7.5 mg TABLET **GC,MO**	2	
paroxetine hcl 20 mg TABLET **GC,MO**	1	QL(30 per 30 days)
sertraline 100 mg TABLET **MO**	6	QL(60 per 30 days)
sertraline 25 mg, 50 mg TABLET **MO**	6	QL(90 per 30 days)
trazodone 100 mg, 150 mg, 50 mg TABLET **MO**	6	
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET **MO**	4	ST,QL(30 per 30 days)
venlafaxine 150 mg CAPSULE, ER 24 HR. **GC,MO**	2	QL(60 per 30 days)
venlafaxine 75 mg CAPSULE, ER 24 HR. **GC,MO**	2	QL(90 per 30 days)
ANTIEMETICS		
meclizine 25 mg TABLET **MO**	3	
ondansetron 4 mg TABLET, DISINTEGRATING **GC,MO**	2	BvsD
ondansetron hcl 4 mg TABLET **GC,MO**	2	BvsD
promethazine 25 mg TABLET **GC,MO**	2	
SANCUSO 3.1 MG/24 HOUR PATCH, WEEKLY **DL**	5	QL(4 per 30 days)
ANTIFUNGALS		
clotrimazole-betamethasone 1-0.05 % CREAM **MO**	3	QL(180 per 30 days)
fluconazole 150 mg TABLET **GC,MO**	2	
ketoconazole 2 % CREAM **MO**	3	QL(60 per 30 days)
ketoconazole 2 % SHAMPOO **GC,MO**	2	QL(120 per 30 days)
ANTIGOUT AGENTS		
allopurinol 100 mg, 300 mg TABLET **GC,MO**	2	
MITIGARE 0.6 MG CAPSULE **MO**	3	
ANTIMIGRAINE AGENTS		
AIMOVIG AUTOINJECTOR 140 MG/ML AUTO-INJECTOR **MO**	4	PA,QL(1 per 30 days)
AIMOVIG AUTOINJECTOR 70 MG/ML AUTO-INJECTOR **MO**	4	PA,QL(2 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
EMGALITY PEN 120 MG/ML PEN INJECTOR MO	4	PA,QL(2 per 30 days)
EMGALITY SYRINGE 120 MG/ML SYRINGE MO	4	PA,QL(2 per 30 days)
EMGALITY SYRINGE 300 MG/3 ML (100 MG/ML X 3) SYRINGE MO	4	PA,QL(3 per 30 days)
rizatriptan 5 mg TABLET GC,MO	2	QL(12 per 30 days)
sumatriptan succinate 100 mg TABLET GC,MO	2	QL(9 per 30 days)
topiramate 50 mg TABLET GC,MO	2	QL(120 per 30 days)
ANTINEOPLASTICS		
ALECENSA 150 MG CAPSULE DL	5	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET DL	5	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET DL	5	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK DL	5	PA,QL(30 per 30 days)
anastrozole 1 mg TABLET GC,MO	1	QL(30 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG TABLET DL	5	PA,QL(30 per 30 days)
ERIVEDGE 150 MG CAPSULE DL	5	PA,QL(28 per 28 days)
ERLEADA 60 MG TABLET DL	5	PA,QL(120 per 30 days)
exemestane 25 mg TABLET MO	4	QL(60 per 30 days)
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE DL	5	PA,QL(21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG TABLET DL	5	PA,QL(21 per 28 days)
IMBRUVICA 140 MG CAPSULE DL	5	PA,QL(120 per 30 days)
IMBRUVICA 420 MG, 560 MG TABLET DL	5	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE DL	5	PA,QL(28 per 28 days)
NUBEQA 300 MG TABLET DL	5	PA,QL(120 per 30 days)
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET DL	5	PA,QL(60 per 30 days)
XTANDI 40 MG CAPSULE DL	5	PA,QL(120 per 30 days)
XTANDI 40 MG TABLET DL	5	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET DL	5	PA,QL(60 per 30 days)
ANTIPARASITICS		
hydroxychloroquine 200 mg TABLET MO	3	
nitazoxanide 500 mg TABLET DL	5	
ANTIPARKINSON AGENTS		
carbidopa-levodopa 25-100 mg TABLET GC,MO	2	
RYTARY 23.75-95 MG CAPSULE, ER MO	4	ST,QL(360 per 30 days)
ANTIPSYCHOTICS		
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON DL	4	QL(1 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE MO	4	QL(3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE DL	4	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE DL	4	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 42 days)
INVEGA HAFYERA 1,092 MG/3.5 ML SYRINGE MO	4	QL(3.5 per 180 days)
INVEGA HAFYERA 1,560 MG/5 ML SYRINGE MO	4	QL(5 per 180 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML SYRINGE DL	4	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML SYRINGE DL	4	QL(1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML SYRINGE MO	4	QL(1.5 per 28 days)
INVEGA TRINZA 273 MG/0.88 ML SYRINGE MO	4	QL(0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML SYRINGE MO	4	QL(1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML SYRINGE MO	4	QL(1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML SYRINGE MO	4	QL(2.63 per 90 days)
PERSERIS 120 MG, 90 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
quetiapine 100 mg TABLET GC,MO	2	QL(90 per 30 days)
quetiapine 25 mg, 50 mg TABLET GC,MO	2	QL(120 per 30 days)
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML SUSPENSION, ER, RECON MO	4	QL(2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML SUSPENSION, ER, RECON DL	4	QL(2 per 28 days)
ANTISPASTICITY AGENTS		
baclofen 10 mg TABLET GC,MO	2	
dantrolene 100 mg, 25 mg, 50 mg CAPSULE MO	4	
tizanidine 2 mg, 4 mg TABLET GC,MO	1	
ANTIVIRALS		
acyclovir 400 mg TABLET GC,MO	2	
DESCOVY 200-25 MG TABLET DL	5	QL(30 per 30 days)
EPCLUSA 150-37.5 MG PELLETS IN PACKET DL	5	PA,QL(28 per 28 days)
EPCLUSA 200-50 MG PELLETS IN PACKET DL	5	PA,QL(56 per 28 days)
EPCLUSA 200-50 MG, 400-100 MG TABLET DL	5	PA,QL(28 per 28 days)
GENVOYA 150-150-200-10 MG TABLET DL	5	QL(30 per 30 days)
HARVONI 33.75-150 MG PELLETS IN PACKET DL	5	PA,QL(28 per 28 days)
HARVONI 45-200 MG PELLETS IN PACKET DL	5	PA,QL(56 per 28 days)
HARVONI 90-400 MG TABLET DL	5	PA,QL(28 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ISENTRESS HD 600 MG TABLET DL	5	QL(60 per 30 days)
ODEFSEY 200-25-25 MG TABLET DL	5	QL(30 per 30 days)
valacyclovir 1 gram, 500 mg TABLET MO	3	
VOSEVI 400-100-100 MG TABLET DL	5	PA,QL(28 per 28 days)
ANXIOLYTICS		
alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET DL,GC	2	QL(120 per 30 days)
buspirone 10 mg, 15 mg, 5 mg TABLET GC,MO	1	
clonazepam 0.5 mg, 1 mg TABLET DL	3	
diazepam 10 mg TABLET DL	3	QL(120 per 30 days)
diazepam 5 mg TABLET DL	3	QL(90 per 30 days)
hydroxyzine hcl 25 mg TABLET MO	3	
lorazepam 0.5 mg, 1 mg TABLET DL,GC	2	QL(90 per 30 days)
BLOOD GLUCOSE REGULATORS		
BAQSIMI 3 MG/ACTUATION SPRAY, NON-AEROSOL MO	3	
BYDUREON BCISE 2 MG/0.85 ML AUTO-INJECTOR MO	4	QL(3.4 per 28 days)
FARXIGA 10 MG TABLET MO	4	QL(30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE CI,MO	3	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	
glimepiride 2 mg, 4 mg TABLET GC,MO	1	
glipizide 10 mg TABLET, ER 24 HR. GC,MO	2	
glipizide 10 mg, 5 mg TABLET GC,MO	1	
GLYXAMBI 10-5 MG, 25-5 MG TABLET MO	3	QL(30 per 30 days)
GVOKE 1 MG/0.2 ML SOLUTION MO	3	
GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML AUTO-INJECTOR MO	3	
GVOKE PFS 1-PACK SYRINGE 0.5 MG/0.1 ML, 1 MG/0.2 ML SYRINGE MO	3	
HUMULIN R U-500 (CONC) INSULIN 500 UNIT/ML SOLUTION CI,DL	5	
HUMULIN R U-500 (CONC) KWIKPEN 500 UNIT/ML (3 ML) INSULIN PEN CI,DL	5	
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET MO	3	QL(60 per 30 days)
INVOKAMET XR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	3	QL(60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET MO	3	QL(30 per 30 days)
JANUMET 50-1,000 MG TABLET MO	3	QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	3	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
JANUMET XR 50-1,000 MG TABLET, ER 24 HR., MULTIPHASE **MO**	3	QL(60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET **MO**	3	QL(30 per 30 days)
JARDIANCE 10 MG, 25 MG TABLET **MO**	3	QL(30 per 30 days)
JENTADUETO 2.5-1,000 MG, 2.5-500 MG, 2.5-850 MG TABLET **MO**	3	QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	3	
metformin 1,000 mg, 500 mg TABLET **MO**	6	
metformin 500 mg TABLET, ER 24 HR. **MO**	6	QL(120 per 30 days)
MOUNJARO 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML PEN INJECTOR **MO**	3	QL(2 per 28 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	3	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	3	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	3	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION **CI,MO**	3	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	3	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	3	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION **CI,MO**	3	
OZEMPIC 0.25 MG OR 0.5 MG(2 MG/1.5 ML) PEN INJECTOR **MO**	3	QL(1.5 per 28 days)
OZEMPIC 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR **MO**	3	QL(3 per 28 days)
pioglitazone 15 mg, 30 mg TABLET **GC,MO**	2	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET **MO**	3	QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN **CI,MO**	3	QL(15 per 24 days)
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET **MO**	3	QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	3	QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN **CI,MO**	3	
TRADJENTA 5 MG TABLET **MO**	3	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	3	QL(30 per 30 days)
TRIJARDY XR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	3	QL(60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML PEN INJECTOR MO	3	QL(2 per 28 days)
VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML) PEN INJECTOR MO	3	QL(9 per 30 days)
XIGDUO XR 10-1,000 MG, 10-500 MG TABLET, IR/ER 24 HR., BIPHASIC MO	4	QL(30 per 30 days)
XULTOPHY 100/3.6 100 UNIT-3.6 MG /ML (3 ML) INSULIN PEN CI,MO	3	QL(15 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR MO	3	
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE MO	3	
BLOOD PRODUCTS AND MODIFIERS		
BRILINTA 60 MG, 90 MG TABLET MO	3	QL(60 per 30 days)
clopidogrel 75 mg TABLET GC,MO	1	QL(30 per 30 days)
ELIQUIS 2.5 MG TABLET MO	3	QL(60 per 30 days)
ELIQUIS 5 MG TABLET MO	3	QL(74 per 30 days)
ELIQUIS DVT-PE TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK MO	3	QL(74 per 30 days)
PROCRIT 10,000 UNIT/ML SOLUTION MO	4	PA,QL(14 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML SOLUTION MO	4	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE DL	5	PA,QL(1.2 per 28 days)
warfarin 5 mg TABLET GC,MO	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION MO	3	ST,QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET MO	3	QL(30 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET MO	3	QL(60 per 30 days)
XARELTO DVT-PE TREAT 30D START 15 MG (42)- 20 MG (9) TABLET, DOSE PACK MO	3	QL(51 per 30 days)
ZARXIO 300 MCG/0.5 ML SYRINGE DL	5	PA,QL(7 per 30 days)
ZARXIO 480 MCG/0.8 ML SYRINGE DL	5	PA,QL(11.2 per 30 days)
CARDIOVASCULAR AGENTS		
amiodarone 200 mg TABLET GC,MO	2	
amlodipine 10 mg, 2.5 mg, 5 mg TABLET MO	6	
atenolol 25 mg, 50 mg TABLET GC,MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET **MO**	6	
bumetanide 1 mg TABLET **GC,MO**	2	
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET **MO**	6	
chlorthalidone 25 mg TABLET **GC,MO**	1	
clonidine hcl 0.1 mg TABLET **GC,MO**	1	
CORLANOR 5 MG, 7.5 MG TABLET **MO**	4	PA,QL(60 per 30 days)
digoxin 125 mcg (0.125 mg) TABLET **GC,MO**	2	QL(30 per 30 days)
diltiazem hcl 120 mg, 180 mg, 240 mg CAPSULE, ER 24 HR. **GC,MO**	2	QL(60 per 30 days)
ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET **MO**	3	QL(60 per 30 days)
ezetimibe 10 mg TABLET **MO**	3	QL(30 per 30 days)
fenofibrate 160 mg TABLET **GC,MO**	2	QL(30 per 30 days)
fenofibrate nanocrystallized 145 mg TABLET **MO**	3	QL(30 per 30 days)
furosemide 20 mg, 40 mg TABLET **MO**	6	
guanfacine 1 mg TABLET **GC,MO**	2	
hydralazine 25 mg, 50 mg TABLET **GC,MO**	1	
hydrochlorothiazide 12.5 mg CAPSULE **MO**	6	
hydrochlorothiazide 12.5 mg, 25 mg TABLET **MO**	6	
irbesartan 300 mg TABLET **GC,MO**	1	QL(30 per 30 days)
isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR. **GC,MO**	1	
lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET **MO**	6	
lisinopril-hydrochlorothiazide 10-12.5 mg, 20-12.5 mg, 20-25 mg TABLET **GC,MO**	1	
losartan 100 mg, 25 mg, 50 mg TABLET **MO**	6	QL(60 per 30 days)
losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET **GC,MO**	1	QL(60 per 30 days)
lovastatin 20 mg, 40 mg TABLET **GC,MO**	1	
metoprolol succinate 100 mg, 25 mg, 50 mg TABLET, ER 24 HR. **MO**	6	
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET **MO**	6	
MULTAQ 400 MG TABLET **MO**	3	QL(60 per 30 days)
NEXLETOL 180 MG TABLET **MO**	3	PA,QL(30 per 30 days)
NEXLIZET 180-10 MG TABLET **MO**	3	PA,QL(30 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET **MO**	3	
olmesartan 40 mg TABLET **GC,MO**	1	QL(30 per 30 days)
pravastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET **GC,MO**	2	
REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR **MO**	3	PA,QL(3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML PEN INJECTOR **MO**	3	PA,QL(3 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
REPATHA SYRINGE 140 MG/ML SYRINGE **MO**	3	PA,QL(3 per 28 days)
rosuvastatin 10 mg, 20 mg, 40 mg, 5 mg TABLET **MO**	6	
simvastatin 10 mg, 20 mg, 40 mg TABLET **MO**	6	
spironolactone 25 mg, 50 mg TABLET **GC,MO**	1	
torsemide 20 mg TABLET **GC,MO**	2	
triamterene-hydrochlorothiazid 37.5-25 mg TABLET **GC,MO**	1	
valsartan 160 mg TABLET **GC,MO**	2	QL(60 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)
ZYPITAMAG 2 MG, 4 MG TABLET **MO**	3	ST,QL(30 per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
AUSTEDO 12 MG, 9 MG TABLET **DL**	5	PA,QL(120 per 30 days)
AUSTEDO 6 MG TABLET **DL**	5	PA,QL(60 per 30 days)
BETASERON 0.3 MG KIT **DL**	5	PA,QL(15 per 30 days)
COPAXONE 20 MG/ML SYRINGE **DL**	5	PA,QL(30 per 30 days)
pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE **MO**	3	QL(90 per 30 days)
SAVELLA 100 MG, 12.5 MG, 25 MG, 50 MG TABLET **MO**	3	QL(60 per 30 days)
SAVELLA 12.5 MG (5)-25 MG(8)-50 MG(42) TABLET, DOSE PACK **MO**	3	QL(55 per 28 days)
DENTAL & ORAL AGENTS		
chlorhexidine gluconate 0.12 % MOUTHWASH **GC,MO**	2	
triamcinolone acetonide 0.1 % PASTE **MO**	3	
DERMATOLOGICAL AGENTS		
ENSTILAR 0.005-0.064 % FOAM **MO**	4	QL(120 per 30 days)
erythromycin with ethanol 2 % SOLUTION **MO**	4	QL(120 per 30 days)
mupirocin 2 % OINTMENT **GC,MO**	2	
OTEZLA 30 MG TABLET **DL**	5	PA,QL(60 per 30 days)
OTEZLA STARTER 10 MG (4)-20 MG (4)-30 MG (47) TABLET, DOSE PACK **DL**	5	PA,QL(55 per 28 days)
ELECTROLYTES/MINERALS/METALS/VITAMINS		
calcium acetate(phosphat bind) 667 mg CAPSULE **MO**	3	
potassium chloride 10 meq CAPSULE, ER **GC,MO**	2	
potassium chloride 10 meq, 20 meq TABLET ER **GC,MO**	2	
potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS **GC,MO**	2	
VELPHORO 500 MG CHEWABLE TABLET **DL**	4	
VELTASSA 16.8 GRAM, 25.2 GRAM, 8.4 GRAM POWDER IN PACKET **MO**	3	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
GASTROINTESTINAL AGENTS		
CLENPIQ 10 MG-3.5 GRAM- 12 GRAM/160 ML SOLUTION **MO**	3	
dicyclomine 10 mg CAPSULE **GC,MO**	2	
dicyclomine 20 mg TABLET **GC,MO**	2	
esomeprazole magnesium 40 mg CAPSULE, DR/EC **MO**	3	QL(60 per 30 days)
famotidine 20 mg, 40 mg TABLET **GC,MO**	2	
lactulose 10 gram/15 ml SOLUTION **GC,MO**	2	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE **MO**	3	QL(30 per 30 days)
misoprostol 200 mcg TABLET **MO**	3	
MOVANTIK 12.5 MG, 25 MG TABLET **MO**	3	QL(30 per 30 days)
omeprazole 20 mg, 40 mg CAPSULE, DR/EC **GC,MO**	1	QL(60 per 30 days)
pantoprazole 20 mg, 40 mg TABLET, DR/EC **GC,MO**	1	QL(60 per 30 days)
sucralfate 1 gram TABLET **GC,MO**	2	
XIFAXAN 200 MG TABLET **MO**	4	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET **DL**	5	PA,QL(84 per 28 days)
GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
CERDELGA 84 MG CAPSULE **DL**	5	PA
CREON 24,000-76,000 -120,000 UNIT CAPSULE, DR/EC **MO**	3	
ELELYSO 200 UNIT RECON SOLUTION **DL**	5	PA
ZENPEP 25,000-79,000- 105,000 UNIT CAPSULE, DR/EC **MO**	4	
GENITOURINARY AGENTS		
finasteride 5 mg TABLET **GC,MO**	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET **MO**	4	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. **MO**	3	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON **MO**	3	QL(300 per 30 days)
oxybutynin chloride 10 mg, 5 mg TABLET, ER 24 HR. **MO**	3	QL(60 per 30 days)
oxybutynin chloride 5 mg TABLET **GC,MO**	2	
tamsulosin 0.4 mg CAPSULE **MO**	6	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
methylprednisolone 4 mg TABLET, DOSE PACK **GC,MO**	2	
prednisone 10 mg, 20 mg, 5 mg TABLET **GC,MO**	1	BvsD
triamcinolone acetonide 0.1 % CREAM **GC,MO**	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
desmopressin 0.1 mg TABLET **MO**	3	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
desmopressin 0.2 mg TABLET **MO**	4	
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) CARTRIDGE **DL**	5	PA
OMNITROPE 5.8 MG RECON SOLUTION **DL**	5	PA
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
DUAVEE 0.45-20 MG TABLET **MO**	4	PA,QL(30 per 30 days)
OSPHENA 60 MG TABLET **MO**	3	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET **MO**	4	
PREMARIN 0.625 MG/GRAM CREAM **MO**	3	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg TABLET **MO**	6	
liothyronine 25 mcg, 5 mcg, 50 mcg TABLET **MO**	3	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
LUPRON DEPOT-PED 11.25 MG KIT **DL**	5	PA,QL(1 per 28 days)
ORGOVYX 120 MG TABLET **DL**	5	PA,QL(32 per 30 days)
SOMATULINE DEPOT 120 MG/0.5 ML SYRINGE **DL**	5	PA,QL(0.5 per 28 days)
SOMATULINE DEPOT 60 MG/0.2 ML SYRINGE **DL**	5	PA,QL(0.2 per 28 days)
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE **DL**	5	PA,QL(0.3 per 28 days)
IMMUNOLOGICAL AGENTS		
COSENTYX 75 MG/0.5 ML SYRINGE **DL**	5	PA,QL(2 per 28 days)
COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE **DL**	5	PA,QL(8 per 28 days)
COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR **DL**	5	PA,QL(8 per 28 days)
DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR **DL**	5	PA,QL(3.42 per 28 days)
DUPIXENT PEN 300 MG/2 ML PEN INJECTOR **DL**	5	PA,QL(8 per 28 days)
DUPIXENT SYRINGE 100 MG/0.67 ML SYRINGE **DL**	5	PA,QL(1.34 per 28 days)
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE **DL**	5	PA,QL(3.42 per 28 days)
DUPIXENT SYRINGE 300 MG/2 ML SYRINGE **DL**	5	PA,QL(8 per 28 days)
ENBREL 25 MG (1 ML) RECON SOLUTION **DL**	5	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML) SYRINGE **DL**	5	PA,QL(8 per 28 days)
ENBREL 25 MG/0.5 ML SOLUTION **DL**	5	PA,QL(8 per 28 days)
ENBREL MINI 50 MG/ML (1 ML) CARTRIDGE **DL**	5	PA,QL(8 per 28 days)
ENBREL SURECLICK 50 MG/ML (1 ML) PEN INJECTOR **DL**	5	PA,QL(8 per 28 days)
ENVARSUS XR 0.75 MG, 1 MG TABLET, ER 24 HR. **MO**	4	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION **DL**	5	PA

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMIRA 40 MG/0.8 ML SYRINGE KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA PEN CROHNS-UC-HS START 40 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS 40 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML SYRINGE KIT **DL**	5	PA,QL(2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SYRINGE KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SYRINGE KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS 80 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC 80 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS 80 MG/0.8 ML-40 MG/0.4 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
methotrexate sodium 2.5 mg TABLET **MO**	3	BvsD
RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. **DL**	5	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET, ER 24 HR. **DL**	5	PA,QL(168 per 365 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION **AV,DL**	3	
SKYRIZI 150 MG/ML PEN INJECTOR	5	PA,QL(6 per 365 days)
SKYRIZI 150 MG/ML SYRINGE	5	PA,QL(6 per 365 days)
SKYRIZI 150MG/1.66ML(75 MG/0.83 ML X2) SYRINGE KIT	5	PA,QL(6 per 365 days)
STELARA 45 MG/0.5 ML SOLUTION **DL**	5	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SYRINGE **DL**	5	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SYRINGE **DL**	5	PA,QL(3 per 84 days)
TDVAX 2-2 LF UNIT/0.5 ML SUSPENSION **AV,DL,GC**	1	
METABOLIC BONE DISEASE AGENTS		
alendronate 70 mg TABLET **GC,MO**	1	QL(4 per 28 days)
FORTEO 20 MCG/DOSE (600MCG/2.4ML) PEN INJECTOR **DL**	5	PA,QL(2.4 per 28 days)
PROLIA 60 MG/ML SYRINGE **MO**	4	QL(1 per 180 days)
RAYALDEE 30 MCG CAPSULE, ER 24 HR. **DL**	5	QL(60 per 30 days)
TYMLOS 80 MCG (3,120 MCG/1.56 ML) PEN INJECTOR **DL**	5	PA,QL(1.56 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL SWABS PADS, MEDICATED **GC,MO**	1	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE **PDS,GC,MO**	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,GC,MO**	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 SYRINGE **PDS,GC,MO**	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,GC,MO**	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE **PDS,GC,MO**	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE **PDS,GC,MO**	1	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,GC,MO**	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE **PDS,GC,MO**	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE **PDS,GC,MO**	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE **PDS,GC,MO**	1	
BD VEO INSULIN SYRINGE UF 0.3 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,GC,MO**	1	
butalbital-acetaminophen-caff 50-325-40 mg TABLET **MO**	4	QL(180 per 30 days)
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 SYRINGE **PDS,GC,MO**	1	
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" NEEDLE **PDS,GC,MO**	1	
PAXLOVID 150-100 MG TABLET, DOSE PACK **MO**	3	QL(40 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLET, DOSE PACK **MO**	3	QL(60 per 10 days)
RECTIV 0.4 % (W/W) OINTMENT **MO**	4	QL(30 per 30 days)
OPHTHALMIC AGENTS		
ALPHAGAN P 0.1 % DROPS **MO**	3	
azelastine 0.05 % DROPS **MO**	3	
brimonidine 0.2 % DROPS **GC,MO**	1	
COMBIGAN 0.2-0.5 % DROPS **MO**	3	QL(5 per 25 days)
dorzolamide-timolol 22.3-6.8 mg/ml DROPS **GC,MO**	2	
erythromycin 5 mg/gram (0.5 %) OINTMENT **GC,MO**	2	QL(3.5 per 28 days)
EYSUVIS 0.25 % DROPS, SUSPENSION **MO**	3	QL(16.6 per 30 days)
ILEVRO 0.3 % DROPS, SUSPENSION **MO**	3	QL(3 per 30 days)
ketorolac 0.5 % DROPS **GC,MO**	2	QL(10 per 30 days)
latanoprost 0.005 % DROPS **GC,MO**	1	QL(5 per 25 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
levobunolol 0.5 % DROPS GC,MO	1	
LOTEMAX SM 0.38 % DROPS, GEL MO	4	
LUMIGAN 0.01 % DROPS MO	3	QL(2.5 per 25 days)
moxifloxacin 0.5 % DROPS MO	3	
prednisolone acetate 1 % DROPS, SUSPENSION MO	3	
RESTASIS 0.05 % DROPPERETTE MO	3	QL(60 per 30 days)
RESTASIS MULTIDOSE 0.05 % DROPS MO	3	QL(5.5 per 25 days)
RHOPRESSA 0.02 % DROPS MO	3	ST,QL(2.5 per 25 days)
ROCKLATAN 0.02-0.005 % DROPS MO	3	ST,QL(2.5 per 25 days)
timolol maleate 0.5 % DROPS GC,MO	1	
VYZULTA 0.024 % DROPS MO	4	QL(2.5 per 25 days)
ZERVIATE 0.24 % DROPPERETTE MO	4	QL(60 per 30 days)
RESPIRATORY TRACT/PULMONARY AGENTS		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL,LA	5	PA,QL(90 per 30 days)
ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER MO	3	QL(12 per 30 days)
albuterol sulfate 90 mcg/actuation HFA AEROSOL INHALER MO	3	QL(36 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE MO	3	QL(30 per 30 days)
azelastine 137 mcg (0.1 %) AEROSOL SPRAY MO	3	QL(30 per 25 days)
BEVESPI AEROSPHERE 9-4.8 MCG HFA AEROSOL INHALER MO	4	QL(10.7 per 30 days)
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE BLISTER WITH DEVICE MO	3	QL(60 per 30 days)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACTUATION HFA AEROSOL INHALER MO	3	QL(10.7 per 30 days)
COMBIVENT RESPIMAT 20-100 MCG/ACTUATION MIST MO	4	QL(4 per 20 days)
fluticasone propion-salmeterol 250-50 mcg/dose BLISTER WITH DEVICE MO	3	QL(60 per 30 days)
fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION GC,MO	2	QL(16 per 30 days)
hydroxyzine pamoate 25 mg CAPSULE MO	3	
levocetirizine 5 mg TABLET GC,MO	2	QL(30 per 30 days)
montelukast 10 mg TABLET GC,MO	1	QL(30 per 30 days)
NUCALA 100 MG/ML AUTO-INJECTOR DL	5	PA,QL(3 per 28 days)
NUCALA 100 MG/ML SYRINGE DL	5	PA,QL(3 per 28 days)
OFEV 100 MG, 150 MG CAPSULE DL,LA	5	PA,QL(60 per 30 days)
OPSUMIT 10 MG TABLET DL,LA	5	PA,QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION MIST **MO**	3	QL(4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG CAPSULE, W/INHALATION DEVICE **MO**	3	QL(30 per 30 days)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACTUATION MIST **MO**	3	QL(4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION MIST **MO**	3	QL(4 per 30 days)
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER **MO**	3	QL(10.2 per 30 days)
TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE **MO**	3	QL(60 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER **MO**	3	QL(36 per 30 days)
zafirlukast 20 mg TABLET **MO**	4	QL(60 per 30 days)
SKELETAL MUSCLE RELAXANTS		
cyclobenzaprine 10 mg, 5 mg TABLET **GC,MO**	2	
methocarbamol 500 mg, 750 mg TABLET **GC,MO**	2	
SLEEP DISORDER AGENTS		
BELSOMRA 10 MG TABLET **MO**	3	QL(60 per 30 days)
BELSOMRA 15 MG, 20 MG TABLET **MO**	3	QL(30 per 30 days)
BELSOMRA 5 MG TABLET **MO**	3	QL(120 per 30 days)
temazepam 15 mg, 30 mg CAPSULE **DL,GC**	2	QL(30 per 30 days)
zolpidem 10 mg, 5 mg TABLET **GC,MO**	2	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

Humana Coverage of Additional Prescription Drugs DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Erectile Dysfunction		
sildenafil 100 mg, 25 mg, 50 mg TABLET	2	QL(6 per 30 days)

Your Humana Plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D. These drugs are not subject to the Medicare appeals process. The amount you pay when you fill a prescription for these drugs does not count toward your total drug costs (in other words, the amount you pay does not help you qualify for catastrophic coverage).

AV - ACIP Covered Part D vaccines • B vs D - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • GC - Gap Coverage • ST - Step Therapy

Index

A

ABILIFY MAINTENA... 14, 15

acamprosate... 11

acetaminophen-codeine... 11

acyclovir... 15

ADEMPAS... 25

ADVAIR HFA... 25

AIMOVIG AUTOINJECTOR... 13

albuterol sulfate... 25

ALECENSA... 14

alendronate... 23

allopurinol... 13

ALPHAGAN P... 24

alprazolam... 16

ALUNBRIG... 14

amiodarone... 18

amitriptyline... 12

amlodipine... 18

amoxicillin... 11

amoxicillin-pot clavulanate... 11

anastrozole... 14

ARISTADA INITIO... 15

ARISTADA... 15

ARNUITY ELLIPTA... 25

atenolol... 18

atorvastatin... 19

AUSTEDO... 20

azelastine... 24, 25

azithromycin... 11

B

baclofen... 15

BAQSIMI... 16

BD ALCOHOL SWABS... 23

BD INSULIN SYRINGE (HALF UNIT)... 23

BD INSULIN SYRINGE U-500... 23

BD INSULIN SYRINGE ULTRA-FINE... 24

BD NANO 2ND GEN PEN NEEDLE... 24

BD ULTRA-FINE MICRO PEN NEEDLE... 24

BD ULTRA-FINE MINI PEN NEEDLE... 24

BD ULTRA-FINE NANO PEN NEEDLE... 24

BD ULTRA-FINE ORIG PEN NEEDLE... 24

BD ULTRA-FINE SHORT PEN NEEDLE... 24

BD VEO INSULIN SYR (HALF UNIT)... 24

BD VEO INSULIN SYRINGE UF... 24

BELBUCA... 11

BELSOMRA... 26

BETASERON... 20

BEVESPI AEROSPHERE... 25

BREO ELLIPTA... 25

BREZTRI AEROSPHERE... 25

BRILINTA... 18

brimonidine... 24

bumetanide... 19

bupropion hcl... 12

buspirone... 16

butalbital-acetaminophen-caff... 24

BYDUREON BCISE... 16

C

CABOMETYX... 14

calcium acetate(phosphat bind)... 20

carbidopa-levodopa... 14

carvedilol... 19

cefdinir... 11

celecoxib... 11

cephalexin... 11

CERDELGA... 21

chlorhexidine gluconate... 20

chlorthalidone... 19

ciprofloxacin hcl... 11

citalopram... 12, 13

clarithromycin... 11

CLENPIQ... 21

clindamycin hcl... 11
clonazepam... 16
clonidine hcl... 19
clopidogrel... 18
clotrimazole-betamethasone... 13
COMBIGAN... 24
COMBIVENT RESPIMAT... 25
COPAXONE... 20
CORLANOR... 19
COSENTYX (2 SYRINGES)... 22
COSENTYX PEN (2 PENS)... 22
COSENTYX... 22
CREON... 21
cyclobenzaprine... 26

D

dantrolene... 15
daptomycin... 12
DESCOVY... 15
desmopressin... 21, 22
diazepam... 16
diclofenac sodium... 11
dicyclomine... 21
digoxin... 19
diltiazem hcl... 19
donepezil... 12
dorzolamide-timolol... 24
doxycycline hyclate... 12
DROPLET INSULIN SYRINGE... 24
DROPLET PEN NEEDLE... 24
DUAVEE... 22
duloxetine... 13
DUPIXENT PEN... 22
DUPIXENT SYRINGE... 22

E

ELELYSO... 21
ELIQUIS DVT-PE TREAT 30D START... 18
ELIQUIS... 18
EMGALITY PEN... 14
EMGALITY SYRINGE... 14
ENBREL MINI... 22
ENBREL SURECLICK... 22
ENBREL... 22
ENSTILAR... 20
ENTRESTO... 19
ENVARSUS XR... 22
EPCLUSA... 15
EPIDIOLEX... 12
ERIVEDGE... 14
ERLEADA... 14
erythromycin with ethanol... 20
erythromycin... 24
escitalopram oxalate... 13
esomeprazole magnesium... 21
exemestane... 14
EYSUVIS... 24
ezetimibe... 19

F

famotidine... 21
FARXIGA... 16
fenofibrate nanocrystallized... 19
fenofibrate... 19
FIASP FLEXTOUCH U-100 INSULIN... 16
FIASP PENFILL U-100 INSULIN... 16
FIASP U-100 INSULIN... 16
finasteride... 21
fluconazole... 13
fluoxetine... 13
fluticasone propion-salmeterol... 25
fluticasone propionate... 25
FORTEO... 23
furosemide... 19

G

gabapentin... 12
GAMUNEX-C... 22
GEMTESA... 21
GENVOYA... 15
glimepiride... 16
glipizide... 16
GLYXAMBI... 16
guanfacine... 19
GVOKE HYPOPEN 2-PACK... 16
GVOKE PFS 1-PACK SYRINGE... 16

GVOKE... 16

H

HARVONI... 15

HUMIRA PEN CROHNS-UC-HS START... 23

HUMIRA PEN PSOR-UVEITS-ADOL HS... 23

HUMIRA PEN... 23

HUMIRA... 23

HUMIRA(CF) PEDI CROHNS STARTER... 23

HUMIRA(CF) PEN CROHNS-UC-HS... 23

HUMIRA(CF) PEN PEDIATRIC UC... 23

HUMIRA(CF) PEN PSOR-UV-ADOL HS... 23

HUMIRA(CF) PEN... 23

HUMIRA(CF)... 23

HUMULIN R U-500 (CONC) INSULIN... 16

HUMULIN R U-500 (CONC) KWIKPEN... 16

hydralazine... 19

hydrochlorothiazide... 19

hydrocodone-acetaminophen... 11

hydroxychloroquine... 14

hydroxyzine hcl... 16

hydroxyzine pamoate... 25

I

IBRANCE... 14

ibuprofen... 11

ILEVRO... 24

IMBRUVICA... 14

imipramine hcl... 13

INVEGA HAFYERA... 15

INVEGA SUSTENNA... 15

INVEGA TRINZA... 15

INVOKAMET XR... 16

INVOKAMET... 16

INVOKANA... 16

irbesartan... 19

ISENTRESS HD... 16

isosorbide mononitrate... 19

J

JANUMET XR... 16, 17

JANUMET... 16

JANUVIA... 17

JARDIANCE... 17

JENTADUETO XR... 17

JENTADUETO... 17

K

ketoconazole... 13

ketorolac... 24

L

lactulose... 21

lamotrigine... 12

LANTUS SOLOSTAR U-100 INSULIN... 17

LANTUS U-100 INSULIN... 17

latanoprost... 24

levetiracetam... 12

levobunolol... 25

levocetirizine... 25

levofloxacin... 12

levothyroxine... 22

LINZESS... 21

liothyronine... 22

lisinopril... 19

lisinopril-hydrochlorothiazide... 19

lorazepam... 16

losartan... 19

losartan-hydrochlorothiazide... 19

LOTEMAX SM... 25

lovastatin... 19

LUMIGAN... 25

LUPRON DEPOT-PED... 22

M

meclizine... 13

meloxicam... 11

memantine... 12

metformin... 17

methocarbamol... 26

methotrexate sodium... 23

methylprednisolone... 21

metoprolol succinate... 19

metoprolol tartrate... 19

metronidazole... 12

mirtazapine... 13

misoprostol... 21

MITIGARE... 13

montelukast... 25

morphine... 11

MOUNJARO... 17

MOVANTIK... 21

moxifloxacin... 25

MULTAQ... 19

mupirocin... 20

MYRBETRIQ... 21

N

NAMZARIC... 12

naproxen... 11

NEXLETOL... 19

NEXLIZET... 19

nitazoxanide... 14

nitrofurantoin monohyd/m-cryst... 12

nitroglycerin... 19

NOVOLIN N FLEXPEN... 17

NOVOLIN N NPH U-100 INSULIN... 17

NOVOLIN 70-30 FLEXPEN U-100... 17

NOVOLIN 70/30 U-100 INSULIN... 17

NOVOLOG FLEXPEN U-100 INSULIN... 17

NOVOLOG MIX 70-30 U-100 INSULN... 17

NOVOLOG MIX 70-30FLEXPEN U-100... 17

NOVOLOG PENFILL U-100 INSULIN... 17

NOVOLOG U-100 INSULIN ASPART... 17

NUBEQA... 14

NUCALA... 25

O

ODEFSEY... 16

OFEV... 25

olmesartan... 19

omeprazole... 21

OMNITROPE... 22

ondansetron hcl... 13

ondansetron... 13

OPSUMIT... 25

ORGOVYX... 22

OSPHENA... 22

OTEZLA STARTER... 20

OTEZLA... 20

oxybutynin chloride... 21

oxycodone... 11

oxycodone-acetaminophen... 11

OZEMPIC... 17

P

pantoprazole... 21

paroxetine hcl... 13

PAXLOVID... 24

PERSERIS... 15

pioglitazone... 17

potassium chloride... 20

pravastatin... 19

prednisolone acetate... 25

prednisone... 21

pregabalin... 20

PREMARIN... 22

primidone... 12

PROCRIT... 18

PROLIA... 23

promethazine... 13

Q

quetiapine... 15

R

RAYALDEE... 23

RECTIV... 24

REPATHA PUSHTRONEX... 19

REPATHA SURECLICK... 19

REPATHA SYRINGE... 20

RESTASIS MULTIDOSE... 25

RESTASIS... 25

RETACRIT... 18

RHOPRESSA... 25

RINVOQ... 23
RISPERDAL CONSTA... 15
rizatriptan... 14
ROCKLATAN... 25
rosuvastatin... 20
RYBELSUS... 17
RYTARY... 14

S

SANCUSO... 13
SAVELLA... 20
sertraline... 13
SHINGRIX (PF)... 23
sildenafil... 27
simvastatin... 20
SKYRIZI... 23
SOLIQUA 100/33... 17
SOMATULINE DEPOT... 22
SPIRIVA RESPIMAT... 26
SPIRIVA WITH HANDIHALER... 26
spironolactone... 20
STELARA... 23
STIOLTO RESPIMAT... 26
STRIVERDI RESPIMAT... 26
sucralfate... 21
sulfacetamide sodium... 12
sulfamethoxazole-trimethoprim... 12
sumatriptan succinate... 14
SYMBICORT... 26
SYNJARDY XR... 17
SYNJARDY... 17

T

tamsulosin... 21
TDVAX... 23
temazepam... 26
timolol maleate... 25
tizanidine... 15
topiramate... 14
torsemide... 20
TOUJEO MAX U-300 SOLOSTAR... 17
TOUJEO SOLOSTAR U-300 INSULIN... 17
TRADJENTA... 17
tramadol... 11
trazodone... 13
TRELEGY ELLIPTA... 26
TRESIBA FLEXTOUCH U-100... 18
TRESIBA U-100 INSULIN... 18
triamcinolone acetonide... 20, 21
triamterene-hydrochlorothiazid... 20
TRIJARDY XR... 18
TRINTELLIX... 13
TRULICITY... 18
TYMLOS... 23

U

UDENYCA... 18

V

valacyclovir... 16
valsartan... 20
VASCEPA... 20
VELPHORO... 20
VELTASSA... 20
venlafaxine... 13
VENTOLIN HFA... 26
VERZENIO... 14
VICTOZA 3-PAK... 18
VOSEVI... 16
VYZULTA... 25

W

warfarin... 18

X

XARELTO DVT-PE TREAT 30D START... 18
XARELTO... 18
XCOPRI MAINTENANCE PACK... 12
XCOPRI TITRATION PACK... 12
XCOPRI... 12
XIFAXAN... 21
XIGDUO XR... 18
XTAMPZA ER... 11
XTANDI... 14
XULTOPHY 100/3.6... 18

Z

zafirlukast... 26
ZARXIO... 18

ZEGALOGUE AUTOINJECTOR... 18

ZEGALOGUE SYRINGE... 18

ZENPEP... 21

ZERVIATE... 25

zolpidem... 26

ZUBSOLV... 11

ZYPITAMAG... 20

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, gender identity, ancestry, ethnicity, marital status, religion, or language. 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 **1-877-320-1235** 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 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).**
- **California residents:** You may also call the California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

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. 1-877-320-1235 (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 Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-320-1235 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-320-1235 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线 : 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-320-1235 (聽障專線 : 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-320-1235 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-320-1235 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다 . 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخطتنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-320-1235 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-320-1235 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-320-1235 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-320-1235 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

Japanese：当社の健康保険と処方薬プランに関するご質問にお答えするために、無料の通訳サービスをご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY：711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。

Notes

Notes

This abridged formulary was updated on 10/11/2023 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact Humana with any questions at 1-800-281-6918 or, for TTY users, 711, five days a week April 1 – September 30 or seven days a week October 1– March 31 from 8 a.m. - 8 p.m. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day 7 days a week, by visiting **Humana.com.**

20240004PDG2449024_v7

S5552-005; S5884-148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180

Humana®

Humana.com