Pennsylvania Public School Employees' Retirement System (PSERS)

# Health Options Program

# Abridged Gold5 Prescription Drug Formulary for the Value Medicare Rx Option

*(Partial List of Covered Drugs)*

# 2024

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

This Abridged Gold5 Prescription Drug Formulary for the Value Medicare Rx Option (PDP) was updated on July 19, 2023. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please call the HOP Administration Unit at 1-800-773-7725, or for TTY users, 1-800-498-5428, 8:00 a.m. to 8:00 p.m. ET, Monday–Friday, or visit HOPbenefits.com.

**Important Message About What You Pay for Vaccines** –The Value Medicare Rx Option covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call the HOP Administration Unit for more information.

**Important Message About What You Pay for Insulin** – You won't pay more than $35 for a one-month supply of each insulin product covered by the Value Medicare Option, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

**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 the Health Options Program, which is sponsored by the Pennsylvania Public School Employees' Retirement System. When it refers to "plan" or "our plan," it means the Value Medicare Rx Option.

This document includes a partial list of the drugs (formulary) for the plan, which is current as of July 19, 2023. 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, 2025, and from time to time during the year.

## *What is the Value Medicare Rx Option Abridged Formulary?*

A formulary is a list of covered drugs selected by the Value Medicare Rx Option in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The Value Medicare Rx Option will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an OptumRx network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage.*

**CMS CONTRACT NUMBER: E3014; FORMULARY ID: 24071**

This document is a partial formulary and includes only some of the drugs covered by the Value Medicare Rx Option. For a complete listing of all prescription drugs covered by the Value Medicare Rx Option, please visit our website at HOPbenefits.com or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

*Please note that this formulary covers the Value Medicare Rx Option only. If you have coverage through the Enhanced or Basic Medicare Rx Option or a Medicare Advantage plan through the Health Options Program, you will have to contact the HOP Administration Unit or the Medicare Advantage plan directly for a copy of the formulary for your prescription drug plan.*

## *Can the formulary (drug list) change?*

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 when a new, less expensive drug is released, or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.) Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost sharing for those members taking it 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. We must follow Medicare rules in making these changes. Below are changes to the drug list that will also affect members currently taking a drug:

- **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 find information in the section below titled "How do I request an exception to the Value Medicare Rx Option 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.

  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 entitled "How do I request an exception to the Value Medicare Rx Option Formulary?"

The enclosed formulary is current as of July 19, 2023. To get updated information about the drugs covered by the Value Medicare Rx Option, please contact us. Our contact information appears on the front and back cover pages. In the event of midyear formulary changes, a revised Comprehensive Formulary for the Value Medicare Rx Option will be posted to HOPbenefits.com.

### *How do I use the formulary?*

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

- **Medical condition**
  The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular Agents." If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.
- **Alphabetical listing**
  If you are not sure what category to look under, you should look for your drug in the Index that begins on page 19. The Index provides an alphabetical list of all the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index, and find your drug. Next to your 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 your drug in the first column of the list.

### *What are generic drugs?*

The Value Medicare Rx Option covers both brand-name drugs and generic drugs. A generic drug is approved by the Food and Drug Administration (FDA) as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

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

Some covered drugs have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** The Value Medicare Rx Option requires you (or your physician) to get prior authorization for certain drugs. This means that you will need to get approval from the Value Medicare Rx Option before you fill your prescriptions. If you don't get approval, the Value Medicare Rx Option may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, the Value Medicare Rx Option limits the amount of the drug that will be covered. For example, the Value Medicare Rx Option covers 30 pills per 30 days for Crestor. If your prescription is for more, OptumRx will contact your doctor to determine whether more than one per day will be covered. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy (ST):** In some cases, the Value Medicare Rx Option requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Value Medicare Rx Option may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explains our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask the Value Medicare Rx Option to make an exception to these restrictions or limits or for a list of other, similar drugs

that may treat your health condition. See the section "How do I request an exception to the Value Medicare Rx Option Formulary?" on page iv, 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 formulary (list of covered drugs), you should first contact OptumRx and ask if your drug is covered. This document includes only a partial list of covered drugs, so the Value Medicare Rx Option may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that the Value Medicare Rx Option does not cover your drug, you have two options:

- You can ask OptumRx for a list of similar drugs that are covered by the Value Medicare Rx Option. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by the plan.
- You can ask the plan to make an exception and cover your drug. See below for information about how to request an exception.

### *How do I request an exception to the Value Medicare Rx Option Formulary?*

You can ask the Value Medicare Rx Option to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary. If approved, this drug will be covered at a predetermined cost-sharing level, and you will not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level (if this drug is not on the specialty tier). If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, the Value Medicare Rx Option limits the amount of drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, the Value Medicare Rx Option will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug, or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 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 get a supporting statement from your doctor or other prescriber.

### *What do I do before I can talk to my doctor about changing my drugs or requesting an exception?*

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum of a 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

### Emergency transitions and level-of-care changes

You may have a change in your treatment setting due to the level of care you require. Such transitions may include if you are:

- Admitted to a long-term care facility following an inpatient hospital stay.
- Discharged from a hospital or skilled nursing facility to a home setting.
- Admitted to a hospital or skilled nursing facility from a home setting.
- Transferred from one skilled nursing facility to another and the new facility is serviced by a different pharmacy.
- Discharged from a skilled nursing facility Medicare Part A stay, where payments include all pharmacy charges, and you now need to use your Part D plan benefit.
- Reverted back to standard Medicare Parts A and B coverage after giving up hospice status.

This transition policy applies to drugs that are covered under the Value Medicare Rx Option and filled at a network pharmacy.

## For more information

For more detailed information about the Value Medicare Rx Option prescription drug coverage, please review your *Evidence of Coverage for the Value Medicare Rx Option* and other plan materials. If you have questions about the Value Medicare Rx Option, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages. 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, 7 days a week. TTY users should call 1-877-486-2048. Or visit medicare.gov.

## Value Medicare Rx Option Abridged Prescription Drug Formulary

The abridged formulary that begins on page 1 provides coverage information about some of the drugs covered by the Value Medicare Rx Option.

If you have trouble finding your drug in the list, turn to the Index that begins on page 19.

**Remember:** This is only a partial listing of drugs covered by the Value Medicare Rx Option. If your prescription is not in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIDODERM), and generic drugs are listed in lowercase italics (e.g., *meloxicam*).

The information in the Requirements/Limits column tells you if the Value Medicare Rx Option has any special requirements for coverage of your drug.

## WHAT THE ABBREVIATIONS MEAN

**B/D:** This prescription drug has a **Part B versus Part D administrative prior authorization requirement.** This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

**NDS:** **Non-Extended Day Supply.** This prescription drug is not available for an extended day's supply under the Value Medicare Rx Option.

**PA:** **Prior Authorization.** You or your physician need to get approval from the Value Medicare Rx Option before you fill this prescription. If you don't get approval, the Value Medicare Rx Option may not cover the drug. See page iii for more information.

**QL:** **Quantity Limit.** The Value Medicare Rx Option limits the amount of this drug that will be covered. See page iii for more information.

**ST:** **Step Therapy.** The Value Medicare Rx Option requires you to first try another drug to treat your medical condition before we will cover this one for that condition. See page iii for more information.

# 2024 Abridged Gold5 Prescription Drug Formulary

**DEDUCTIBLE**

- In general, you must pay the annual deductible of $545 before the Value Medicare Rx Option pays any portion of your prescription drug costs.

**PREFERRED GENERIC DRUGS** (TIER 1)

- In Initial Coverage, you'll pay a maximum of $2 for up to a 30-day supply (and a maximum of up to $6 for a 31- to 90-day supply) of preferred generic drugs without having to satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, the plan pays the full cost of covered Part D drugs.

**GENERIC DRUGS** (TIER 2)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, the plan pays the full cost of covered Part D drugs.

**PREFERRED BRAND-NAME DRUGS** (TIER 3)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, the plan pays the full cost of covered Part D drugs.

**NON-PREFERRED DRUGS** (TIER 4)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, the plan pays the full cost of covered Part D drugs.

**SPECIALTY DRUGS** (TIER 5)

- In Initial Coverage, you'll pay 25% of the cost after you satisfy the annual deductible.
- In the Coverage Gap, you'll pay 25% of the cost.
- In Catastrophic Coverage, the plan pays the full cost of covered Part D drugs.
- Specialty drugs are limited to a 30-day supply.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **Analgesics** | | |
| ***Nonsteroidal Anti-inflammatory Drugs*** | | |
| *celecoxib caps* | 2 | QL (60 EA per 30 days) |
| *diclofenac sodium dr* | 2 | |
| *diclofenac sodium gel 1%* | 2 | QL (1000 GM per 30 days) |
| *ibuprofen tabs 400mg, 600mg, 800mg* | 1 | |
| *meloxicam tabs* | 1 | |
| *nabumetone tabs* | 2 | |
| *naproxen tabs 250mg, 375mg, 500mg* | 1 | |
| ***Opioid Analgesics, Long-acting*** | | |
| *fentanyl pt72 100mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr* | 4 | NDS |
| *methadone hcl tabs* | 2 | NDS |
| *morphine sulfate er tbcr* | 3 | NDS |
| XTAMPZA ER | 3 | NDS |
| ***Opioid Analgesics, Short-acting*** | | |
| *acetaminophen/codeine tabs* | 2 | NDS |
| *hydrocodone bitartrate/acetaminophen tabs 325mg; 10mg, 325mg; 5mg* | 2 | NDS |
| *hydrocodone/acetaminophen tabs 325mg; 7.5mg* | 2 | NDS |
| *hydromorphone hcl tabs 2mg, 4mg* | 2 | NDS |
| *hydromorphone hcl tabs 8mg* | 4 | NDS |
| *morphine sulfate tabs* | 3 | NDS |
| *oxycodone hydrochloride tabs 10mg, 15mg, 5mg* | 2 | NDS |
| *oxycodone hydrochloride tabs 20mg, 30mg* | 3 | NDS |
| *oxycodone/acetaminophen tabs 325mg; 5mg, 325mg; 7.5mg* | 2 | NDS |
| *oxycodone/acetaminophen tabs 325mg; 10mg, 325mg; 2.5mg* | 3 | NDS |
| *tramadol hcl tabs* | 1 | NDS |
| **Anesthetics** | | |
| ***Local Anesthetics*** | | |
| *lidocaine oint 5%* | 3 | QL (150 GM per 30 days) PA |
| *lidocaine ptch 5%* | 4 | PA |
| *premium lidocaine* | 3 | QL (150 GM per 30 days) PA |
| **Antibacterials** | | |
| ***Antibacterials, Other*** | | |
| *clindamycin hcl caps 300mg* | 2 | |
| *clindamycin hydrochloride caps 150mg, 75mg* | 2 | |
| *methenamine hippurate* | 4 | |
| *metronidazole tabs 250mg, 500mg* | 1 | |
| *nitrofurantoin macrocrystals caps 100mg, 50mg* | 4 | |
| *nitrofurantoin monohydrate/macrocrystals* | 2 | |
| *nitrofurantoin monohydrate caps* | 2 | |
| ***Beta-lactam, Cephalosporins*** | | |
| *cefadroxil caps* | 2 | |
| *cefdinir caps* | 2 | |
| *cefpodoxime proxetil tabs* | 4 | |
| *cefuroxime axetil tabs* | 2 | |
| *cephalexin caps 250mg, 500mg* | 2 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***Beta-lactam, Penicillins*** | | |
| *amoxicillin/clavulanate potassium tabs 500mg; 125mg, 875mg; 125mg* | 2 | |
| *amoxicillin/clavulanate potassium tabs 250mg; 125mg* | 4 | |
| *amoxicillin caps, tabs* | 1 | |
| *penicillin v potassium tabs* | 2 | |
| ***Macrolides*** | | |
| *azithromycin tabs 250mg* | 1 | |
| *azithromycin tabs 500mg, 600mg* | 3 | |
| ***Quinolones*** | | |
| *ciprofloxacin hydrochloride tabs 250mg, 500mg* | 1 | |
| *levofloxacin tabs* | 2 | |
| ***Sulfonamides*** | | |
| *sulfamethoxazole/trimethoprim ds* | 1 | |
| ***Tetracyclines*** | | |
| *doxycycline hyclate caps 100mg, 50mg* | 2 | |
| *doxycycline hyclate tabs 100mg* | 2 | |
| *doxycycline monohydrate caps 100mg, 50mg* | 2 | |
| *doxycycline monohydrate tabs 100mg, 50mg* | 2 | |
| **Anticonvulsants** | | |
| ***Anticonvulsants, Other*** | | |
| BRIVIACT SOLN | 5 | PA |
| BRIVIACT TABS 100MG, 25MG, 50MG, 75MG | 5 | PA |
| *lamotrigine tabs* | 1 | |
| *levetiracetam tabs* | 2 | |
| *topiramate tabs* | 1 | |
| XCOPRI TABS | 5 | PA |
| XCOPRI TBPK 0 | 4 | PA |
| XCOPRI TBPK 0 | 5 | PA |
| ***Gamma-aminobutyric Acid (GABA) Augmenting Agents*** | | |
| *clonazepam tabs 2mg* | 1 | QL (300 EA per 30 days) |
| *clonazepam tabs 0.5mg, 1mg* | 1 | QL (90 EA per 30 days) |
| *divalproex sodium dr* | 2 | |
| *divalproex sodium er* | 2 | |
| *divalproex sodium csdr* | 2 | |
| *gabapentin caps 100mg, 300mg* | 1 | QL (360 EA per 30 days) |
| *gabapentin caps 400mg* | 2 | QL (270 EA per 30 days) |
| *gabapentin tabs 800mg* | 2 | QL (150 EA per 30 days) |
| *gabapentin tabs 600mg* | 2 | QL (180 EA per 30 days) |
| *primidone tabs 250mg, 50mg* | 2 | |
| ***Sodium Channel Agents*** | | |
| *carbamazepine tabs* | 3 | |
| *oxcarbazepine tabs* | 2 | |
| *phenytoin sodium extended* | 2 | |
| **Antidementia Agents** | | |
| ***Antidementia Agents, Other*** | | |
| NAMZARIC CP24 | 4 | QL (30 EA per 30 days) ST |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***Cholinesterase Inhibitors*** | | |
| *donepezil hcl tabs 10mg* | 1 | |
| *donepezil hcl tabs 23mg* | 4 | |
| *donepezil hydrochloride tabs 10mg, 5mg* | 1 | |
| ***N-methyl-D-aspartate (NMDA) Receptor Antagonist*** | | |
| *memantine hydrochloride tabs* | 2 | |
| **Antidepressants** | | |
| ***Antidepressants, Other*** | | |
| *bupropion hcl tabs 100mg* | 2 | |
| *bupropion hydrochloride er (sr) tb12 150mg, 200mg* | 2 | QL (60 EA per 30 days) |
| *bupropion hydrochloride er (sr) tb12 100mg* | 2 | QL (90 EA per 30 days) |
| *bupropion hydrochloride er (xl) tb24 300mg* | 2 | QL (30 EA per 30 days) |
| *bupropion hydrochloride er (xl) tb24 150mg* | 2 | QL (90 EA per 30 days) |
| *bupropion hydrochloride tabs 75mg* | 2 | |
| *mirtazapine tabs* | 2 | |
| ***SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor*** | | |
| *citalopram hydrobromide tabs* | 1 | |
| *desvenlafaxine er tb24 100mg* | 2 | QL (120 EA per 30 days) |
| *desvenlafaxine er tb24 25mg, 50mg* | 2 | QL (30 EA per 30 days) |
| *duloxetine hydrochloride cpep 20mg, 60mg* | 2 | QL (60 EA per 30 days) |
| *duloxetine hydrochloride cpep 30mg* | 2 | QL (90 EA per 30 days) |
| *escitalopram oxalate tabs* | 1 | |
| *fluoxetine hcl caps 20mg* | 1 | |
| *fluoxetine hydrochloride caps 10mg, 40mg* | 1 | |
| *paroxetine hcl tabs 30mg, 40mg* | 2 | |
| *paroxetine hydrochloride tabs 10mg, 20mg* | 2 | |
| *sertraline hcl tabs 25mg, 50mg* | 1 | |
| *sertraline hydrochloride tabs 100mg* | 1 | |
| *trazodone hydrochloride tabs 100mg, 150mg, 50mg* | 2 | |
| *venlafaxine hcl er cp24 150mg, 37.5mg* | 2 | |
| *venlafaxine hydrochloride* | 2 | |
| *venlafaxine hydrochloride er cp24 75mg* | 2 | |
| ***Tricyclics*** | | |
| *amitriptyline hcl tabs 100mg, 150mg, 25mg, 75mg* | 3 | |
| *amitriptyline hydrochloride tabs 10mg, 50mg* | 3 | |
| *nortriptyline hcl caps 25mg, 75mg* | 2 | |
| *nortriptyline hydrochloride caps 10mg, 50mg* | 2 | |
| **Antiemetics** | | |
| ***Antiemetics, Other*** | | |
| *meclizine hcl tabs* | 4 | |
| *prochlorperazine maleate tabs* | 2 | |
| *promethazine hcl tabs 12.5mg* | 2 | |
| *promethazine hydrochloride tabs 25mg* | 2 | |
| ***Emetogenic Therapy Adjuncts*** | | |
| *ondansetron hydrochloride tabs* | 1 | B/D |
| *ondansetron odt* | 2 | B/D |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **Antifungals** | | |
| ***Antifungals*** | | |
| *fluconazole tabs* | 2 | |
| *ketoconazole sham* | 2 | |
| *ketoconazole crea* | 2 | QL (90 GM per 30 days) |
| *nystatin crea, susp* | 2 | |
| *nystatin powd* | 2 | QL (120 GM per 30 days) |
| *nystop* | 2 | QL (120 GM per 30 days) |
| *terbinafine hcl tabs* | 2 | QL (84 EA per 180 days) |
| **Antigout Agents** | | |
| ***Antigout Agents*** | | |
| *allopurinol tabs 100mg, 300mg* | 1 | |
| COLCHICINE TABS 0.6MG | 3 | |
| *febuxostat* | 4 | |
| **Antimigraine Agents** | | |
| ***Prophylactic*** | | |
| AIMOVIG INJ 140MG/ML | 4 | QL (1 ML per 30 days) PA |
| AIMOVIG INJ 70MG/ML | 4 | QL (2 ML per 30 days) PA |
| EMGALITY INJ 120MG/ML | 4 | QL (1 ML per 30 days) PA |
| EMGALITY INJ 100MG/ML | 5 | QL (3 ML per 30 days) PA |
| NURTEC | 5 | QL (18 EA per 30 days) PA |
| UBRELVY | 5 | QL (16 EA per 30 days) PA |
| ***Serotonin (5-HT) Receptor Agonist*** | | |
| *rizatriptan benzoate odt* | 3 | QL (18 EA per 30 days) |
| *sumatriptan succinate tabs* | 2 | QL (9 EA per 30 days) |
| **Antineoplastics** | | |
| ***Antiandrogens*** | | |
| *abiraterone acetate tabs 250mg* | 4 | PA |
| *abiraterone acetate tabs 500mg* | 5 | PA |
| NUBEQA | 5 | PA |
| XTANDI | 5 | PA |
| ***Antiestrogens/Modifiers*** | | |
| *tamoxifen citrate tabs* | 2 | |
| ***Antimetabolites*** | | |
| *hydroxyurea caps* | 2 | |
| ***Aromatase Inhibitors, 3rd Generation*** | | |
| *anastrozole tabs* | 1 | |
| *letrozole* | 2 | |
| ***Molecular Target Inhibitors*** | | |
| ALECENSA | 5 | PA |
| BRUKINSA | 5 | PA |
| CALQUENCE CAPS | 5 | PA |
| IMBRUVICA CAPS, TABS | 5 | PA |
| ODOMZO | 5 | PA |
| SPRYCEL | 5 | PA |
| TASIGNA | 5 | PA |
| ***Monoclonal Antibody/Antibody-Drug Conjugate*** | | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| RUXIENCE INJ 500MG/50ML | 5 | PA |
| TRAZIMERA INJ 150MG | 5 | PA |
| **Antiparasitics** | | |
| ***Antiprotozoals*** | | |
| *hydroxychloroquine sulfate tabs 100mg, 200mg* | 2 | |
| **Antiparkinson Agents** | | |
| ***Anticholinergics*** | | |
| *benztropine mesylate tabs* | 2 | |
| ***Dopamine Agonists*** | | |
| NEUPRO | 4 | |
| *pramipexole dihydrochloride* | 2 | |
| *ropinirole hcl tabs 0.5mg, 1mg, 2mg, 4mg, 5mg* | 2 | |
| *ropinirole hydrochloride tabs 0.25mg, 3mg* | 2 | |
| ***Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors*** | | |
| *carbidopa/levodopa* | 2 | |
| *carbidopa/levodopa er* | 3 | |
| INBRIJA | 5 | PA |
| RYTARY | 4 | ST |
| **Antipsychotics** | | |
| ***2nd Generation/Atypical*** | | |
| ABILIFY MAINTENA | 5 | |
| *aripiprazole tabs* | 2 | QL (30 EA per 30 days) |
| ARISTADA | 5 | |
| INVEGA HAFYERA INJ 1560MG/5ML | 5 | ST |
| INVEGA SUSTENNA INJ 39MG/0.25ML | 4 | |
| INVEGA SUSTENNA INJ 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML | 5 | |
| INVEGA TRINZA | 5 | |
| *olanzapine tabs* | 2 | QL (30 EA per 30 days) |
| PERSERIS | 5 | |
| *quetiapine fumarate tabs 300mg, 400mg* | 2 | QL (60 EA per 30 days) |
| *quetiapine fumarate tabs 100mg, 200mg, 25mg, 50mg* | 2 | QL (90 EA per 30 days) |
| REXULTI | 5 | QL (30 EA per 30 days) |
| *risperidone tabs* | 1 | QL (60 EA per 30 days) |
| ***Treatment-Resistant*** | | |
| *clozapine tabs 50mg* | 3 | QL (180 EA per 30 days) |
| *clozapine tabs 25mg* | 3 | QL (270 EA per 30 days) |
| *clozapine tabs 200mg* | 4 | QL (120 EA per 30 days) |
| *clozapine tabs 100mg* | 4 | QL (270 EA per 30 days) |
| **Antispasticity Agents** | | |
| ***Antispasticity Agents*** | | |
| *baclofen tabs 10mg, 20mg* | 2 | |
| *baclofen tabs 5mg* | 3 | |
| *tizanidine hcl tabs 2mg* | 2 | |
| *tizanidine hydrochloride tabs 4mg* | 2 | |
| **Antivirals** | | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***Anti-hepatitis C (HCV) Agents*** | | |
| MAVYRET TABS | 5 | QL (336 EA per 365 days) PA |
| SOFOSBUVIR/VELPATASVIR | 5 | QL (84 EA per 365 days) PA |
| VOSEVI | 5 | QL (84 EA per 365 days) PA |
| ***Anti-influenza Agents*** | | |
| XOFLUZA TBPK 80MG | 3 | QL (2 EA per 365 days) |
| XOFLUZA TBPK 20MG, 40MG | 3 | QL (4 EA per 365 days) |
| ***Antiherpetic Agents*** | | |
| *acyclovir tabs* | 2 | |
| *valacyclovir hcl tabs 1gm* | 3 | QL (120 EA per 30 days) |
| *valacyclovir hydrochloride tabs 500mg* | 3 | QL (120 EA per 30 days) |
| **Anxiolytics** | | |
| ***Anxiolytics, Other*** | | |
| *buspirone hcl tabs 15mg* | 1 | |
| *buspirone hcl tabs 30mg* | 4 | |
| *buspirone hydrochloride tabs 10mg, 5mg* | 1 | |
| *buspirone hydrochloride tabs 7.5mg* | 4 | |
| *hydroxyzine pamoate caps* | 4 | |
| ***Benzodiazepines*** | | |
| *alprazolam tabs 0.25mg, 0.5mg, 1mg* | 2 | QL (120 EA per 30 days) |
| *alprazolam tabs 2mg* | 2 | QL (150 EA per 30 days) |
| *diazepam tabs 10mg* | 2 | QL (120 EA per 30 days) |
| *diazepam tabs 5mg* | 2 | QL (240 EA per 30 days) |
| *diazepam tabs 2mg* | 2 | QL (300 EA per 30 days) |
| *lorazepam tabs 2mg* | 2 | QL (150 EA per 30 days) |
| *lorazepam tabs 0.5mg, 1mg* | 2 | QL (90 EA per 30 days) |
| **Blood Glucose Regulators** | | |
| ***Antidiabetic Agents*** | | |
| FARXIGA | 3 | |
| *glimepiride* | 1 | |
| *glipizide er* | 1 | |
| *glipizide tabs* | 1 | |
| JANUMET | 3 | |
| JANUMET XR | 3 | |
| JANUVIA | 3 | QL (30 EA per 30 days) |
| JARDIANCE | 3 | |
| JENTADUETO | 3 | |
| JENTADUETO XR | 3 | |
| *metformin hydrochloride er tb24 500mg, 750mg* | 1 | |
| *metformin hydrochloride tabs 1000mg, 500mg, 850mg* | 1 | |
| MOUNJARO INJ 2.5MG/0.5ML, 5MG/0.5ML | 3 | QL (2 ML per 28 days) PA |
| OZEMPIC INJ 2MG/1.5ML | 3 | QL (1.5 ML per 28 days) PA |
| OZEMPIC INJ 2MG/1.5ML, 4MG/3ML, 5.5MG/ML; 14MG/ML; 8MG/3ML | 3 | QL (3 ML per 28 days) PA |
| *pioglitazone hcl tabs 45mg* | 1 | |
| *pioglitazone hydrochloride tabs 15mg, 30mg* | 1 | |
| RYBELSUS TABS 14MG, 7MG | 3 | QL (30 EA per 30 days) PA |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| RYBELSUS TABS 3MG | 3 | QL (60 EA per 365 days) PA |
| SOLIQUA 100/33 | 3 | PA |
| SYNJARDY | 3 | |
| SYNJARDY XR | 3 | |
| TRADJENTA | 3 | QL (30 EA per 30 days) |
| TRIJARDY XR | 3 | |
| TRULICITY | 3 | QL (2 ML per 28 days) PA |
| XIGDUO XR | 3 | |
| ***Glycemic Agents*** | | |
| BAQSIMI ONE PACK | 3 | |
| BAQSIMI TWO PACK | 3 | |
| GLUCAGON EMERGENCY KIT FOR LOW BLOOD SUGAR INJ 1MG/ML | 3 | |
| GVOKE HYPOPEN 1-PACK INJ 1MG/0.2ML | 3 | |
| GVOKE HYPOPEN 2-PACK | 3 | |
| GVOKE PFS | 3 | |
| ***Insulins*** | | |
| HUMALOG | 3 | |
| HUMALOG JUNIOR KWIKPEN | 3 | |
| HUMALOG KWIKPEN | 3 | |
| HUMALOG MIX 50/50 | 3 | |
| HUMALOG MIX 50/50 KWIKPEN | 3 | |
| HUMALOG MIX 75/25 | 3 | |
| HUMALOG MIX 75/25 KWIKPEN | 3 | |
| HUMULIN 70/30 | 3 | |
| HUMULIN 70/30 KWIKPEN | 3 | |
| HUMULIN N | 3 | |
| HUMULIN N KWIKPEN | 3 | |
| HUMULIN R | 3 | |
| HUMULIN R U-500 (CONCENTRATED) | 3 | |
| HUMULIN R U-500 KWIKPEN | 3 | |
| INSULIN LISPRO | 3 | |
| LANTUS | 3 | |
| LANTUS SOLOSTAR | 3 | |
| LEVEMIR | 3 | |
| LEVEMIR FLEXPEN | 3 | |
| LYUMJEV | 3 | |
| LYUMJEV KWIKPEN | 3 | |
| NOVOLIN 70/30 | 3 | |
| NOVOLIN 70/30 FLEXPEN | 3 | |
| NOVOLIN N | 3 | |
| NOVOLIN N FLEXPEN | 3 | |
| NOVOLIN R | 3 | |
| NOVOLIN R FLEXPEN | 3 | |
| NOVOLOG | 3 | |
| NOVOLOG MIX 70/30 | 3 | |
| NOVOLOG MIX 70/30 PREFILLED FLEXPEN | 3 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| NOVOLOG PENFILL | 3 | |
| TOUJEO MAX SOLOSTAR | 3 | |
| TOUJEO SOLOSTAR | 3 | |
| TRESIBA | 3 | |
| TRESIBA FLEXTOUCH | 3 | |
| **Blood Products and Modifiers** | | |
| ***Anticoagulants*** | | |
| ELIQUIS STARTER PACK | 3 | QL (148 EA per 365 days) |
| ELIQUIS TABS 2.5MG | 3 | QL (60 EA per 30 days) |
| ELIQUIS TABS 5MG | 3 | QL (90 EA per 30 days) |
| *warfarin sodium tabs* | 1 | |
| XARELTO STARTER PACK | 3 | QL (102 EA per 365 days) |
| XARELTO TABS 10MG, 20MG | 3 | QL (30 EA per 30 days) |
| XARELTO TABS 15MG, 2.5MG | 3 | QL (60 EA per 30 days) |
| ***Blood Products and Modifiers, Other*** | | |
| NEULASTA | 5 | PA |
| NEULASTA ONPRO KIT | 5 | PA |
| PROCRIT INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML | 4 | PA |
| PROCRIT INJ 40000UNIT/ML | 5 | PA |
| RETACRIT INJ 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML | 4 | PA |
| RETACRIT INJ 40000UNIT/ML | 5 | PA |
| UDENYCA | 5 | PA |
| ZARXIO | 5 | |
| ***Platelet Modifying Agents*** | | |
| BRILINTA | 3 | |
| *clopidogrel tabs 75mg* | 1 | |
| *clopidogrel tabs 300mg* | 2 | |
| **Cardiovascular Agents** | | |
| ***Alpha-adrenergic Agonists*** | | |
| *clonidine hcl ptwk* | 4 | |
| *clonidine hydrochloride tabs* | 1 | |
| *midodrine hcl* | 2 | |
| ***Alpha-adrenergic Blocking Agents*** | | |
| *terazosin hcl caps 10mg, 1mg, 5mg* | 1 | |
| *terazosin hydrochloride caps 2mg* | 1 | |
| ***Angiotensin II Receptor Antagonists*** | | |
| *candesartan cilexetil* | 1 | |
| EDARBI | 4 | |
| *irbesartan* | 1 | |
| *losartan potassium tabs* | 1 | |
| *olmesartan medoxomil tabs* | 1 | |
| *telmisartan* | 1 | |
| *valsartan tabs* | 1 | |
| ***Angiotensin-converting Enzyme (ACE) Inhibitors*** | | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *benazepril hcl tabs 10mg, 40mg, 5mg* | 1 | |
| *benazepril hydrochloride tabs 20mg* | 1 | |
| *enalapril maleate tabs* | 1 | |
| *lisinopril tabs* | 1 | |
| *quinapril hcl tabs 20mg, 40mg* | 1 | |
| *ramipril* | 1 | |
| ***Antiarrhythmics*** | | |
| *amiodarone hydrochloride tabs 200mg* | 1 | |
| *amiodarone hydrochloride tabs 100mg, 400mg* | 3 | |
| *digoxin tabs 125mcg, 250mcg, 62.5mcg* | 2 | |
| *flecainide acetate* | 2 | |
| MULTAQ | 3 | |
| *sotalol hcl* | 2 | |
| *sotalol hydrochloride tabs 120mg* | 2 | |
| ***Beta-adrenergic Blocking Agents*** | | |
| *atenolol tabs* | 1 | |
| *bisoprolol fumarate* | 2 | |
| *carvedilol* | 1 | |
| *labetalol hydrochloride tabs* | 2 | |
| *metoprolol succinate er* | 1 | |
| *metoprolol tartrate tabs* | 1 | |
| *nebivolol hydrochloride tabs 10mg, 5mg* | 3 | |
| *nebivolol tabs 5mg* | 3 | |
| *propranolol hcl tabs 40mg* | 2 | |
| *propranolol hydrochloride er cp24 60mg, 80mg* | 2 | |
| *propranolol hydrochloride tabs 10mg, 20mg, 60mg, 80mg* | 2 | |
| ***Calcium Channel Blocking Agents, Dihydropyridines*** | | |
| *amlodipine besylate tabs* | 1 | |
| *felodipine er* | 2 | |
| *nifedipine er* | 2 | |
| ***Calcium Channel Blocking Agents, Nondihydropyridines*** | | |
| *cartia xt* | 2 | |
| *diltiazem hcl tabs* | 2 | |
| *diltiazem hydrochloride er cp24* | 2 | |
| *verapamil hcl er tbcr 120mg, 240mg* | 2 | |
| *verapamil hydrochloride er tbcr 180mg* | 2 | |
| ***Cardiovascular Agents, Other*** | | |
| *amlodipine besylate/benazepril hydrochloride* | 1 | |
| *bisoprolol fumarate/hydrochlorothiazide* | 2 | |
| EDARBYCLOR | 4 | |
| ENTRESTO | 3 | QL (60 EA per 30 days) |
| *lisinopril/hydrochlorothiazide* | 1 | |
| *losartan potassium/hydrochlorothiazide* | 1 | |
| *olmesartan medoxomil/hydrochlorothiazide* | 1 | |
| *ranolazine er* | 2 | |
| *triamterene/hydrochlorothiazide caps 25mg; 37.5mg* | 1 | |
| *triamterene/hydrochlorothiazide tabs* | 1 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *valsartan/hydrochlorothiazide* | 1 | |
| ***Diuretics, Loop*** | | |
| *bumetanide tabs* | 2 | |
| *furosemide tabs* | 1 | |
| *torsemide tabs* | 1 | |
| ***Diuretics, Potassium-sparing*** | | |
| *spironolactone tabs* | 1 | |
| ***Diuretics, Thiazide*** | | |
| *chlorthalidone tabs 25mg, 50mg* | 2 | |
| *hydrochlorothiazide caps, tabs* | 1 | |
| *metolazone* | 2 | |
| ***Dyslipidemics, Fibric Acid Derivatives*** | | |
| *fenofibrate tabs 145mg, 160mg, 48mg, 54mg* | 2 | |
| *gemfibrozil tabs* | 2 | |
| ***Dyslipidemics, HMG CoA Reductase Inhibitors*** | | |
| *atorvastatin calcium* | 1 | |
| LIVALO | 4 | ST |
| *lovastatin tabs* | 1 | |
| *pravastatin sodium* | 1 | |
| *rosuvastatin calcium* | 1 | |
| *simvastatin tabs* | 1 | |
| ***Dyslipidemics, Other*** | | |
| *ezetimibe* | 2 | |
| *ezetimibe/simvastatin* | 2 | |
| NEXLETOL | 4 | QL (30 EA per 30 days) PA |
| NEXLIZET | 4 | QL (30 EA per 30 days) PA |
| *omega-3-acid ethyl esters* | 3 | PA |
| PRALUENT | 3 | QL (2 ML per 28 days) PA |
| REPATHA PUSHTRONEX SYSTEM | 3 | QL (7 ML per 28 days) PA |
| REPATHA SURECLICK | 3 | QL (3 ML per 28 days) PA |
| ***Vasodilators, Direct-acting Arterial/Venous*** | | |
| *isosorbide mononitrate er* | 1 | |
| *nitroglycerin subl 0.3mg, 0.4mg, 0.6mg* | 2 | |
| ***Vasodilators, Direct-acting Arterial*** | | |
| *hydralazine hcl tabs 10mg* | 1 | |
| *hydralazine hydrochloride tabs 25mg, 50mg* | 1 | |
| *hydralazine hydrochloride tabs 100mg* | 2 | |
| **Central Nervous System Agents** | | |
| ***Attention Deficit Hyperactivity Disorder Agents, Amphetamines*** | | |
| *amphetamine/dextroamphetamine cp24* | 3 | QL (60 EA per 30 days) |
| *amphetamine/dextroamphetamine tabs* | 3 | QL (90 EA per 30 days) |
| ***Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines*** | | |
| *methylphenidate hydrochloride tabs* | 2 | QL (90 EA per 30 days) |
| ***Central Nervous System, Other*** | | |
| AUSTEDO | 5 | QL (120 EA per 30 days) PA |
| *butalbital/acetaminophen/caffeine tabs 325mg; 50mg; 40mg* | 3 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| INGREZZA CAPS 60MG, 80MG | 5 | QL (30 EA per 30 days) PA |
| INGREZZA CAPS 40MG | 5 | QL (60 EA per 30 days) PA |
| ***Fibromyalgia Agents*** | | |
| *pregabalin caps 300mg* | 2 | QL (60 EA per 30 days) |
| *pregabalin caps 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg* | 2 | QL (90 EA per 30 days) |
| SAVELLA | 3 | QL (60 EA per 30 days) |
| ***Multiple Sclerosis Agents*** | | |
| AVONEX PEN | 5 | QL (4 EA per 28 days) PA |
| AVONEX INJ 30MCG/0.5ML | 5 | QL (4 EA per 28 days) PA |
| BETASERON | 5 | QL (15 EA per 30 days) PA |
| MAYZENT TABS 0.25MG | 5 | QL (120 EA per 30 days) PA |
| MAYZENT TABS 2MG | 5 | QL (30 EA per 30 days) PA |
| REBIF | 5 | QL (6 ML per 28 days) PA |
| REBIF REBIDOSE | 5 | QL (6 ML per 28 days) PA |
| REBIF REBIDOSE TITRATION PACK | 5 | QL (8.4 ML per 365 days) PA |
| REBIF TITRATION PACK | 5 | QL (8.4 ML per 365 days) PA |
| VUMERITY | 5 | QL (120 EA per 30 days) PA |
| ZEPOSIA | 5 | QL (30 EA per 30 days) PA |
| ZEPOSIA 7-DAY STARTER PACK | 5 | QL (14 EA per 365 days) PA |
| **Dental and Oral Agents** | | |
| ***Dental and Oral Agents*** | | |
| *chlorhexidine gluconate soln* | 1 | |
| *doxycycline hyclate tabs 20mg* | 3 | |
| **Dermatological Agents** | | |
| ***Acne and Rosacea Agents*** | | |
| *metronidazole crea 0.75%* | 3 | |
| *metronidazole gel 0.75%* | 3 | |
| *metronidazole gel 1%* | 4 | |
| ***Dermatitis and Pruitus Agents*** | | |
| *betamethasone dipropionate augmented crea* | 2 | |
| *betamethasone dipropionate augmented oint* | 3 | |
| *clobetasol propionate crea, oint* | 2 | |
| *clobetasol propionate soln* | 3 | |
| *fluocinonide crea 0.05%* | 3 | |
| *fluocinonide crea 0.1%* | 3 | QL (120 GM per 30 days) |
| *fluocinonide oint, soln* | 3 | |
| *hydrocortisone crea 2.5%* | 2 | |
| *hydrocortisone oint 2.5%* | 2 | |
| *tacrolimus* | 4 | |
| *triamcinolone acetonide crea* | 2 | |
| *triamcinolone acetonide oint 0.025%, 0.1%, 0.5%* | 2 | |
| ***Dermatological Agents, Other*** | | |
| *clotrimazole/betamethasone dipropionate crea* | 2 | |
| *fluorouracil crea 5%* | 2 | QL (40 GM per 30 days) |
| OTEZLA TABS 30MG | 5 | QL (60 EA per 30 days) PA |
| SANTYL | 4 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***Topical Anti-infectives*** | | |
| *ciclopirox nail lacquer* | 2 | PA |
| *clindamycin phosphate soln* | 2 | QL (60 ML per 30 days) |
| *mupirocin oint* | 2 | QL (110 GM per 30 days) |
| **Electrolytes/Minerals/Metals/Vitamins** | | |
| ***Electrolyte/Mineral Replacement*** | | |
| *klor-con 8* | 2 | |
| *klor-con m20* | 2 | |
| *potassium chloride er cpcr* | 2 | |
| *potassium chloride er tbcr 10meq, 20meq, 8meq* | 2 | |
| *potassium citrate er* | 4 | |
| ***Phosphate Binders*** | | |
| *sevelamer carbonate tabs* | 4 | |
| VELPHORO | 5 | |
| ***Potassium Binders*** | | |
| *veltassa* | 4 | |
| **Gastrointestinal Agents** | | |
| ***Anti-Constipation Agents*** | | |
| *lactulose soln* | 2 | |
| LINZESS | 3 | QL (30 EA per 30 days) |
| MOTEGRITY | 3 | QL (30 EA per 30 days) |
| ***Anti-Diarrheal Agents*** | | |
| *diphenoxylate hydrochloride/atropine sulfate* | 3 | |
| *loperamide hcl caps* | 2 | |
| ***Antispasmodics, Gastrointestinal*** | | |
| *dicyclomine hydrochloride caps, tabs* | 2 | |
| ***Gastrointestinal Agents, Other*** | | |
| CLENPIQ SOLN 12GM/160ML; 3.5GM/160ML; 10MG/160ML | 3 | |
| *gavilyte-c* | 2 | |
| *peg-3350/electrolytes* | 2 | |
| ***Histamine2 (H2) Receptor Antagonists*** | | |
| *famotidine tabs 20mg, 40mg* | 2 | |
| ***Protectants*** | | |
| *sucralfate tabs* | 2 | |
| ***Proton Pump Inhibitors*** | | |
| DEXILANT | 4 | QL (30 EA per 30 days) |
| *esomeprazole magnesium cpdr* | 2 | QL (60 EA per 30 days) |
| *lansoprazole cpdr* | 2 | QL (60 EA per 30 days) |
| *omeprazole cpdr 20mg, 40mg* | 1 | QL (60 EA per 30 days) |
| *pantoprazole sodium tbec* | 1 | QL (60 EA per 30 days) |
| **Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment** | | |
| ***Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment*** | | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| CREON CPEP 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT | 3 | |
| ZENPEP CPEP 105000UNIT; 25000UNIT; 79000UNIT, 14000UNIT; 3000UNIT; 10000UNIT, 168000UNIT; 40000UNIT; 126000UNIT, 24000UNIT; 5000UNIT; 17000UNIT, 42000UNIT; 10000UNIT; 32000UNIT, 63000UNIT; 15000UNIT; 47000UNIT, 84000UNIT; 20000UNIT; 63000UNIT | 3 | |
| **Genitourinary Agents** | | |
| ***Antispasmodics, Urinary*** | | |
| GEMTESA | 4 | |
| MYRBETRIQ TB24 | 3 | |
| *oxybutynin chloride er* | 2 | |
| *oxybutynin chloride tabs 5mg* | 2 | |
| *solifenacin succinate* | 2 | |
| *tolterodine tartrate er* | 3 | |
| *trospium chloride* | 3 | |
| ***Benign Prostatic Hypertrophy Agents*** | | |
| *alfuzosin hcl er* | 2 | |
| *doxazosin mesylate* | 2 | |
| *dutasteride caps* | 2 | |
| *finasteride tabs* | 1 | |
| *tadalafil tabs 2.5mg, 5mg* | 3 | QL (30 EA per 30 days) PA |
| *tamsulosin hydrochloride* | 2 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)** | | |
| ***Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)*** | | |
| *dexamethasone tabs 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg* | 2 | |
| *fludrocortisone acetate tabs* | 2 | |
| *methylprednisolone dose pack tbpk* | 2 | |
| *prednisone tbpk* | 2 | |
| *prednisone tabs 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg* | 1 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)** | | |
| ***Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)*** | | |
| GENOTROPIN | 5 | PA |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)** | | |
| ***Androgens*** | | |
| *testosterone cypionate inj 100mg/ml, 200mg/ml* | 2 | PA |
| *testosterone pump gel 1.62%* | 3 | PA |
| TESTOSTERONE GEL 25MG/2.5GM, 50MG/5GM | 3 | PA |
| *testosterone gel 20.25mg/1.25gm, 40.5mg/2.5gm* | 3 | PA |
| ***Estrogens*** | | |
| *estradiol crea, oral tabs* | 2 | |
| *estradiol vaginal tabs* | 4 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ESTRING | 4 | QL (1 EA per 90 days) |
| PREMARIN CREA | 4 | |
| PREMARIN TABS 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG | 4 | |
| PREMPHASE | 4 | |
| PREMPRO | 4 | |
| *yuvafem* | 4 | |
| ***Progestins*** | | |
| *progesterone caps* | 2 | |
| ***Selective Estrogen Receptor Modifying Agents*** | | |
| *raloxifene hydrochloride* | 2 | |
| **Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)** | | |
| ***Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)*** | | |
| EUTHYROX TABS 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 25MCG, 50MCG, 75MCG, 88MCG | 3 | |
| *levothyroxine sodium tabs* | 1 | |
| *liothyronine sodium tabs* | 2 | |
| SYNTHROID TABS | 3 | |
| **Hormonal Agents, Suppressant (Pituitary)** | | |
| ***Hormonal Agents, Suppressant (Pituitary)*** | | |
| LUPRON DEPOT (1-MONTH) INJ 7.5MG | 5 | QL (1 EA per 28 days) PA |
| LUPRON DEPOT (3-MONTH) | 5 | QL (1 EA per 84 days) PA |
| LUPRON DEPOT (6-MONTH) | 5 | QL (1 EA per 168 days) PA |
| ORGOVYX | 5 | PA |
| **Hormonal Agents, Suppressant (Thyroid)** | | |
| ***Antithyroid Agents*** | | |
| *methimazole tabs 10mg, 5mg* | 2 | |
| **Immunological Agents** | | |
| ***Immunological Agents, Other*** | | |
| COSENTYX SENSOREADY PEN | 5 | QL (10 ML per 28 days) PA |
| COSENTYX INJ 150MG/ML | 5 | QL (10 ML per 28 days) PA |
| ORENCIA CLICKJECT | 5 | QL (4 ML per 28 days) PA |
| ORENCIA INJ 125MG/ML | 5 | QL (4 ML per 28 days) PA |
| OTEZLA TBPK 0 | 5 | QL (110 EA per 365 days) PA |
| RINVOQ | 5 | QL (30 EA per 30 days) PA |
| SKYRIZI PEN | 5 | QL (1 ML per 28 days) PA |
| SKYRIZI INJ 75MG/0.83ML | 5 | PA |
| SKYRIZI INJ 150MG/ML | 5 | QL (1 ML per 28 days) PA |
| STELARA INJ 130MG/26ML | 5 | PA |
| STELARA INJ 45MG/0.5ML, 90MG/ML | 5 | QL (3 ML per 84 days) PA |
| XELJANZ XR | 5 | QL (30 EA per 30 days) PA |
| XELJANZ TABS | 5 | QL (60 EA per 30 days) PA |
| ***Immunosuppressants*** | | |
| ASTAGRAF XL | 4 | B/D |
| *azathioprine tabs 50mg* | 2 | B/D |
| ENBREL MINI | 5 | QL (8 ML per 28 days) PA |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ENBREL SURECLICK | 5 | QL (8 ML per 28 days) PA |
| ENBREL INJ 25MG | 5 | PA |
| ENBREL INJ 25MG/0.5ML | 5 | QL (4 ML per 28 days) PA |
| ENBREL INJ 50MG/ML | 5 | QL (8 ML per 28 days) PA |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJ 80MG/0.8ML | 5 | QL (6 EA per 365 days) PA |
| HUMIRA PEN-CD/UC/HS STARTER INJ 80MG/0.8ML | 5 | QL (4 EA per 28 days) PA |
| HUMIRA PEN-CD/UC/HS STARTER INJ 40MG/0.8ML | 5 | QL (6 EA per 28 days) PA |
| HUMIRA PEN-PS/UV STARTER INJ 40MG/0.8ML | 5 | QL (6 EA per 28 days) PA |
| HUMIRA PEN-PS/UV STARTER INJ 0 | 5 | QL (6 EA per 365 days) PA |
| HUMIRA PEN INJ 40MG/0.4ML, 80MG/0.8ML | 5 | QL (4 EA per 28 days) PA |
| HUMIRA PEN INJ 40MG/0.8ML | 5 | QL (6 EA per 28 days) PA |
| HUMIRA INJ 20MG/0.2ML, 40MG/0.8ML | 5 | QL (2 EA per 28 days) PA |
| HUMIRA INJ 40MG/0.4ML | 5 | QL (4 EA per 28 days) PA |
| *leflunomide* | 2 | |
| *methotrexate sodium tabs* | 2 | |
| ORENCIA INJ 250MG | 5 | PA |
| ***Vaccines*** | | |
| ADACEL | 3 | |
| SHINGRIX | 3 | |
| **Inflammatory Bowel Disease Agents** | | |
| ***Aminosalicylates*** | | |
| *sulfasalazine tabs* | 2 | |
| ***Glucocorticoids*** | | |
| *budesonide cpep* | 4 | |
| *proctozone-hc* | 2 | |
| **Metabolic Bone Disease Agents** | | |
| ***Metabolic Bone Disease Agents*** | | |
| *alendronate sodium tabs 10mg, 35mg* | 1 | |
| *alendronate sodium tabs 70mg* | 1 | QL (4 EA per 28 days) |
| *calcitriol caps* | 2 | |
| *ibandronate sodium tabs* | 2 | QL (1 EA per 28 days) |
| PROLIA | 4 | QL (2 ML per 365 days) |
| RAYALDEE | 5 | |
| *risedronate sodium tabs 30mg, 5mg* | 4 | |
| *risedronate sodium tabs 150mg* | 4 | QL (1 EA per 28 days) |
| *risedronate sodium tabs 35mg* | 4 | QL (4 EA per 28 days) |
| TERIPARATIDE | 5 | PA |
| **Miscellaneous Therapeutic Agents** | | |
| ***Miscellaneous Therapeutic Agents*** | | |
| *bd veo insulin syringe ultra-fine/0.3ml/31g x 6mm* | 2 | QL (200 EA per 30 days) |
| OMNIPOD DASH PDM KIT (GEN 4) | 3 | QL (1 EA per 365 days) |
| OMNIPOD DASH PODS (GEN 4) | 3 | QL (30 EA per 30 days) |
| PAXLOVID TBPK 150MG; 100MG | 3 | QL (20 EA per 5 days) |
| PAXLOVID TBPK 150MG; 100MG | 3 | QL (30 EA per 5 days) |
| V-GO 20 | 3 | |
| V-GO 30 | 3 | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| V-GO 40 | 3 | |
| **Ophthalmic Agents** | | |
| ***Ophthalmic Agents, Other*** | | |
| COMBIGAN | 3 | |
| *dorzolamide hcl/timolol maleate* | 2 | |
| *neomycin/polymyxin/dexamethasone* | 2 | |
| *polymyxin b sulfate/trimethoprim sulfate* | 1 | |
| RESTASIS | 3 | |
| RESTASIS MULTIDOSE | 3 | |
| ROCKLATAN | 3 | QL (2.5 ML per 25 days) |
| SIMBRINZA | 3 | |
| TOBRADEX ST | 4 | |
| XIIDRA | 4 | QL (60 EA per 30 days) |
| ***Ophthalmic Anti-allergy Agents*** | | |
| *olopatadine hcl* | 3 | |
| *olopatadine hydrochloride soln 0.2%* | 3 | |
| ***Ophthalmic Anti-Infectives*** | | |
| BESIVANCE | 4 | |
| *erythromycin* | 2 | |
| *moxifloxacin hydrochloride soln* | 3 | |
| *ofloxacin* | 2 | |
| ***Ophthalmic Anti-inflammatories*** | | |
| *diclofenac sodium soln 0.1%* | 2 | |
| FLAREX | 3 | |
| *fluorometholone* | 3 | |
| ILEVRO | 3 | QL (4 ML per 30 days) |
| *ketorolac tromethamine soln 0.5%* | 2 | |
| *ketorolac tromethamine soln 0.4%* | 3 | |
| LOTEMAX SM | 4 | QL (20 GM per 365 days) |
| *prednisolone acetate* | 2 | |
| PROLENSA | 4 | QL (12 ML per 365 days) |
| ***Ophthalmic Beta-Adrenergic Blocking Agents*** | | |
| *timolol maleate soln* | 1 | |
| ***Ophthalmic Intraocular Pressure Lowering Agents, Other*** | | |
| *brimonidine tartrate soln 0.2%* | 2 | |
| *dorzolamide hydrochloride* | 2 | |
| RHOPRESSA | 3 | QL (2.5 ML per 25 days) |
| ***Ophthalmic Prostaglandin and Prostamide Analogs*** | | |
| *latanoprost soln* | 1 | |
| LUMIGAN | 3 | QL (2.5 ML per 25 days) |
| **Respiratory Tract/Pulmonary Agents** | | |
| ***Anti-inflammatories, Inhaled Corticosteroids*** | | |
| ARNUITY ELLIPTA | 3 | QL (30 EA per 30 days) |
| ASMANEX HFA | 4 | QL (13 GM per 30 days) |
| ASMANEX TWISTHALER 120 METERED DOSES | 4 | QL (1 EA per 30 days) |
| ASMANEX TWISTHALER 14 METERED DOSES | 4 | QL (1 EA per 30 days) |
| ASMANEX TWISTHALER 30 METERED DOSES | 4 | QL (1 EA per 30 days) |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ASMANEX TWISTHALER 60 METERED DOSES | 4 | QL (1 EA per 30 days) |
| BREZTRI AEROSPHERE | 3 | QL (23.6 GM per 28 days) |
| *fluticasone propionate* | 1 | |
| *mometasone furoate* | 4 | QL (34 GM per 30 days) |
| ***Antihistamines*** | | |
| *azelastine hydrochloride soln 0.1%* | 2 | QL (60 ML per 30 days) |
| *hydroxyzine hydrochloride tabs 10mg, 25mg* | 3 | |
| *levocetirizine dihydrochloride tabs* | 2 | |
| ***Antileukotrienes*** | | |
| *montelukast sodium tabs* | 1 | |
| ***Bronchodilators, Anticholinergic*** | | |
| ATROVENT HFA | 4 | QL (25.8 GM per 30 days) |
| INCRUSE ELLIPTA | 3 | QL (30 EA per 30 days) |
| *ipratropium bromide soln* | 2 | |
| LONHALA MAGNAIR REFILL KIT | 5 | QL (60 ML per 30 days) |
| SPIRIVA HANDIHALER | 3 | QL (30 EA per 30 days) |
| SPIRIVA RESPIMAT AERS 2.5MCG/ACT | 3 | |
| SPIRIVA RESPIMAT AERS 1.25MCG/ACT | 3 | QL (8 GM per 30 days) |
| YUPELRI | 5 | QL (90 ML per 30 days) B/D |
| ***Bronchodilators, Sympathomimetic*** | | |
| *albuterol sulfate hfa aers 108mcg/act* | 2 | QL (13.4 GM per 30 days) |
| *albuterol sulfate hfa aers 108mcg/act* | 2 | QL (17 GM per 30 days) |
| *albuterol sulfate hfa aers 108mcg/act* | 2 | QL (48 GM per 30 days) |
| EPINEPHRINE INJ 0.15MG/0.3ML, 0.3MG/0.3ML | 3 | |
| *epinephrine inj 0.15mg/0.15ml, 0.3mg/0.3ml* | 3 | |
| PROAIR RESPICLICK | 3 | QL (2 EA per 30 days) |
| SEREVENT DISKUS | 3 | QL (60 EA per 30 days) |
| ***Cystic Fibrosis Agents*** | | |
| TOBI PODHALER | 5 | QL (224 EA per 56 days) |
| ***Pulmonary Antihypertensives*** | | |
| OPSUMIT | 5 | QL (30 EA per 30 days) PA |
| ORENITRAM TBCR 0.25MG, 1MG, 2.5MG, 5MG | 5 | PA |
| ***Pulmonary Fibrosis Agents*** | | |
| OFEV | 5 | PA |
| ***Respiratory Tract Agents, Other*** | | |
| ANORO ELLIPTA | 3 | QL (60 EA per 30 days) |
| BREO ELLIPTA | 3 | QL (60 EA per 30 days) |
| COMBIVENT RESPIMAT | 3 | QL (8 GM per 30 days) |
| FASENRA | 5 | PA |
| FASENRA PEN | 5 | PA |
| *fluticasone propionate/salmeterol diskus* | 2 | QL (60 EA per 30 days) |
| NUCALA INJ 100MG | 5 | QL (3 EA per 28 days) PA |
| NUCALA INJ 100MG/ML | 5 | QL (3 ML per 28 days) PA |
| STIOLTO RESPIMAT | 3 | QL (24 GM per 30 days) |
| TRELEGY ELLIPTA | 3 | QL (60 EA per 30 days) |
| *wixela inhub* | 2 | QL (60 EA per 30 days) |
| **Skeletal Muscle Relaxants** | | |

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***Skeletal Muscle Relaxants*** | | |
| *cyclobenzaprine hydrochloride tabs 10mg, 5mg* | 3 | |
| *methocarbamol tabs 500mg, 750mg* | 4 | |
| **Sleep Disorder Agents** | | |
| ***Sleep Promoting Agents*** | | |
| BELSOMRA | 3 | QL (30 EA per 30 days) |
| *eszopiclone* | 4 | QL (30 EA per 30 days) |
| *temazepam caps 15mg, 30mg* | 3 | QL (30 EA per 30 days) |
| *zolpidem tartrate er* | 4 | QL (30 EA per 30 days) |
| *zolpidem tartrate tabs* | 2 | QL (30 EA per 30 days) |

# Index


| Drug Name | Page # |
|---|---|
| ABILIFY MAINTENA | 5 |
| *abiraterone acetate* | 4 |
| *acetaminophen/codeine* | 1 |
| *acyclovir* | 6 |
| ADACEL | 15 |
| AIMOVIG | 4 |
| *albuterol sulfate hfa* | 17 |
| ALECENSA | 4 |
| *alendronate sodium* | 15 |
| *alfuzosin hcl er* | 13 |
| *allopurinol* | 4 |
| *alprazolam* | 6 |
| *amiodarone hydrochloride* | 9 |
| *amitriptyline hcl* | 3 |
| *amitriptyline hydrochloride* | 3 |
| *amlodipine besylate* | 9 |
| *amlodipine besylate/benazepril hydrochloride* | 9 |
| *amoxicillin* | 2 |
| *amoxicillin/clavulanate potassium* | 2 |
| *amphetamine/dextroamphetamine* | 10 |
| *anastrozole* | 4 |
| ANORO ELLIPTA | 17 |
| *aripiprazole* | 5 |
| ARISTADA | 5 |
| ARNUITY ELLIPTA | 16 |
| ASMANEX HFA | 16 |
| ASMANEX TWISTHALER 120 METERED DOSES | 16 |
| ASMANEX TWISTHALER 14 METERED DOSES | 16 |
| ASMANEX TWISTHALER 30 METERED DOSES | 16 |
| ASMANEX TWISTHALER 60 METERED DOSES | 17 |
| ASTAGRAF XL | 14 |
| *atenolol* | 9 |
| *atorvastatin calcium* | 10 |
| ATROVENT HFA | 17 |
| AUSTEDO | 10 |
| AVONEX | 11 |
| AVONEX PEN | 11 |
| *azathioprine* | 14 |
| *azelastine hydrochloride* | 17 |
| *azithromycin* | 2 |

| Drug Name | Page # |
|---|---|
| *baclofen* | 5 |
| BAQSIMI ONE PACK | 7 |
| BAQSIMI TWO PACK | 7 |
| *bd veo insulin syringe ultra-fine/0.3ml/31g x 6mm* | 15 |
| BELSOMRA | 18 |
| *benazepril hcl* | 9 |
| *benazepril hydrochloride* | 9 |
| *benztropine mesylate* | 5 |
| BESIVANCE | 16 |
| *betamethasone dipropionate augmented* | 11 |
| BETASERON | 11 |
| *bisoprolol fumarate* | 9 |
| *bisoprolol fumarate/hydrochlorothiazide* | 9 |
| BREO ELLIPTA | 17 |
| BREZTRI AEROSPHERE | 17 |
| BRILINTA | 8 |
| *brimonidine tartrate* | 16 |
| BRIVIACT | 2 |
| BRUKINSA | 4 |
| *budesonide* | 15 |
| *bumetanide* | 10 |
| *bupropion hcl* | 3 |
| *bupropion hydrochloride* | 3 |
| *bupropion hydrochloride er (sr)* | 3 |
| *bupropion hydrochloride er (xl)* | 3 |
| *buspirone hcl* | 6 |
| *buspirone hydrochloride* | 6 |
| *butalbital/acetaminophen/caffeine* | 10 |
| *calcitriol* | 15 |
| CALQUENCE | 4 |
| *candesartan cilexetil* | 8 |
| *carbamazepine* | 2 |
| *carbidopa/levodopa* | 5 |
| *carbidopa/levodopa er* | 5 |
| *cartia xt* | 9 |
| *carvedilol* | 9 |
| *cefadroxil* | 1 |
| *cefdinir* | 1 |
| *cefpodoxime proxetil* | 1 |
| *cefuroxime axetil* | 1 |
| *celecoxib* | 1 |
| *cephalexin* | 1 |
| *chlorhexidine gluconate* | 11 |
| *chlorthalidone* | 10 |
| *ciclopirox nail lacquer* | 12 |
| *ciprofloxacin hydrochloride* | 2 |
| *citalopram hydrobromide* | 3 |

| Drug Name | Page # |
| --- | --- |
| CLENPIQ | 12 |
| *clindamycin hcl* | 1 |
| *clindamycin hydrochloride* | 1 |
| *clindamycin phosphate* | 12 |
| *clobetasol propionate* | 11 |
| *clonazepam* | 2 |
| *clonidine hcl* | 8 |
| *clonidine hydrochloride* | 8 |
| *clopidogrel* | 8 |
| *clotrimazole/betamethasone dipropionate* | 11 |
| *clozapine* | 5 |
| COLCHICINE | 4 |
| COMBIGAN | 16 |
| COMBIVENT RESPIMAT | 17 |
| COSENTYX | 14 |
| COSENTYX SENSOREADY PEN | 14 |
| CREON | 13 |
| *cyclobenzaprine hydrochloride* | 18 |
| *desvenlafaxine er* | 3 |
| *dexamethasone* | 13 |
| DEXILANT | 12 |
| *diazepam* | 6 |
| *diclofenac sodium* | 1 |
| *diclofenac sodium* | 16 |
| *diclofenac sodium dr* | 1 |
| *dicyclomine hydrochloride* | 12 |
| *digoxin* | 9 |
| *diltiazem hcl* | 9 |
| *diltiazem hydrochloride er* | 9 |
| *diphenoxylate hydrochloride/atropine sulfate* | 12 |
| *divalproex sodium* | 2 |
| *divalproex sodium dr* | 2 |
| *divalproex sodium er* | 2 |
| *donepezil hcl* | 3 |
| *donepezil hydrochloride* | 3 |
| *dorzolamide hcl/timolol maleate* | 16 |
| *dorzolamide hydrochloride* | 16 |
| *doxazosin mesylate* | 13 |
| *doxycycline hyclate* | 2 |
| *doxycycline hyclate* | 11 |
| *doxycycline monohydrate* | 2 |
| *duloxetine hydrochloride* | 3 |
| *dutasteride* | 13 |
| EDARBI | 8 |
| EDARBYCLOR | 9 |
| ELIQUIS | 8 |
| ELIQUIS STARTER PACK | 8 |
| EMGALITY | 4 |
| *enalapril maleate* | 9 |
| ENBREL | 15 |
| ENBREL MINI | 14 |
| ENBREL SURECLICK | 15 |
| ENTRESTO | 9 |
| EPINEPHRINE | 17 |
| *erythromycin* | 16 |
| *escitalopram oxalate* | 3 |
| *esomeprazole magnesium* | 12 |
| *estradiol* | 13 |
| ESTRING | 14 |
| *eszopiclone* | 18 |
| EUTHYROX | 14 |
| *ezetimibe* | 10 |
| *ezetimibe/simvastatin* | 10 |
| *famotidine* | 12 |
| FARXIGA | 6 |
| FASENRA | 17 |
| FASENRA PEN | 17 |
| *febuxostat* | 4 |
| *felodipine er* | 9 |
| *fenofibrate* | 10 |
| *fentanyl* | 1 |
| *finasteride* | 13 |
| FLAREX | 16 |
| *flecainide acetate* | 9 |
| *fluconazole* | 4 |
| *fludrocortisone acetate* | 13 |
| *fluocinonide* | 11 |
| *fluorometholone* | 16 |
| *fluorouracil* | 11 |
| *fluoxetine hcl* | 3 |
| *fluoxetine hydrochloride* | 3 |
| *fluticasone propionate* | 17 |
| *fluticasone propionate/salmeterol diskus* | 17 |
| *furosemide* | 10 |
| *gabapentin* | 2 |
| *gavilyte-c* | 12 |
| *gemfibrozil* | 10 |
| GEMTESA | 13 |
| GENOTROPIN | 13 |
| *glimepiride* | 6 |
| *glipizide* | 6 |
| *glipizide er* | 6 |
| GLUCAGON EMERGENCY KIT FOR LOW BLOOD SUGAR | 7 |
| GVOKE HYPOPEN 1-PACK | 7 |

| Drug Name | Page # |
|---|---|
| GVOKE HYPOPEN 2-PACK | 7 |
| GVOKE PFS | 7 |
| HUMALOG | 7 |
| HUMALOG JUNIOR KWIKPEN | 7 |
| HUMALOG KWIKPEN | 7 |
| HUMALOG MIX 50/50 | 7 |
| HUMALOG MIX 50/50 KWIKPEN | 7 |
| HUMALOG MIX 75/25 | 7 |
| HUMALOG MIX 75/25 KWIKPEN | 7 |
| HUMIRA | 15 |
| HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK | 15 |
| HUMIRA PEN | 15 |
| HUMIRA PEN-CD/UC/HS STARTER | 15 |
| HUMIRA PEN-PS/UV STARTER | 15 |
| HUMULIN 70/30 | 7 |
| HUMULIN 70/30 KWIKPEN | 7 |
| HUMULIN N | 7 |
| HUMULIN N KWIKPEN | 7 |
| HUMULIN R | 7 |
| HUMULIN R U-500 (CONCENTRATED) | 7 |
| HUMULIN R U-500 KWIKPEN | 7 |
| *hydralazine hcl* | 10 |
| *hydralazine hydrochloride* | 10 |
| *hydrochlorothiazide* | 10 |
| *hydrocodone bitartrate/acetaminophen* | 1 |
| *hydrocodone/acetaminophen* | 1 |
| *hydrocortisone* | 11 |
| *hydromorphone hcl* | 1 |
| *hydroxychloroquine sulfate* | 5 |
| *hydroxyurea* | 4 |
| *hydroxyzine hydrochloride* | 17 |
| *hydroxyzine pamoate* | 6 |
| *ibandronate sodium* | 15 |
| *ibuprofen* | 1 |
| ILEVRO | 16 |
| IMBRUVICA | 4 |
| INBRIJA | 5 |
| INCRUSE ELLIPTA | 17 |
| INGREZZA | 11 |
| INSULIN LISPRO | 7 |
| INVEGA HAFYERA | 5 |
| INVEGA SUSTENNA | 5 |
| INVEGA TRINZA | 5 |
| *ipratropium bromide* | 17 |
| *irbesartan* | 8 |
| *isosorbide mononitrate er* | 10 |
| JANUMET | 6 |
| JANUMET XR | 6 |
| JANUVIA | 6 |
| JARDIANCE | 6 |
| JENTADUETO | 6 |
| JENTADUETO XR | 6 |
| *ketoconazole* | 4 |
| *ketorolac tromethamine* | 16 |
| *klor-con 8* | 12 |
| *klor-con m20* | 12 |
| *labetalol hydrochloride* | 9 |
| *lactulose* | 12 |
| *lamotrigine* | 2 |
| *lansoprazole* | 12 |
| LANTUS | 7 |
| LANTUS SOLOSTAR | 7 |
| *latanoprost* | 16 |
| *leflunomide* | 15 |
| *letrozole* | 4 |
| LEVEMIR | 7 |
| LEVEMIR FLEXPEN | 7 |
| *levetiracetam* | 2 |
| *levocetirizine dihydrochloride* | 17 |
| *levofloxacin* | 2 |
| *levothyroxine sodium* | 14 |
| *lidocaine* | 1 |
| LINZESS | 12 |
| *liothyronine sodium* | 14 |
| *lisinopril* | 9 |
| *lisinopril/hydrochlorothiazide* | 9 |
| LIVALO | 10 |
| LONHALA MAGNAIR REFILL KIT | 17 |
| *loperamide hcl* | 12 |
| *lorazepam* | 6 |
| *losartan potassium* | 8 |
| *losartan potassium/hydrochlorothiazide* | 9 |
| LOTEMAX SM | 16 |
| *lovastatin* | 10 |
| LUMIGAN | 16 |
| LUPRON DEPOT (1-MONTH) | 14 |
| LUPRON DEPOT (3-MONTH) | 14 |
| LUPRON DEPOT (6-MONTH) | 14 |
| LYUMJEV | 7 |
| LYUMJEV KWIKPEN | 7 |
| MAVYRET | 6 |
| MAYZENT | 11 |
| *meclizine hcl* | 3 |
| *meloxicam* | 1 |
| *memantine hydrochloride* | 3 |

| Drug Name | Page # |
|---|---|
| *metformin hydrochloride* | 6 |
| *metformin hydrochloride er* | 6 |
| *methadone hcl* | 1 |
| *methenamine hippurate* | 1 |
| *methimazole* | 14 |
| *methocarbamol* | 18 |
| *methotrexate sodium* | 15 |
| *methylphenidate hydrochloride* | 10 |
| *methylprednisolone dose pack* | 13 |
| *metolazone* | 10 |
| *metoprolol succinate er* | 9 |
| *metoprolol tartrate* | 9 |
| *metronidazole* | 1 |
| *metronidazole* | 11 |
| *midodrine hcl* | 8 |
| *mirtazapine* | 3 |
| *mometasone furoate* | 17 |
| *montelukast sodium* | 17 |
| *morphine sulfate* | 1 |
| *morphine sulfate er* | 1 |
| MOTEGRITY | 12 |
| MOUNJARO | 6 |
| *moxifloxacin hydrochloride* | 16 |
| MULTAQ | 9 |
| *mupirocin* | 12 |
| MYRBETRIQ | 13 |
| *nabumetone* | 1 |
| NAMZARIC | 2 |
| *naproxen* | 1 |
| *nebivolol* | 9 |
| *nebivolol hydrochloride* | 9 |
| *neomycin/polymyxin/dexamethasone* | 16 |
| NEULASTA | 8 |
| NEULASTA ONPRO KIT | 8 |
| NEUPRO | 5 |
| NEXLETOL | 10 |
| NEXLIZET | 10 |
| *nifedipine er* | 9 |
| *nitrofurantoin macrocrystals* | 1 |
| *nitrofurantoin monohydrate* | 1 |
| *nitrofurantoin monohydrate/macrocrystals* | 1 |
| *nitroglycerin* | 10 |
| *nortriptyline hcl* | 3 |
| *nortriptyline hydrochloride* | 3 |
| NOVOLIN 70/30 | 7 |
| NOVOLIN 70/30 FLEXPEN | 7 |
| NOVOLIN N | 7 |
| NOVOLIN N FLEXPEN | 7 |
| NOVOLIN R | 7 |
| NOVOLIN R FLEXPEN | 7 |
| NOVOLOG | 7 |
| NOVOLOG MIX 70/30 | 7 |
| NOVOLOG MIX 70/30 PREFILLED FLEXPEN | 7 |
| NOVOLOG PENFILL | 8 |
| NUBEQA | 4 |
| NUCALA | 17 |
| NURTEC | 4 |
| *nystatin* | 4 |
| *nystop* | 4 |
| ODOMZO | 4 |
| OFEV | 17 |
| *ofloxacin* | 16 |
| *olanzapine* | 5 |
| *olmesartan medoxomil* | 8 |
| *olmesartan medoxomil/hydrochlorothiazide* | 9 |
| *olopatadine hcl* | 16 |
| *olopatadine hydrochloride* | 16 |
| *omega-3-acid ethyl esters* | 10 |
| *omeprazole* | 12 |
| OMNIPOD DASH PDM KIT (GEN 4) | 15 |
| OMNIPOD DASH PODS (GEN 4) | 15 |
| *ondansetron hydrochloride* | 3 |
| *ondansetron odt* | 3 |
| OPSUMIT | 17 |
| ORENCIA | 14 |
| ORENCIA | 15 |
| ORENCIA CLICKJECT | 14 |
| ORENITRAM | 17 |
| ORGOVYX | 14 |
| OTEZLA | 11 |
| OTEZLA | 14 |
| *oxcarbazepine* | 2 |
| *oxybutynin chloride* | 13 |
| *oxybutynin chloride er* | 13 |
| *oxycodone hydrochloride* | 1 |
| *oxycodone/acetaminophen* | 1 |
| OZEMPIC | 6 |
| *pantoprazole sodium* | 12 |
| *paroxetine hcl* | 3 |
| *paroxetine hydrochloride* | 3 |
| PAXLOVID | 15 |
| *peg-3350/electrolytes* | 12 |
| *penicillin v potassium* | 2 |
| PERSERIS | 5 |
| *phenytoin sodium extended* | 2 |

| Drug Name | Page # |
|---|---|
| *pioglitazone hcl* | 6 |
| *pioglitazone hydrochloride* | 6 |
| *polymyxin b sulfate/trimethoprim sulfate* | 16 |
| *potassium chloride er* | 12 |
| *potassium citrate er* | 12 |
| PRALUENT | 10 |
| *pramipexole dihydrochloride* | 5 |
| *pravastatin sodium* | 10 |
| *prednisolone acetate* | 16 |
| *prednisone* | 13 |
| *pregabalin* | 11 |
| PREMARIN | 14 |
| *premium lidocaine* | 1 |
| PREMPHASE | 14 |
| PREMPRO | 14 |
| *primidone* | 2 |
| PROAIR RESPICLICK | 17 |
| *prochlorperazine maleate* | 3 |
| PROCRIT | 8 |
| *proctozone-hc* | 15 |
| *progesterone* | 14 |
| PROLENSA | 16 |
| PROLIA | 15 |
| *promethazine hcl* | 3 |
| *promethazine hydrochloride* | 3 |
| *propranolol hcl* | 9 |
| *propranolol hydrochloride* | 9 |
| *propranolol hydrochloride er* | 9 |
| *quetiapine fumarate* | 5 |
| *quinapril hcl* | 9 |
| *raloxifene hydrochloride* | 14 |
| *ramipril* | 9 |
| *ranolazine er* | 9 |
| RAYALDEE | 15 |
| REBIF | 11 |
| REBIF REBIDOSE | 11 |
| REBIF REBIDOSE TITRATION PACK | 11 |
| REBIF TITRATION PACK | 11 |
| REPATHA PUSHTRONEX SYSTEM | 10 |
| REPATHA SURECLICK | 10 |
| RESTASIS | 16 |
| RESTASIS MULTIDOSE | 16 |
| RETACRIT | 8 |
| REXULTI | 5 |
| RHOPRESSA | 16 |
| RINVOQ | 14 |
| *risedronate sodium* | 15 |
| *risperidone* | 5 |

| Drug Name | Page # |
|---|---|
| *rizatriptan benzoate odt* | 4 |
| ROCKLATAN | 16 |
| *ropinirole hcl* | 5 |
| *ropinirole hydrochloride* | 5 |
| *rosuvastatin calcium* | 10 |
| RUXIENCE | 5 |
| RYBELSUS | 6 |
| RYTARY | 5 |
| SANTYL | 11 |
| SAVELLA | 11 |
| SEREVENT DISKUS | 17 |
| *sertraline hcl* | 3 |
| *sertraline hydrochloride* | 3 |
| *sevelamer carbonate* | 12 |
| SHINGRIX | 15 |
| SIMBRINZA | 16 |
| *simvastatin* | 10 |
| SKYRIZI | 14 |
| SKYRIZI PEN | 14 |
| SOFOSBUVIR/VELPATASVIR | 6 |
| *solifenacin succinate* | 13 |
| SOLIQUA 100/33 | 7 |
| *sotalol hcl* | 9 |
| *sotalol hydrochloride* | 9 |
| SPIRIVA HANDIHALER | 17 |
| SPIRIVA RESPIMAT | 17 |
| *spironolactone* | 10 |
| SPRYCEL | 4 |
| STELARA | 14 |
| STIOLTO RESPIMAT | 17 |
| *sucralfate* | 12 |
| *sulfamethoxazole/trimethoprim ds* | 2 |
| *sulfasalazine* | 15 |
| *sumatriptan succinate* | 4 |
| SYNJARDY | 7 |
| SYNJARDY XR | 7 |
| SYNTHROID | 14 |
| *tacrolimus* | 11 |
| *tadalafil* | 13 |
| *tamoxifen citrate* | 4 |
| *tamsulosin hydrochloride* | 13 |
| TASIGNA | 4 |
| *telmisartan* | 8 |
| *temazepam* | 18 |
| *terazosin hcl* | 8 |
| *terazosin hydrochloride* | 8 |
| *terbinafine hcl* | 4 |
| TERIPARATIDE | 15 |

| Drug Name | Page # |
|---|---|
| TESTOSTERONE | 13 |
| *testosterone cypionate* | 13 |
| *testosterone pump* | 13 |
| *timolol maleate* | 16 |
| *tizanidine hcl* | 5 |
| *tizanidine hydrochloride* | 5 |
| TOBI PODHALER | 17 |
| TOBRADEX ST | 16 |
| *tolterodine tartrate er* | 13 |
| *topiramate* | 2 |
| *torsemide* | 10 |
| TOUJEO MAX SOLOSTAR | 8 |
| TOUJEO SOLOSTAR | 8 |
| TRADJENTA | 7 |
| *tramadol hcl* | 1 |
| TRAZIMERA | 5 |
| *trazodone hydrochloride* | 3 |
| TRELEGY ELLIPTA | 17 |
| TRESIBA | 8 |
| TRESIBA FLEXTOUCH | 8 |
| *triamcinolone acetonide* | 11 |
| *triamterene/hydrochlorothiazide* | 9 |
| TRIJARDY XR | 7 |
| *trospium chloride* | 13 |
| TRULICITY | 7 |
| UBRELVY | 4 |
| UDENYCA | 8 |
| *valacyclovir hcl* | 6 |
| *valacyclovir hydrochloride* | 6 |
| *valsartan* | 8 |
| *valsartan/hydrochlorothiazide* | 10 |
| VELPHORO | 12 |
| *veltassa* | 12 |
| *venlafaxine hcl er* | 3 |
| *venlafaxine hydrochloride* | 3 |
| *venlafaxine hydrochloride er* | 3 |
| *verapamil hcl er* | 9 |
| *verapamil hydrochloride er* | 9 |
| V-GO 20 | 15 |
| V-GO 30 | 15 |
| V-GO 40 | 16 |
| VOSEVI | 6 |
| VUMERITY | 11 |
| *warfarin sodium* | 8 |
| *wixela inhub* | 17 |
| XARELTO | 8 |
| XARELTO STARTER PACK | 8 |
| XCOPRI | 2 |
| XELJANZ | 14 |
| XELJANZ XR | 14 |
| XIGDUO XR | 7 |
| XIIDRA | 16 |
| XOFLUZA | 6 |
| XTAMPZA ER | 1 |
| XTANDI | 4 |
| YUPELRI | 17 |
| *yuvafem* | 14 |
| ZARXIO | 8 |
| ZENPEP | 13 |
| ZEPOSIA | 11 |
| ZEPOSIA 7-DAY STARTER PACK | 11 |
| *zolpidem tartrate* | 18 |
| *zolpidem tartrate er* | 18 |

This abridged formulary was updated on July 19, 2023. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact the HOP Administration Unit at 1-800-773-7725, or for TTY users, 1-800-498-5428, 8:00 a.m. to 8:00 p.m. ET, Monday–Friday, or visit HOPbenefits.com.

**THE VALUE MEDICARE Rx OPTION (PDP) IS A STAND-ALONE PRESCRIPTION DRUG PLAN WITH A MEDICARE CONTRACT. ENROLLMENT IN THE VALUE MEDICARE Rx OPTION (PDP) DEPENDS ON CONTRACT RENEWAL. CMS CONTRACT NUMBER: E3014; FORMULARY ID: 24071**

Doc. Number: 113

## Pennsylvania Public School Employees' Retirement System (PSERS)

## 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 1-800-773-7725; TTY: 711. Someone who speaks English/Language 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 1-800-773-7725; 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 1-800-773-7725; TTY: 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 1-800-773-7725; TTY: 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 [1-800-773-7725; 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 [1-800-773-7725; 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 [1-800-773-7725; 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 [1-800-773-7725; 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 1-800-773-7725; 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 1-800-773-7725; 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 بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-773-7725; 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 केजवाब देने केलिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने केलिए, बस हमें 1-800-773-7725; 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 1-800-773-7725; 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 1-800-773-7725; 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 1-800-773-7725; 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 pom ożew uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzyst zać pomocy tłumacza znająceg jo ęzyk polski, należy zadzwonić pod numer 1-800-773-7725; TTY: 711. Ta usług ja est bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 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がありますございます。通訳をご用命になるには、1-800-773-7725; TTY: 711 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

**Cambodian (Khmer)**: ខ្មែរ៖ យើងមានសេវាបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដើម្បីឆ្លើយរាល់សំណួរដែលអ្នកមានអំពីផែនការសុខភាព ឬឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ សូមទូរសព្ទមកកាន់យើងខ្ញុំតាមរយៈលេខ 1-800-773-7725; TTY៖ 711។ អ្នកដែលចេះនិយាយភាសាអង់គ្លេស/ខ្មែរអាចជួយអ្នកបាន។ នេះគឺជាសេវាកម្មឥតគិតថ្លៃ។

**Greek:** Διαθέτουμε δωρεάν υπηρεσίες διερμηνείας για να απαντήσουμε σε οποιεσδήποτε ερωτήσεις που μπορεί να έχετε σχετικά με το πρόγραμμα υγείας ή το πρόγραμμα χορήγησης φαρμάκων μας. Για υπηρεσίες διερμηνείας, καλέστε μας στο 1-800-773-7725· Τηλέτυπο: 711. Κάποιο άτομο που μιλάει αγγλικά/ελληνικά μπορεί να σας βοηθήσει. Αυτή η υπηρεσία είναι δωρεάν.

**Gujarati:** અમારી સ્વાસ્થ્ય કેદવા યોજના વિશે તમને કોઈ પણ પ્રશ્ન હોઈ શકે છે, તેનો જવાબ આપવા માટેઅમારી પાસે નિ:શુલ્ક અનુવાદક ની સેવાઓ છે. અનુવાદક મેળવવા માટે ફક્ત અમને કોલ કરો, 1-800-773-7725; તેમજ મુકબધીરો માટેટેલી ટાઇપરાઈટર નંબર 711 પર. અંગ્રેજી/ગુજરાતી ભાષા બોલતી વ્યક્તિ તમને મદદ કરી શકે છે. આ સેવા નિ:શુલ્ક છે.

**Hrvatski:** pružamo besplatne usluge usmenog prevođenja kako bismo odgovorili na sva Vaša eventualna pitanja o pokriću zdravstvenih usluga ili lijekova. Za razgovor s usmenim prevoditeljem nazovite nas na broj telefona: 1-800-773-7725; TTY: 711. Pomoći će Vam govornik engleskoga/hrvatskoga jezika. Ova je usluga besplatna.

**Ukrainian:** Ми надаємо безкоштовні послуги перекладача, який відповість на будь-які питання щодо нашого медичного обслуговування та призначення лікарських препаратів. Щоб скористатися послугами перекладача, зателефонуйте за номером 1-800-773-7725; текстовий телефон: 711. Вам допоможе людина, яка розмовляє англійською або українською мовою. Послуга безкоштовна.