2025

Prescription Drug Guide

Humana Medicare Employer Plan Abbreviated Formulary

Partial List of covered drugs or "Drug List"

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

66

Formulary 25805

This abridged formulary was updated on 10/15/2024 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the Humana Medicare Employer Plan with any questions at the number on the back of your membership card or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m., Eastern time. 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.

Humana®

Welcome to The Humana Medicare Employer Plan!

Note to existing members: This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this Drug List (Formulary) refers to "we," "us", or "our," it means Humana. When it refers to "plan" or "our plan", it means the Humana Medicare Employer Plan. This document includes a partial Drug List (formulary) for our plan which is current as of January 1, 2025. For a complete, updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (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 Humana Medicare Employer abridged formulary?

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

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

If you are thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, please contact Group Medicare Customer Care number listed in your enrollment materials. If you are a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card. Our live representatives are available Monday through Friday from 8 a.m. - 9 p.m., Eastern time. Our automated phone system is available after hours, weekends, and holidays.

Can the formulary change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the formulary during the year, move them to different cost sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: **Humana.com/medicaredruglist**.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **Immediate substitutions of certain new versions of brand name drugs and original biological products**. We may immediately remove a drug on our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand name drug, or adding certain new biosimilar versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand name drug or biological product, we may not tell you in advance before we make an immediate 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 for you the drug that is being changed. For more information, see the section below titled "How do I request an exception to the Humana Formulary?"

Some of these drug types may be new to you. For more information, see the section below titled "What are original biological products and how are they related to biosimilars?"

- **Drugs removed from the market**. If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later 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 remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. 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. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and a notice of the change.

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 drug you have been taking. 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 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 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 formulary 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 happen 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, 2025. To get updated information about the drugs covered by Humana please contact us. Our contact information appears on the front and back cover pages.

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 what category to look under, you should look for your drug in the Index that begins on page 36. The Index provides an alphabetical list of all of 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 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.

What are generic drugs?

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 work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered” if you have a Medicare Advantage plan. If you have a Prescription Drug Plan (PDP), please see the Evidence of Coverage, Chapter 3, Section 3.1, "The 'Drug List' tells which Part D drugs are covered". The type of plan can be found at the top of your Evidence of Coverage.

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

- **Tier 1 - 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

How much will I pay for covered drugs?

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

The amount of money you pay depends on:

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

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

Are there any restrictions on my coverage?

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

- **Prior Authorization (PA):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs. This means that you will need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you do not get approval, the Humana Medicare Employer Plan may not cover the drug.

- **Quantity Limits (QL):** For certain drugs, the Humana Medicare Employer Plan limits the amount of the drug that is covered. The Humana Medicare Employer Plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it 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, the Humana Medicare Employer Plan requires that you 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 Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan will then cover Drug B.

- **Part B versus Part D (BvsD):** Some drugs may be covered under Medicare Part B or Part D, depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider can fax information about your condition and need for those drugs to the Humana Medicare Employer Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m. (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 get more information about the restrictions applied to specific covered drugs by visiting **Humana.com/medicaredruglist**. We have posted online documents that explain 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 Humana Medicare Employer Plan to make an exception to these restrictions, 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 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 formulary (list of covered drugs), you should first contact Humana Medicare Employer Plan Customer Care and ask if your drug is covered. This document includes only a partial list of covered drugs, so Humana Group Medicare Plan 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 Humana Medicare Employer Plan does not cover your drug, you have two options:

- You can ask Group Medicare Customer Care for a list of similar drugs that are covered by Humana Medicare Employer Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Humana Formulary?

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

- **Formulary exception:** You can ask us to cover a drug even if it is not on our 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 ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Humana Group Medicare Plan limits the amount of the 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.

- **Tier exception:** You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

Generally, the Humana Medicare Employer Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception**. Generally, we must make our decision within 72 hours of getting your presciber's supporting statement. You can ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

What can I do if my drug is not on the formulary or has a restriction?

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 has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor 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 has a coverage restriction, 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 30 day supply of

medication. If coverage is not approved, 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 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) while you pursue a formulary exception.

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

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

For these changes in treatment settings, the Humana Medicare Employer Plan will cover as much as a 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. The Humana Medicare Employer Plan 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

The Humana Medicare Employer Plan will consider on a case-by-case basis an extension of the transition period if your exception request or appeal 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. 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 Medicare Employer Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Humana Group Medicare Plan, 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, seven days a week. **TTY** users should call **1-877-486-2048**. You can also visit **www.medicare.gov**.

Humana Medicare Employer Plan Formulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 36.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug is not listed 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.

Your 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 30.

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:

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.
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.
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.
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. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 6 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANALGESICS		
celecoxib 100 mg, 200 mg CAPSULE **MO**	2	QL(60 per 30 days)
diclofenac sodium 1 % GEL **MO**	2	QL(1000 per 30 days)
diclofenac sodium 75 mg TABLET, DR/EC **MO**	1	
hydrocodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET **DL**	2	QL(360 per 30 days)
ibuprofen 600 mg, 800 mg TABLET **MO**	1	
meloxicam 15 mg TABLET **MO**	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET **MO**	1	QL(60 per 30 days)
naproxen 500 mg TABLET **MO**	1	
oxycodone 10 mg, 15 mg, 5 mg TABLET **DL**	2	QL(360 per 30 days)
oxycodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET **DL**	2	QL(360 per 30 days)
tramadol 50 mg TABLET **DL**	2	QL(240 per 30 days)
ANESTHETICS		
lidocaine 5 % ADHESIVE PATCH, MEDICATED **MO**	2	PA,QL(90 per 30 days)
ANTIBACTERIALS		
amoxicillin 500 mg CAPSULE **MO**	1	
amoxicillin 500 mg TABLET **MO**	1	
amoxicillin-pot clavulanate 875-125 mg TABLET **MO**	2	
azithromycin 250 mg TABLET **MO**	2	
cefdinir 300 mg CAPSULE **MO**	2	
cephalexin 500 mg CAPSULE **MO**	1	
ciprofloxacin hcl 500 mg TABLET **MO**	1	
DIFICID 200 MG TABLET **DL**	5	
DIFICID 40 MG/ML SUSPENSION FOR RECONSTITUTION **DL**	5	
doxycycline hyclate 100 mg CAPSULE **MO**	2	
doxycycline hyclate 100 mg TABLET **MO**	2	
levofloxacin 500 mg TABLET **MO**	2	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE **MO**	2	
sulfamethoxazole-trimethoprim 800-160 mg TABLET **MO**	1	
ANTICONVULSANTS		
EPIDIOLEX 100 MG/ML 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
gabapentin 100 mg, 300 mg, 400 mg CAPSULE **MO**	2	QL(270 per 30 days)
gabapentin 600 mg, 800 mg TABLET **MO**	2	QL(180 per 30 days)
levetiracetam 500 mg TABLET **MO**	2	
NAYZILAM 5 MG/SPRAY (0.1 ML) SPRAY, NON-AEROSOL **DL**	4	QL(10 per 30 days)
ANTIDEMENTIA AGENTS		
donepezil 10 mg TABLET **MO**	1	QL(60 per 30 days)
donepezil 5 mg TABLET **MO**	1	QL(30 per 30 days)
memantine 10 mg, 5 mg TABLET **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 **MO**	2	
bupropion hcl 150 mg TABLET, ER 24 HR. **MO**	2	QL(90 per 30 days)
bupropion hcl 150 mg TABLET, SR 12 HR. **MO**	2	QL(90 per 30 days)
bupropion hcl 300 mg TABLET, ER 24 HR. **MO**	2	QL(60 per 30 days)
citalopram 10 mg, 40 mg TABLET **MO**	1	QL(30 per 30 days)
citalopram 20 mg TABLET **MO**	1	QL(60 per 30 days)
escitalopram oxalate 10 mg TABLET **MO**	1	QL(45 per 30 days)
escitalopram oxalate 20 mg, 5 mg TABLET **MO**	1	QL(30 per 30 days)
fluoxetine 20 mg CAPSULE **MO**	1	QL(120 per 30 days)
fluoxetine 40 mg CAPSULE **MO**	1	QL(60 per 30 days)
mirtazapine 15 mg, 30 mg, 7.5 mg TABLET **MO**	2	
sertraline 100 mg TABLET **MO**	1	QL(60 per 30 days)
sertraline 25 mg, 50 mg TABLET **MO**	1	QL(90 per 30 days)
trazodone 100 mg, 150 mg, 50 mg TABLET **MO**	1	
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET **MO**	4	ST,QL(30 per 30 days)
venlafaxine 150 mg CAPSULE, ER 24 HR. **MO**	2	QL(60 per 30 days)
venlafaxine 75 mg CAPSULE, ER 24 HR. **MO**	2	QL(90 per 30 days)
ANTIEMETICS		
meclizine 25 mg TABLET **MO**	2	
ondansetron 4 mg TABLET, DISINTEGRATING **MO**	2	BvsD

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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ondansetron hcl 4 mg TABLET **MO**	1	BvsD
promethazine 25 mg TABLET **MO**	2	
ANTIFUNGALS		
clotrimazole-betamethasone 1-0.05 % CREAM **MO**	2	QL(180 per 30 days)
fluconazole 150 mg TABLET **MO**	2	
ketoconazole 2 % CREAM **MO**	2	QL(60 per 30 days)
ketoconazole 2 % SHAMPOO **MO**	2	QL(120 per 30 days)
ANTIGOUT AGENTS		
allopurinol 100 mg, 300 mg TABLET **MO**	1	
ANTIMIGRAINE AGENTS		
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)
QULIPTA 10 MG, 30 MG, 60 MG TABLET **MO**	4	PA,QL(30 per 30 days)
UBRELVY 100 MG, 50 MG TABLET **MO**	3	PA,QL(16 per 30 days)
ANTIMYASTHENIC AGENTS		
VYVGART 20 MG/ML SOLUTION **DL**	5	PA
VYVGART HYTRULO 1,008 MG-11,200 UNIT/5.6 ML SOLUTION **DL**	5	PA,QL(22.4 per 28 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 **MO**	1	QL(30 per 30 days)
BRUKINSA 80 MG CAPSULE **DL**	5	PA,QL(120 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG TABLET **DL**	5	PA,QL(30 per 30 days)
CALQUENCE 100 MG CAPSULE **DL**	5	PA,QL(60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) 100 MG TABLET **DL**	5	PA,QL(60 per 30 days)
ERIVEDGE 150 MG CAPSULE **DL**	5	PA,QL(28 per 28 days)
ERLEADA 240 MG TABLET **DL**	5	PA,QL(30 per 30 days)
ERLEADA 60 MG TABLET **DL**	5	PA,QL(120 per 30 days)
IMBRUVICA 140 MG CAPSULE **DL**	5	PA,QL(120 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
IMBRUVICA 420 MG TABLET DL	5	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE DL	5	PA,QL(28 per 28 days)
IMBRUVICA 70 MG/ML SUSPENSION DL	5	PA
KISQALI 200 MG/DAY (200 MG X 1) TABLET DL	5	PA,QL(21 per 28 days)
KISQALI 400 MG/DAY (200 MG X 2) TABLET DL	5	PA,QL(42 per 28 days)
KISQALI 600 MG/DAY (200 MG X 3) TABLET DL	5	PA,QL(63 per 28 days)
KISQALI FEMARA CO-PACK 200 MG/DAY(200 MG X 1)-2.5 MG TABLET DL	5	PA,QL(49 per 28 days)
KISQALI FEMARA CO-PACK 400 MG/DAY(200 MG X 2)-2.5 MG TABLET DL	5	PA,QL(70 per 28 days)
KISQALI FEMARA CO-PACK 600 MG/DAY(200 MG X 3)-2.5 MG TABLET DL	5	PA,QL(91 per 28 days)
LYNPARZA 100 MG, 150 MG TABLET DL	5	PA,QL(120 per 30 days)
NUBEQA 300 MG TABLET DL	5	PA,QL(120 per 30 days)
ORGOVYX 120 MG TABLET DL	5	PA,QL(32 per 30 days)
RUXIENCE 10 MG/ML SOLUTION DL	5	PA
TRAZIMERA 420 MG RECON SOLUTION DL	5	PA
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)
ZEJULA 100 MG CAPSULE DL	5	PA,QL(90 per 30 days)
ZEJULA 100 MG, 200 MG, 300 MG TABLET DL	5	PA,QL(30 per 30 days)
ZIRABEV 25 MG/ML SOLUTION DL	5	PA
ANTIPARASITICS		
hydroxychloroquine 200 mg TABLET MO	2	
ANTIPARKINSON AGENTS		
carbidopa-levodopa 25-100 mg TABLET MO	2	
INBRIJA 42 MG CAPSULE, W/INHALATION DEVICE DL	5	PA,QL(300 per 30 days)
RYTARY 23.75-95 MG, 48.75-195 MG CAPSULE, ER MO	4	ST,QL(360 per 30 days)
RYTARY 36.25-145 MG CAPSULE, ER MO	4	ST,QL(270 per 30 days)
RYTARY 61.25-245 MG CAPSULE, ER MO	4	ST,QL(300 per 30 days)
ANTIPSYCHOTICS		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET MO	4	PA
ABILIFY ASIMTUFII 720 MG/2.4 ML SUSPENSION, ER, SYRINGE	5	QL(2.4 per 56 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ABILIFY ASIMTUFII 960 MG/3.2 ML SUSPENSION, ER, SYRINGE	5	QL(3.2 per 56 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON **DL**	5	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE **DL**	5	QL(1 per 28 days)
ABILIFY MYCITE MAINTENANCE KIT 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET WITH SENSOR AND STRIP **DL**	5	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 10 MG TABLET W/SENSOR AND STRIP, POD **DL**	5	PA,QL(30 per 30 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	5	QL(3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE **DL**	5	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE **DL**	5	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE **DL**	5	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE **DL**	5	QL(2.4 per 42 days)
INVEGA 3 MG, 9 MG TABLET, ER 24 HR. **DL**	5	PA,QL(30 per 30 days)
INVEGA 6 MG TABLET, ER 24 HR. **DL**	5	PA,QL(60 per 30 days)
INVEGA HAFYERA 1,092 MG/3.5 ML SYRINGE	5	QL(3.5 per 180 days)
INVEGA HAFYERA 1,560 MG/5 ML SYRINGE	5	QL(5 per 180 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML SYRINGE **DL**	5	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML SYRINGE **DL**	5	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	5	QL(0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML SYRINGE	5	QL(1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML SYRINGE	5	QL(1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML SYRINGE	5	QL(2.63 per 90 days)
LYBALVI 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG TABLET **DL**	5	PA,QL(30 per 30 days)
quetiapine 100 mg TABLET **MO**	2	QL(90 per 30 days)
quetiapine 25 mg, 50 mg TABLET **MO**	2	QL(120 per 30 days)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG TABLET **DL**	5	PA,QL(30 per 30 days)
RISPERDAL 0.5 MG TABLET **MO**	4	QL(120 per 30 days)
RISPERDAL 1 MG, 2 MG TABLET **MO**	4	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION **DL**	5	
RISPERDAL 3 MG, 4 MG TABLET **DL**	5	QL(60 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**	5	QL(2 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANTISPASTICITY AGENTS		
baclofen 10 mg TABLET **MO**	1	
tizanidine 2 mg, 4 mg TABLET **MO**	1	
ANTIVIRALS		
BIKTARVY 30-120-15 MG, 50-200-25 MG TABLET **DL**	5	QL(30 per 30 days)
DESCOVY 120-15 MG, 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)
LAGEVRIO (EUA) 200 MG CAPSULE **MO**	3	QL(40 per 5 days)
ODEFSEY 200-25-25 MG TABLET **DL**	5	QL(30 per 30 days)
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)
valacyclovir 1 gram, 500 mg TABLET **MO**	2	
VEMLIDY 25 MG TABLET **DL**	5	QL(30 per 30 days)
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**	2	QL(120 per 30 days)
buspirone 10 mg, 5 mg TABLET **MO**	1	
clonazepam 0.5 mg, 1 mg TABLET **DL**	2	
diazepam 5 mg TABLET **DL**	2	QL(90 per 30 days)
hydroxyzine hcl 25 mg TABLET **MO**	2	
lorazepam 0.5 mg, 1 mg TABLET **DL**	2	QL(90 per 30 days)
BLOOD GLUCOSE REGULATORS		
FARXIGA 10 MG, 5 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 **MO**	1	
glipizide 10 mg, 5 mg TABLET **MO**	1	
GLYXAMBI 10-5 MG, 25-5 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMALOG JUNIOR KWIKPEN U-100 100 UNIT/ML INSULIN PEN, HALF-UNIT **CI,MO**	3	
HUMALOG KWIKPEN INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML (50-50) INSULIN PEN **CI,MO**	3	
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML (75-25) INSULIN PEN **CI,MO**	3	
HUMALOG MIX 75-25(U-100)INSULN 100 UNIT/ML (75-25) SUSPENSION **CI,MO**	3	
HUMALOG TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR **CI,MO**	4	ST
HUMALOG U-100 INSULIN 100 UNIT/ML CARTRIDGE **CI,MO**	3	
HUMALOG U-100 INSULIN 100 UNIT/ML SOLUTION **CI,MO**	3	
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION **CI,MO**	3	
HUMULIN 70/30 U-100 KWIKPEN 100 UNIT/ML (70-30) INSULIN PEN **CI,MO**	3	
HUMULIN N NPH INSULIN KWIKPEN 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
HUMULIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION **CI,MO**	3	
HUMULIN R REGULAR U-100 INSULN 100 UNIT/ML SOLUTION **CI,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, 50-500 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)
JANUMET XR 50-1,000 MG, 50-500 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 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	

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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML INSULIN PEN CI,MO	3	
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	
LYUMJEV TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR CI,MO	4	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	
metformin 1,000 mg, 500 mg TABLET MO	1	
metformin 500 mg TABLET, ER 24 HR. MO	1	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	PA,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	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	
NOVOLIN R REGULAR U100 INSULIN 100 UNIT/ML SOLUTION 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/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR MO	3	PA,QL(3 per 28 days)
pioglitazone 30 mg TABLET MO	1	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET MO	3	PA,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	

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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN **CI,MO**	3	
TRESIBA FLEXTOUCH U-200 200 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	PA,QL(2 per 28 days)
XIGDUO XR 10-1,000 MG, 10-500 MG, 5-500 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	4	QL(30 per 30 days)
XIGDUO XR 2.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC **MO**	4	QL(60 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 **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)
NIVESTYM 300 MCG/0.5 ML SYRINGE **DL**	5	PA,QL(7 per 30 days)
NIVESTYM 300 MCG/ML SOLUTION **DL**	5	PA,QL(14 per 30 days)
NIVESTYM 480 MCG/0.8 ML SYRINGE **DL**	5	PA,QL(11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML SOLUTION **DL**	5	PA,QL(22.4 per 30 days)
PROMACTA 12.5 MG POWDER IN PACKET **DL,LA**	5	PA,QL(360 per 30 days)
PROMACTA 12.5 MG, 25 MG TABLET **DL,LA**	5	PA,QL(30 per 30 days)
PROMACTA 25 MG POWDER IN PACKET **DL,LA**	5	PA,QL(180 per 30 days)
PROMACTA 50 MG TABLET **DL,LA**	5	PA,QL(90 per 30 days)
PROMACTA 75 MG TABLET **DL,LA**	5	PA,QL(60 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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 SOLUTION **MO**	4	PA,QL(14 per 30 days)
RETACRIT 40,000 UNIT/ML SOLUTION **DL**	5	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE **DL**	5	PA,QL(1.2 per 28 days)
UDENYCA AUTOINJECTOR 6 MG/0.6 ML AUTO-INJECTOR **DL**	5	PA,QL(1.2 per 28 days)
warfarin 5 mg TABLET **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 **MO**	2	
amlodipine 10 mg, 2.5 mg, 5 mg TABLET **MO**	1	
atenolol 25 mg, 50 mg TABLET **MO**	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET **MO**	1	
bumetanide 1 mg TABLET **MO**	2	
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET **MO**	1	
chlorthalidone 25 mg TABLET **MO**	1	
clonidine hcl 0.1 mg TABLET **MO**	1	
ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET **MO**	3	QL(60 per 30 days)
ezetimibe 10 mg TABLET **MO**	1	QL(30 per 30 days)
fenofibrate 160 mg TABLET **MO**	2	QL(30 per 30 days)
fenofibrate nanocrystallized 145 mg TABLET **MO**	2	QL(30 per 30 days)
furosemide 20 mg, 40 mg TABLET **MO**	1	
hydralazine 25 mg TABLET **MO**	2	
hydralazine 50 mg TABLET **MO**	1	
hydrochlorothiazide 12.5 mg CAPSULE **MO**	1	
hydrochlorothiazide 12.5 mg, 25 mg TABLET **MO**	1	
isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR. **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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
KERENDIA 10 MG, 20 MG TABLET **MO**	3	PA,QL(30 per 30 days)
lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET **MO**	1	
lisinopril-hydrochlorothiazide 10-12.5 mg, 20-12.5 mg, 20-25 mg TABLET **MO**	1	
losartan 100 mg, 25 mg, 50 mg TABLET **MO**	1	QL(60 per 30 days)
losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET **MO**	1	QL(60 per 30 days)
metoprolol succinate 100 mg, 25 mg, 50 mg TABLET, ER 24 HR. **MO**	1	
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET **MO**	1	
MULTAQ 400 MG TABLET **MO**	3	QL(60 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET **MO**	2	
olmesartan 40 mg TABLET **MO**	1	QL(30 per 30 days)
pravastatin 20 mg, 40 mg TABLET **MO**	1	
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)
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**	1	
simvastatin 10 mg, 20 mg, 40 mg TABLET **MO**	1	
spironolactone 25 mg, 50 mg TABLET **MO**	1	
torsemide 20 mg TABLET **MO**	2	
triamterene-hydrochlorothiazid 37.5-25 mg TABLET **MO**	1	
valsartan 160 mg TABLET **MO**	1	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)
VERQUVO 10 MG, 2.5 MG, 5 MG TABLET **MO**	3	PA,QL(30 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)
AUSTEDO XR 12 MG, 6 MG TABLET, ER 24 HR. **DL**	5	PA,QL(90 per 30 days)
AUSTEDO XR 24 MG TABLET, ER 24 HR. **DL**	5	PA,QL(60 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) 6 MG (14)-12 MG (14)-24 MG (14) TABLET, ER 24 HR., DOSE PACK **DL**	5	PA,QL(42 per 28 days)
BETASERON 0.3 MG KIT **DL**	5	PA,QL(15 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
COPAXONE 20 MG/ML SYRINGE DL	5	PA,QL(30 per 30 days)
COPAXONE 40 MG/ML SYRINGE DL	5	PA,QL(12 per 28 days)
duloxetine 20 mg CAPSULE, DR/EC MO	2	QL(120 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC MO	2	QL(90 per 30 days)
duloxetine 60 mg CAPSULE, DR/EC MO	2	QL(60 per 30 days)
KESIMPTA PEN 20 MG/0.4 ML PEN INJECTOR DL	5	PA,QL(1.2 per 28 days)
pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE MO	2	QL(90 per 30 days)
RADICAVA ORS STARTER KIT SUSP 105 MG/5 ML SUSPENSION DL	5	PA,QL(70 per 28 days)
VUMERITY 231 MG CAPSULE, DR/EC DL	5	PA,QL(120 per 30 days)
DENTAL & ORAL AGENTS		
chlorhexidine gluconate 0.12 % MOUTHWASH MO	1	
DERMATOLOGICAL AGENTS		
ENSTILAR 0.005-0.064 % FOAM MO	4	QL(120 per 30 days)
mupirocin 2 % OINTMENT MO	1	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
LOKELMA 10 GRAM, 5 GRAM POWDER IN PACKET MO	3	QL(30 per 30 days)
potassium chloride 10 meq CAPSULE, ER MO	2	
potassium chloride 10 meq, 20 meq TABLET ER MO	2	
potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS MO	2	
GASTROINTESTINAL AGENTS		
dicyclomine 10 mg CAPSULE MO	2	
esomeprazole magnesium 40 mg CAPSULE, DR/EC MO	2	QL(60 per 30 days)
famotidine 20 mg, 40 mg TABLET MO	2	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE MO	3	QL(30 per 30 days)
MOVANTIK 12.5 MG, 25 MG TABLET MO	3	QL(30 per 30 days)
omeprazole 20 mg, 40 mg CAPSULE, DR/EC MO	1	QL(60 per 30 days)
pantoprazole 20 mg, 40 mg TABLET, DR/EC MO	1	QL(60 per 30 days)
sucralfate 1 gram TABLET MO	2	
SUFLAVE 178.7-7.3-0.5 GRAM RECON SOLUTION MO	4	
SUTAB 1.479-0.188- 0.225 GRAM TABLET MO	3	
TALICIA 10-250-12.5 MG CAPSULE, IR/DR, BIPHASIC MO	4	

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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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		
AMVUTTRA 25 MG/0.5 ML SYRINGE **DL**	5	PA,QL(0.5 per 90 days)
CREON 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT CAPSULE, DR/EC **MO**	3	
ELELYSO 200 UNIT RECON SOLUTION **DL**	5	PA
ONPATTRO 2 MG/ML SOLUTION **DL**	5	PA
STRENSIQ 40 MG/ML SOLUTION **DL**	5	PA
VYNDAMAX 61 MG CAPSULE **DL**	5	PA,QL(30 per 30 days)
ZEMAIRA 1,000 MG RECON SOLUTION **DL**	5	PA
ZENPEP 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT CAPSULE, DR/EC **MO**	4	
GENITOURINARY AGENTS		
finasteride 5 mg TABLET **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 TABLET, ER 24 HR. **MO**	1	QL(60 per 30 days)
oxybutynin chloride 5 mg TABLET **MO**	2	
tamsulosin 0.4 mg CAPSULE **MO**	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ACTHAR 80 UNIT/ML GEL **DL**	5	PA,QL(30 per 30 days)
methylprednisolone 4 mg TABLET, DOSE PACK **MO**	2	
prednisone 10 mg, 20 mg, 5 mg TABLET **MO**	1	BvsD
triamcinolone acetonide 0.1 % CREAM **MO**	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
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

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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
estradiol 0.01 % (0.1 mg/gram) CREAM **MO**	2	
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**	1	
TIROSINT 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG CAPSULE **MO**	4	
TIROSINT-SOL 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML SOLUTION **MO**	4	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE **DL**	5	PA,QL(0.3 per 28 days)
IMMUNOLOGICAL AGENTS		
ADALIMUMAB-ADBM 10 MG/0.2 ML, 20 MG/0.4 ML SYRINGE KIT **DL**	5	PA,QL(2 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML SYRINGE KIT **DL**	5	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT **DL**	5	PA,QL(6 per 28 days)
AREXVY (PF) 120 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION **AV,DL**	1	
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)
COSENTYX UNOREADY PEN 300 MG/2 ML (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)

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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
ENVARSUS XR 0.75 MG, 1 MG TABLET, ER 24 HR. MO	4	PA
ENVARSUS XR 4 MG TABLET, ER 24 HR. DL	4	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION DL	5	PA
HAEGARDA 2,000 UNIT, 3,000 UNIT RECON SOLUTION DL	5	PA,QL(24 per 28 days)
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 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	2	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	1	
SKYRIZI 150 MG/ML PEN INJECTOR	5	PA,QL(2 per 84 days)
SKYRIZI 150 MG/ML SYRINGE	5	PA,QL(2 per 84 days)
SKYRIZI 180 MG/1.2 ML (150 MG/ML) WEARABLE INJECTOR DL	5	PA,QL(8.4 per 365 days)
SKYRIZI 360 MG/2.4 ML (150 MG/ML) WEARABLE INJECTOR DL	5	PA,QL(16.8 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)
TREMFYA 100 MG/ML AUTO-INJECTOR	5	PA,QL(3 per 84 days)
TREMFYA 100 MG/ML SYRINGE	5	PA,QL(3 per 84 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
METABOLIC BONE DISEASE AGENTS		
alendronate 70 mg TABLET **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)
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 **MO**	1	
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" NEEDLE **PDS,MO**	1	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE **PDS,MO**	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE **PDS,MO**	1	
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,MO**	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE **PDS,MO**	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE **PDS,MO**	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE **PDS,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,MO**	1	
CEQUR SIMPLICITY INSERTER MISCELLANEOUS **MO**	3	
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,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,MO**	1	
DROPSAFE ALCOHOL PREP PADS PADS, MEDICATED **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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
GIVLAARI 189 MG/ML SOLUTION **DL**	5	PA
OXLUMO 94.5 MG/0.5 ML SOLUTION	5	PA
OPHTHALMIC AGENTS		
brimonidine 0.2 % DROPS **MO**	1	
COMBIGAN 0.2-0.5 % DROPS **MO**	3	QL(5 per 25 days)
dorzolamide-timolol 22.3-6.8 mg/ml DROPS **MO**	1	
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)
latanoprost 0.005 % DROPS **MO**	1	QL(5 per 25 days)
LOTEMAX 0.5 % DROPS, GEL **MO**	4	ST
LOTEMAX 0.5 % DROPS, SUSPENSION **MO**	4	ST
LOTEMAX 0.5 % OINTMENT **MO**	4	ST
LOTEMAX SM 0.38 % DROPS, GEL **MO**	4	
LUMIGAN 0.01 % DROPS **MO**	3	QL(2.5 per 25 days)
prednisolone acetate 1 % DROPS, SUSPENSION **MO**	2	
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)
SIMBRINZA 1-0.2 % DROPS, SUSPENSION **MO**	4	QL(16 per 30 days)
timolol maleate 0.5 % DROPS **MO**	1	
VYZULTA 0.024 % DROPS **MO**	4	QL(2.5 per 25 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 DISKUS 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE BLISTER WITH DEVICE **MO**	4	PA,QL(60 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 2.5 mg /3 ml (0.083 %) SOLUTION FOR NEBULIZATION **MO**	2	BvsD
albuterol sulfate 90 mcg/actuation HFA AEROSOL INHALER **MO**	2	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)
AUVI-Q 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML AUTO-INJECTOR **MO**	3	QL(4 per 30 days)
azelastine 137 mcg (0.1 %) SPRAY, NON-AEROSOL **MO**	2	QL(30 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 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)
FASENRA 30 MG/ML SYRINGE DL	5	PA,QL(1 per 28 days)
FASENRA PEN 30 MG/ML AUTO-INJECTOR DL	5	PA,QL(1 per 28 days)
fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION MO	2	QL(16 per 30 days)
ipratropium-albuterol 0.5 mg-3 mg(2.5 mg base)/3 ml SOLUTION FOR NEBULIZATION MO	2	BvsD
levocetirizine 5 mg TABLET MO	1	QL(30 per 30 days)
montelukast 10 mg TABLET MO	1	QL(30 per 30 days)
NUCALA 100 MG RECON SOLUTION DL	5	PA,QL(3 per 28 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)
NUCALA 40 MG/0.4 ML SYRINGE DL	5	PA,QL(0.4 per 28 days)
OFEV 100 MG, 150 MG CAPSULE DL,LA	5	PA,QL(60 per 30 days)
OPSUMIT 10 MG TABLET DL	5	PA,QL(30 per 30 days)
OPSYNVI 10-20 MG, 10-40 MG TABLET DL	5	PA,QL(30 per 30 days)
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)
TYVASO DPI 16 MCG, 32 MCG, 48 MCG, 64 MCG CARTRIDGE WITH INHALER DL	5	PA,QL(112 per 28 days)
TYVASO DPI 16(112)-32(112) -48(28) MCG CARTRIDGE WITH INHALER DL	5	PA,QL(252 per 28 days)
TYVASO DPI 32-48 MCG CARTRIDGE WITH INHALER DL	5	PA,QL(224 per 28 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER MO	3	QL(36 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 • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SKELETAL MUSCLE RELAXANTS		
cyclobenzaprine 10 mg, 5 mg TABLET **MO**	2	
methocarbamol 500 mg, 750 mg TABLET **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**	2	QL(30 per 30 days)
zolpidem 10 mg, 5 mg TABLET **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 • BvsD - 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 • ST - Step Therapy

Humana Medicare Employer Plan Coverage of Additional Prescription Drugs

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cosmetics - Mail Order Available		
bimatoprost 0.03 % DROPS WITH APPLICATOR	1	
blanche 4 % CREAM	1	
finasteride 1 mg TABLET	1	
hydrocortisone-pramoxine 2.5-1 % CREAM	1	
hydroquinone 4 % CREAM	1	
LATISSE 0.03 % DROPS WITH APPLICATOR	4	
obagi elastiderm 4 % CREAM	1	
obagi nu-derm blender 4 % CREAM	1	
obagi nu-derm clear 4 % CREAM	1	
PROPECIA 1 MG TABLET	4	
refissa 0.05 % CREAM	1	
RENOVA 0.02 % CREAM	4	
sulfacetamide sodium 10 % CLEANSER	1	
sulfacetamide sodium-sulfur 10-5 % (w/w) CREAM	1	
tretinoin (emollient) 0.05 % CREAM	1	
TRI-LUMA 0.01-4-0.05 % CREAM	4	
Cough/Cold - Mail Order Available		
benzonatate 100 mg, 150 mg, 200 mg CAPSULE	1	
bromfed dm 2-30-10 mg/5 ml SYRUP	1	
brompheniramine-pseudoeph-dm 2-30-10 mg/5 ml SYRUP	1	
HYCODAN 5-1.5 MG/5 ML (5 ML) SYRUP	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG TABLET	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG/5 ML SYRUP	1	
hydrocodone-chlorpheniramine 10-8 mg/5 ml SUSPENSION, ER 12 HR.	1	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

AV - ACIP Covered Part D vaccines • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cough/Cold - Mail Order Available		
hydrocodone-homatropine 5-1.5 mg TABLET	1	
hydrocodone-homatropine 5-1.5 mg/5 ml, 5-1.5 mg/5 ml (5 ml) SYRUP	1	
hydromet 5-1.5 mg/5 ml SYRUP	1	
OBREDON 2.5-200 MG/5 ML SOLUTION	4	
promethazine vc-codeine 6.25-5-10 mg/5 ml SYRUP	1	
promethazine-codeine 6.25-10 mg/5 ml SYRUP	1	
promethazine-dm 6.25-15 mg/5 ml SYRUP	1	
promethazine-phenyleph-codeine 6.25-5-10 mg/5 ml SYRUP	1	
RESPA-AR 8-90-0.24 MG TABLET, ER 12 HR.	4	
TUXARIN ER 8-54.3 MG TABLET, ER 12 HR.	4	
TUZISTRA XR 14.7-2.8 MG/5 ML SUSPENSION, ER 12 HR.	4	
Dental - Mail Order Available		
CLINPRO 5000 1.1 % PASTE	4	
denta 5000 plus 1.1 % CREAM	4	
denta 5000 plus sensitive 1.1-5 % PASTE	4	
dentagel 1.1 % GEL	4	
fluoride (sodium) 0.2 % SOLUTION	1	
fluoride (sodium) 1.1 % CREAM	1	
fluoride (sodium) 1.1 % GEL	1	
fluoride (sodium) 1.1 % PASTE	1	
fraiche 5000 1.1 % GEL	4	
PREVIDENT 0.2 % SOLUTION	4	
prevident 1.1 % GEL	4	
PREVIDENT 5000 BOOSTER PLUS 1.1 % PASTE	4	
PREVIDENT 5000 DRY MOUTH 1.1 % PASTE	4	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

AV - ACIP Covered Part D vaccines • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Dental - Mail Order Available		
PREVIDENT 5000 ENAMEL PROTECT 1.1-5 % PASTE	4	
PREVIDENT 5000 ORTHO DEFENSE 1.1 % PASTE	4	
PREVIDENT 5000 PLUS 1.1 % CREAM	4	
PREVIDENT 5000 SENSITIVE 1.1-5 % PASTE	4	
PREVIDENT KIDS 1.1 % PASTE	4	
sf 1.1 % GEL	1	
sf 5000 plus 1.1 % CREAM	1	
sodium fluoride 5000 dry mouth 1.1 % PASTE	1	
sodium fluoride 5000 plus 1.1 % CREAM	1	
sodium fluoride-pot nitrate 1.1-5 % PASTE	1	
Erectile Dysfunction - Mail Order Available		
ADDYI 100 MG TABLET	4	
CIALIS 10 MG, 20 MG TABLET	4	QL(6 per 30 days)
sildenafil 100 mg, 25 mg, 50 mg TABLET	1	QL(6 per 30 days)
STENDRA 100 MG, 200 MG, 50 MG TABLET	4	QL(6 per 30 days)
tadalafil 10 mg, 20 mg TABLET	1	QL(6 per 30 days)
vardenafil 10 mg TABLET, DISINTEGRATING	1	QL(6 per 30 days)
vardenafil 10 mg, 2.5 mg, 20 mg, 5 mg TABLET	1	QL(6 per 30 days)
VIAGRA 100 MG, 25 MG, 50 MG TABLET	4	QL(6 per 30 days)
VYLEESI 1.75 MG/0.3 ML AUTO-INJECTOR	4	
Fertility - Mail Order Available		
cetrorelix 0.25 mg KIT	1	
CETROTIDE 0.25 MG KIT	4	
clomid 50 mg TABLET	1	
clomiphene citrate 50 mg TABLET	1	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

AV - ACIP Covered Part D vaccines • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Fertility - Mail Order Available		
FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML CARTRIDGE	4	
fyremadel 250 mcg/0.5 ml SYRINGE	1	
GANIRELIX 250 MCG/0.5 ML SYRINGE	4	
ganirelix 250 mcg/0.5 ml SYRINGE	4	
GONAL-F 1,050 UNIT, 450 UNIT RECON SOLUTION	4	
GONAL-F RFF 75 UNIT RECON SOLUTION	4	
GONAL-F RFF REDI-JECT 300/0.5 UNIT/ML, 450/0.75 UNIT/ML, 900/1.5 UNIT/ML PEN INJECTOR	4	
MENOPUR 75 UNIT RECON SOLUTION	4	
OVIDREL 250 MCG/0.5 ML SYRINGE	4	
Vitamins/Minerals - Mail Order Available		
ascorbic acid (vitamin c) 500 mg/ml SOLUTION	1	
b complex 100 100-2-100-2-2 mg/ml SOLUTION	1	
b-complex injection 100-2-100-2-2 mg/ml SOLUTION	1	
cyanocobalamin (vitamin b-12) 1,000 mcg/ml SOLUTION	1	
cyanocobalamin (vitamin b-12) 500 mcg/spray SPRAY, NON-AEROSOL	1	
dodex 1,000 mcg/ml SOLUTION	1	
DRISDOL 1,250 MCG (50,000 UNIT) CAPSULE	4	
ergocalciferol (vitamin d2) 1,250 mcg (50,000 unit) CAPSULE	1	
folic acid 1 mg TABLET	1	
folic acid 5 mg/ml SOLUTION	1	
hydroxocobalamin 1,000 mcg/ml SOLUTION	1	
INFUVITE ADULT 3,300 UNIT- 150 MCG/10 ML SOLUTION	4	
INFUVITE PEDIATRIC 80 MG-400 UNIT- 200 MCG/5 ML SOLUTION	4	
MEPHYTON 5 MG TABLET	4	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

AV - ACIP Covered Part D vaccines • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Vitamins/Minerals - Mail Order Available		
NASCOBAL 500 MCG/SPRAY SPRAY, NON-AEROSOL	4	
phytonadione (vitamin k1) 1 mg/0.5 ml SYRINGE	1	
phytonadione (vitamin k1) 1 mg/0.5 ml, 10 mg/ml SOLUTION	1	
phytonadione (vitamin k1) 5 mg TABLET	1	
pyridoxine (vitamin b6) 100 mg/ml SOLUTION	1	
thiamine hcl (vitamin b1) 100 mg/ml SOLUTION	1	
vitamin d2 1,250 mcg (50,000 unit) CAPSULE	1	
vitamin k 1 mg/0.5 ml SOLUTION	1	
vitamin k1 10 mg/ml SOLUTION	1	
Weight Loss - Mail Order Available		
adipex-p 37.5 mg CAPSULE	1	
ADIPEX-P 37.5 MG TABLET	1	
benzphetamine 50 mg TABLET	1	
CONTRAVE 8-90 MG TABLET ER	4	QL(120 per 30 days)
diethylpropion 25 mg TABLET	1	
diethylpropion 75 mg TABLET ER	1	
lomaira 8 mg TABLET	1	
phendimetrazine tartrate 105 mg CAPSULE, ER	4	
phendimetrazine tartrate 35 mg TABLET	1	
phentermine 15 mg, 30 mg, 37.5 mg CAPSULE	1	
phentermine 37.5 mg TABLET	1	
PLENITY 0.75 GRAM CAPSULE	4	
PLENITY (WELCOME KIT) 0.75 GRAM CAPSULE	4	
QSYMIA 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG CAPSULE ER MULTIPHASE 24 HR.	4	QL(30 per 30 days)
SAXENDA 3 MG/0.5 ML (18 MG/3 ML) PEN INJECTOR	4	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

AV - ACIP Covered Part D vaccines • BvsD - 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 • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Weight Loss - Mail Order Available		
ZEPBOUND 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	4	
ZEPBOUND 2.5 MG/0.5 ML, 5 MG/0.5 ML SOLUTION	4	

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

AV - ACIP Covered Part D vaccines • BvsD - 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 • ST - Step Therapy

Index

C

D

E

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 10/15/2024 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the Humana Medicare Employer Plan with any questions at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m., Eastern time. 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**.

GRP066PDG2580525_v1

Humana®

Humana.com