Optum Rx®

IRON ROAD HEALTHCARE

Iron Road Healthcare Medicare Part D Prescription Drug Plan (PDP)

Your 2024 Abridged Formulary (partial list of covered drugs)

Sponsored by UPREHS, administered by Optum Rx®
Effective January 1, 2024 – December 1, 2024

Please read: this document contains information about the drugs we cover in this plan.

This abridged formulary was updated on March 1, 2024, and is not a complete list of drugs covered by our plan. For more recent information or if you have questions, please contact:

Optum Rx Member Services

Phone (toll-free)**:**	**1-866-443-1095**
TTY users:	**711**
Hours of operation:	24 hours a day, 7 days a week
Website:	**optumrx.com**

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you Call Member Services 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 our plan, no matter what cost-sharing tier it's on.

Note to existing members: This formulary has changed since last year. Please review this document to make sure it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us," or "our," it means Optum Rx. When it refers to "plan" or "our plan," it means Iron Road Healthcare Medicare Part D Prescription Drug Plan.
In most instances, you must use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2024.

Formulary ID 24051
Version 11
S8841_124_MC-DS10_C_UNP

What is the Abridged Formulary?

A formulary is a list of covered drugs selected by Iron Road Healthcare in consultation with Optum Rx and a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. This plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Optum Rx network pharmacy, and other plan rules are followed.

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

Can the formulary (drug list) change?

Yes. If you are taking a drug on our 2024 formulary that is 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 generic drug becomes available, or when new adverse information about the safety or effectiveness of a drug is released.

If we make a negative change to our formulary (i.e. add prior authorization, quantity limit, and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, if applicable), we must notify affected members. Members will receive a notice regarding the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug. The member will receive a 60-day supply of the drug. If the Food and Drug Administration (FDA) 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.

The enclosed formulary is current as of 4/1/2024. To get updated information about covered drugs, please contact Optum Rx. You may also visit our website at optum.com where you will find the most up-to-date information about our list of covered drugs (formulary) by using the "Drug Information" tool (found under the "Member Tools" tab). Our contact information is shown on the front and back cover pages.

How do I use the formulary?

There are 2 ways to find your drug within the formulary:

- **Medical Condition**

  The formulary begins on page 7. The drugs in this formulary are grouped into categories depending on the type of medical condition(s) 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 7. 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 26. The Index provides an alphabetical list of all drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index.

Formulary design

The formulary structure features preferred and non-preferred generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, and high-cost drugs.

Drug Tier	Helpful Tips
Tier 1	Preferred generic drugs are listed under Tier 1 and have the lowest copayments.
Tier 2	Drugs listed under Tier 2 include non-preferred generic drugs that have higher copayments than preferred generic drugs.
Tier 3	Drugs listed under Tier 3 include preferred brand-name drugs that have lower copayments than non-preferred brand-name drugs.
Tier 4	Drugs listed under Tier 4 include non-preferred brand-name drugs that higher copayments than preferred brand-name drugs.
Tier 5	Specialty or high-cost drugs listed under Tier 5 cost $950 or more for up to a 30-day maximum supply.

Covered Prescription Drugs	**Retail Pharmacy** (up to a 30-day supply)	**Retail Pharmacy** (up to a 90-day supply)	**Depot Drug Preferred Mail-Order Pharmacy** (up to a 90-day supply)	**Non-Preferred Home Delivery Pharmacy** (up to a 90-day supply)
Cost Sharing Tier 1 (Preferred Generic Drugs)	$15	$45	$9	$45
Cost Sharing Tier 2 (Non-Preferred Generic Drugs)	$20	$60	$30	$60
Cost Sharing Tier 3 (Preferred Brand Drugs)	$40	$120	$60	$120
Cost Sharing Tier 4 (Non-Preferred Brand Drugs)	Greater of: $90 or 33%	Greater of: $270 or 33%	Greater of: $225 or 33%	Greater of: $270 or 33%
Cost Sharing Tier 5 (High-Cost Drugs) *	33%	n/a	n/a	n/a

* High-Cost drugs are those that cost $950 or more for up to a 30-day maximum supply.

You must obtain a 90-day supply of Tier 1 Generics when using Depot Drug mail. If you need less than a 90-day supply of Tier 1 Generics, you must use a retail network pharmacy. You may obtain a 30, 60, or 90-day supply of Tier 2, 3, or 4 prescription drugs from Depot Drug mail. If you use a mail-order pharmacy outside of the plan's network, your prescription will not be covered.

Please refer to your *Evidence of Coverage* for more information.

What are generic drugs?

Our 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.

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)	You or your physician may need to get prior authorization for certain drugs. This means you will need to get approval from Optum Rx before you fill your prescriptions. If you do not get approval, the drug may not be covered.
Quantity Limits (QL)	For certain drugs, there is a limit on the amount of the drug we will cover.
Step Therapy (ST)	In some cases, it is required 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

To find out if your drug has any additional requirements or limits, look in the formulary that begins on page 7. You can also get more information about restrictions applied to specific covered drugs by visiting our website or by calling Optum Rx. Our contact information, along with the date we last updated the formulary, is shown on the front and back cover pages.

You can ask Optum Rx 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 formulary?” on page 4 for additional information.

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 Optum Rx and ask if your drug is covered. This document includes only a partial list of covered drugs, so we may cover your drug. Our contact information, along with the date we last updated the formulary, is shown on the front and back cover pages.

If your drug is not covered, you have 2 options:

- You can ask Optum Rx for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.
- You can ask Optum Rx 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 formulary?

You can ask Optum Rx 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 a drug even if it is not on our formulary. If approved, the 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 the drug is not in the high-cost drug 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, we may limit 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.

Note: If we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve your request for an exception if the drug is included on the plan's formulary, or if 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 Optum Rx for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception, you must submit a statement from your doctor (or other prescriber) supporting your request.** Generally, we must make our decision within 72 hours of getting your doctor's (or other prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe 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 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 (or other prescriber) to decide if you should switch to an appropriate drug that we cover or request a formulary exception. While you talk to your doctor (or other prescriber) 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 not on our formulary, or if your ability to get your drugs is limited, we will cover a temporary 30-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. 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, we will allow you to refill your prescription until we have provided you with 31-day transition supply, written for as many pills as necessary, unless you have a prescription written for fewer days. We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If 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 for fewer days) while you get a formulary exception.

If you are a current enrollee with a level-of-care change and you need a drug that is not on our formulary, or if your ability to get your drugs is limited, we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days) while you seek a formulary exception. If you are in the process of seeking an exception, we will consider allowing continued coverage until a decision is made.

For more information

For more detailed information about your prescription drug coverage, please review your other plan materials. If you have questions about the plan, please call Optum Rx. Our contact information, along with the date we last updated the formulary, is shown 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), TTY 1-877-486-2048, 24 hours a day, 7 days a week. You may also visit medicare.gov.

Formulary

The formulary below provides coverage information about some of your covered drugs. If you have trouble finding your drug in the list, turn to the Index that begins on 26.

Remember: This is only a partial list of covered drugs. If your prescription is not in this partial list, please contact us. Our contact information, along with the date we last updated the formulary, is shown on the front and back cover pages.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., COZAAR), and generic drugs are listed in lower-case italics (e.g., *atenolol*). The following abbreviations listed in the "Requirements/Limits" column let you know if there are any special requirements for coverage of your drug.

Requirements/Limits	Helpful Tips
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 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 Days' Supply. This prescription drug is not available for an extended days' supply.
PA	Prior Authorization. Our plan requires you or your physician to get prior authorization for certain drugs. This means you will need to get approval from Optum Rx before you fill your prescriptions. If you do not get approval, your drug may not be covered.
QL	Quantity Limit. For certain drugs, our plan limits the amount of the drug we will cover.
ST	Step Therapy. In some cases, our plan 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, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
Nonsteroidal Anti-inflammatory Drugs		
celecoxib capsule	2	QL(60 EA per 30 days)
diclofenac sodium dr	2	
diclofenac sodium gel	2	QL(1000 GM per 30 days)
ibu	1	
ibuprofen tablet 400mg, 600mg, 800mg	1	
meloxicam tablet	1	
nabumetone tablet	2	
naproxen tablet 250mg, 375mg, 500mg	1	
Opioid Analgesics, Long-acting		
fentanyl patch 72 hour 100mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr	4	NDS
morphine sulfate er tablet extended release	3	NDS
XTAMPZA ER	3	NDS
Opioid Analgesics, Short-acting		
acetaminophen/codeine tablet	2	NDS
endocet tablet 325mg; 5mg	2	NDS
endocet tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 7.5mg	3	NDS
hydrocodone bitartrate/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg	2	NDS
hydrocodone/acetaminophen tablet 325mg; 7.5mg	2	NDS
hydromorphone hcl tablet 2mg, 4mg	2	NDS
hydromorphone hcl tablet 8mg	4	NDS
lorcet	2	NDS
lorcet hd	2	NDS
lorcet plus tablet 325mg; 7.5mg	2	NDS
oxycodone hydrochloride tablet 10mg, 15mg, 5mg	2	NDS
oxycodone hydrochloride tablet 20mg, 30mg	3	NDS
oxycodone/acetaminophen tablet 325mg; 5mg, 325mg; 7.5mg	2	NDS
oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg	3	NDS
tramadol hydrochloride tablet 50mg	1	NDS
vicodin hp tablet 300mg; 10mg	4	NDS
Anti-Addiction/Substance Abuse Treatment Agents		
Opioid Reversal Agents		
naloxone hydrochloride liquid	3	
Antibacterials		
Antibacterials, Other		
clindamycin hcl capsule 300mg	2	
clindamycin hydrochloride capsule 150mg, 75mg	2	
metronidazole tablet	1	
nitrofurantoin monohydrate/macrocrystals	2	
nitrofurantoin monohydrate capsule	2	

Drug Name	Drug Tier	Requirements/Limits
Beta-lactam, Cephalosporins		
cefadroxil capsule	2	
cefdinir capsule	2	
cefpodoxime proxetil tablet	4	
cefuroxime axetil tablet	2	
cephalexin capsule 250mg, 500mg	2	
Beta-lactam, Penicillins		
amoxicillin/clavulanate potassium tablet 500mg; 125mg, 875mg; 125mg	2	
amoxicillin/clavulanate potassium tablet 250mg; 125mg	4	
amoxicillin capsule, tablet	1	
Macrolides		
azithromycin tablet 250mg	1	
azithromycin tablet 500mg, 600mg	3	
DIFICID TABLET	5	
Quinolones		
ciprofloxacin hcl tablet 750mg	1	
ciprofloxacin hcl tablet 100mg	3	
ciprofloxacin hydrochloride tablet 250mg, 500mg	1	
levofloxacin tablet	2	
Sulfonamides		
sulfamethoxazole/trimethoprim ds	1	
sulfamethoxazole/trimethoprim tablet	1	
Tetracyclines		
doxycycline hyclate capsule 100mg, 50mg	2	
doxycycline hyclate tablet 100mg	2	
doxycycline monohydrate tablet 100mg, 50mg	2	
morgidox 1x100mg capsule	2	
morgidox 2x100mg capsule	2	
Anticonvulsants		
Anticonvulsants, Other		
lamotrigine tablet	1	
levetiracetam tablet	2	
roweepra	2	
subvenite	1	
topiramate tablet	1	
Gamma-aminobutyric Acid (GABA) Augmenting Agents		
clonazepam tablet 2mg	1	QL(300 EA per 30 days)
clonazepam tablet 0.5mg, 1mg	1	QL(90 EA per 30 days)
divalproex sodium dr	2	
gabapentin capsule 100mg, 300mg	1	QL(360 EA per 30 days)
gabapentin capsule 400mg	2	QL(270 EA per 30 days)
gabapentin tablet 800mg	2	QL(150 EA per 30 days)
gabapentin tablet 600mg	2	QL(180 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
primidone tablet	2	
Antidementia Agents		
Cholinesterase Inhibitors		
donepezil hcl tablet 10mg	1	
donepezil hcl tablet 23mg	4	
donepezil hydrochloride tablet 10mg, 5mg	1	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hcl titration pak	2	
memantine hydrochloride tablet	2	
Antidepressants		
Antidepressants, Other		
bupropion hydrochloride er (sr) tablet extended release 12 hour 150mg, 200mg	2	QL(60 EA per 30 days)
bupropion hydrochloride er (sr) tablet extended release 12 hour 100mg	2	QL(90 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 300mg	2	QL(30 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 150mg	2	QL(90 EA per 30 days)
mirtazapine tablet	2	
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
citalopram hydrobromide tablet	1	
duloxetine hydrochloride capsule delayed release particles 20mg, 60mg	2	QL(60 EA per 30 days)
duloxetine hydrochloride capsule delayed release particles 30mg	2	QL(90 EA per 30 days)
escitalopram oxalate tablet	1	
fluoxetine hydrochloride capsule	1	
paroxetine hcl tablet 30mg, 40mg	2	
paroxetine hydrochloride tablet 10mg, 20mg	2	
sertraline hcl tablet 50mg	1	
sertraline hydrochloride tablet 100mg, 25mg	1	
trazodone hydrochloride tablet 100mg, 150mg, 50mg	1	
TRINTELLIX	4	QL(30 EA per 30 days)
venlafaxine hydrochloride er capsule extended release 24 hour	2	
Tricyclics		
amitriptyline hcl tablet 100mg, 150mg, 25mg, 75mg	3	
amitriptyline hydrochloride tablet 100mg, 10mg, 50mg	3	
nortriptyline hcl capsule 25mg, 75mg	2	
nortriptyline hydrochloride capsule 10mg, 50mg	2	
Antiemetics		
Antiemetics, Other		

Drug Name	Drug Tier	Requirements/Limits
meclizine hcl tablet	4	
prochlorperazine maleate tablet	2	
Emetogenic Therapy Adjuncts		
ondansetron hydrochloride tablet	1	B/D
ondansetron odt	2	B/D
Antifungals		
Antifungals		
fluconazole tablet	2	
ketoconazole shampoo	2	
ketoconazole cream	2	QL(90 GM per 30 days)
nyamyc	2	QL(120 GM per 30 days)
nystatin powder	2	QL(120 GM per 30 days)
nystop	2	QL(120 GM per 30 days)
Antigout Agents		
Antigout Agents		
allopurinol tablet 100mg, 300mg	1	
colchicine tablet 0.6mg	3	
Antimigraine Agents		
Prophylactic		
AIMOVIG INJECTION 140MG/ML	4	QL(1 ML per 28 days); PA
AIMOVIG INJECTION 70MG/ML	4	QL(2 ML per 28 days); PA
EMGALITY INJECTION 120MG/ML	4	QL(2 ML per 28 days); PA
EMGALITY INJECTION 100MG/ML	5	QL(3 ML per 28 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		
sumatriptan succinate tablet	2	QL(9 EA per 30 days)
Antineoplastics		
Antiandrogens		
ERLEADA	5	PA
NUBEQA	5	PA
XTANDI	5	PA
Aromatase Inhibitors, 3rd Generation		
anastrozole tablet	1	
letrozole	2	
Antiparasitics		
Antiprotozoals		
hydroxychloroquine sulfate tablet 100mg, 200mg	2	
Antiparkinson Agents		
Dopamine Agonists		
pramipexole dihydrochloride	2	
ropinirole hcl tablet 0.5mg, 1mg, 2mg, 4mg, 5mg	2	
ropinirole hydrochloride tablet 0.25mg, 3mg	2	

Drug Name	Drug Tier	Requirements/Limits
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	2	
INBRIJA	5	PA
RYTARY	4	ST
Antipsychotics		
2nd Generation/Atypical		
aripiprazole tablet	2	QL(30 EA per 30 days)
ARISTADA	5	
ARISTADA INITIO	5	
INVEGA HAFYERA	5	ST
INVEGA SUSTENNA INJECTION 39MG/0.25ML	4	
INVEGA SUSTENNA INJECTION 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	5	
INVEGA TRINZA	5	
olanzapine tablet	2	QL(30 EA per 30 days)
PERSERIS	5	
quetiapine fumarate tablet 300mg, 400mg	2	QL(60 EA per 30 days)
quetiapine fumarate tablet 100mg, 150mg, 200mg, 25mg, 50mg	2	QL(90 EA per 30 days)
REXULTI	5	QL(30 EA per 30 days)
RISPERDAL CONSTA INJECTION 12.5MG	4	
RISPERDAL CONSTA INJECTION 25MG, 37.5MG, 50MG	5	
risperidone tablet	1	QL(60 EA per 30 days)
Antispasticity Agents		
Antispasticity Agents		
baclofen tablet 10mg, 20mg	2	
baclofen tablet 5mg	3	
tizanidine hcl tablet 2mg	2	
tizanidine hydrochloride tablet 4mg	2	
Antivirals		
Anti-hepatitis C (HCV) Agents		
MAVYRET TABLET	5	QL(336 EA per 365 days); PA
MAVYRET PACKET	5	QL(560 EA per 365 days); PA
sofosbuvir/velpatasvir	5	QL(84 EA per 365 days); PA
VOSEVI	5	QL(84 EA per 365 days); PA
Antiherpetic Agents		
acyclovir tablet	2	
valacyclovir hydrochloride	3	QL(120 EA per 30 days)
Anxiolytics		
Anxiolytics, Other		
buspirone hcl tablet 15mg	1	
buspirone hydrochloride tablet 10mg, 5mg	1	
buspirone hydrochloride tablet 30mg, 7.5mg	4	

Drug Name	Drug Tier	Requirements/Limits
Benzodiazepines		
alprazolam tablet 0.25mg, 0.5mg, 1mg	2	QL(120 EA per 30 days)
alprazolam tablet 2mg	2	QL(150 EA per 30 days)
diazepam tablet 10mg	2	QL(120 EA per 30 days)
diazepam tablet 5mg	2	QL(240 EA per 30 days)
diazepam tablet 2mg	2	QL(300 EA per 30 days)
lorazepam tablet 2mg	2	QL(150 EA per 30 days)
lorazepam tablet 0.5mg, 1mg	2	QL(90 EA per 30 days)
Blood Glucose Regulators		
Antidiabetic Agents		
FARXIGA	3	
glimepiride	1	
glipizide er	1	
glipizide xl	1	
glipizide tablet 10mg, 5mg	1	
GLYXAMBI	3	
JANUMET	3	
JANUMET XR	3	
JANUVIA	3	QL(30 EA per 30 days)
JARDIANCE	3	
JENTADUETO	3	
JENTADUETO XR	3	
metformin hydrochloride er tablet extended release 24 hour 500mg, 750mg	1	
metformin hydrochloride tablet 1000mg, 500mg, 850mg	1	
MOUNJARO	3	QL(2 ML per 28 days); PA
OZEMPIC INJECTION 2MG/1.5ML	3	QL(1.5 ML per 28 days); PA
OZEMPIC INJECTION 2MG/1.5ML, 2MG/3ML, 4MG/3ML, 8MG/3ML	3	QL(3 ML per 28 days); PA
pioglitazone hcl tablet 45mg	1	
pioglitazone hydrochloride tablet 15mg, 30mg	1	
RYBELSUS TABLET 14MG, 7MG	3	QL(30 EA per 30 days); PA
RYBELSUS TABLET 3MG	3	QL(60 EA per 365 days); PA
SOLIQUA 100/33	3	
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	
GVOKE HYPOPEN 1-PACK	3	

Drug Name	Drug Tier	Requirements/Limits
GVOKE HYPOPEN 2-PACK	3	
GVOKE KIT	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 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	
LEVEMIR FLEXTOUCH	3	
LYUMJEV	3	
LYUMJEV KWIKPEN	3	
NOVOLIN 70/30	3	
NOVOLIN 70/30 FLEXPEN	3	
NOVOLIN N	3	
NOVOLIN N FLEXPEN	3	
NOVOLIN N FLEXPEN RELION	3	
NOVOLIN N RELION	3	
NOVOLIN R	3	
NOVOLIN R FLEXPEN	3	
NOVOLIN R RELION	3	
NOVOLOG	3	
NOVOLOG FLEXPEN	3	
NOVOLOG FLEXPEN RELION	3	
NOVOLOG MIX 70/30	3	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	3	
NOVOLOG PENFILL	3	
TOUJEO MAX SOLOSTAR	3	
TOUJEO SOLOSTAR	3	
TRESIBA	3	
TRESIBA FLEXTOUCH	3	

Drug Name	Drug Tier	Requirements/Limits
Blood Products and Modifiers		
Anticoagulants		
ELIQUIS TABLET 2.5MG	3	QL(60 EA per 30 days)
ELIQUIS TABLET 5MG	3	QL(90 EA per 30 days)
jantoven	1	
warfarin sodium tablet	1	
XARELTO TABLET 10MG, 20MG	3	QL(30 EA per 30 days)
XARELTO TABLET 15MG, 2.5MG	3	QL(60 EA per 30 days)
Blood Products and Modifiers, Other		
NEULASTA	5	PA
NEULASTA ONPRO KIT	5	PA
PROCRIT INJECTION 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA
PROCRIT INJECTION 40000UNIT/ML	5	PA
RETACRIT INJECTION 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	4	PA
RETACRIT INJECTION 40000UNIT/ML	5	PA
UDENYCA	5	PA
ZARXIO	5	
Platelet Modifying Agents		
BRILINTA	3	
clopidogrel tablet 75mg	1	
clopidogrel tablet 300mg	2	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hydrochloride tablet	1	
midodrine hcl	2	
Alpha-adrenergic Blocking Agents		
terazosin hcl capsule 10mg, 1mg, 5mg	1	
terazosin hydrochloride capsule 2mg	1	
Angiotensin II Receptor Antagonists		
EDARBI	4	
irbesartan	1	
losartan potassium tablet	1	
olmesartan medoxomil tablet	1	
telmisartan	1	
valsartan tablet	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
benazepril hcl tablet 10mg, 40mg, 5mg	1	
benazepril hydrochloride tablet 20mg	1	
enalapril maleate tablet	1	
lisinopril tablet	1	
ramipril	1	

Drug Name	Drug Tier	Requirements/Limits
Antiarrhythmics		
amiodarone hydrochloride tablet 200mg	1	
amiodarone hydrochloride tablet 100mg, 400mg	3	
digitek tablet 0.125mg, 0.25mg	2	
digox	2	
digoxin tablet 125mcg, 250mcg, 62.5mcg	2	
flecainide acetate	2	
MULTAQ	3	
PACERONE TABLET 200MG	1	
PACERONE TABLET 100MG, 400MG	3	
sorine	2	
sotalol hcl	2	
sotalol hydrochloride tablet 120mg, 160mg, 80mg	2	
Beta-adrenergic Blocking Agents		
atenolol tablet	1	
bisoprolol fumarate	2	
carvedilol	1	
metoprolol succinate er	1	
metoprolol tartrate tablet	1	
nebivolol hydrochloride	3	
nebivolol tablet 5mg	3	
propranolol hcl er capsule extended release 24 hour 120mg, 160mg	2	
propranolol hcl tablet 40mg	2	
propranolol hydrochloride er capsule extended release 24 hour 60mg, 80mg	2	
propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg	2	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate tablet	1	
nifedipine er	2	
Calcium Channel Blocking Agents, Nondihydropyridines		
cartia xt	2	
diltiazem hcl cd	2	
diltiazem hydrochloride er capsule extended release 24 hour	2	
verapamil hcl er tablet extended release 120mg, 240mg	2	
verapamil hydrochloride er tablet extended release 180mg	2	
Cardiovascular Agents, Other		
amlodipine besylate/benazepril hydrochloride	1	
CORLANOR TABLET	4	QL(60 EA per 30 days); PA
EDARBYCLOR	4	
ENTRESTO	3	QL(60 EA per 30 days)
lisinopril/hydrochlorothiazide	1	
losartan potassium/hydrochlorothiazide	1	
triamterene/hydrochlorothiazide capsule 25mg; 37.5mg	1	

Drug Name	Drug Tier	Requirements/Limits
triamterene/hydrochlorothiazide tablet	1	
valsartan/hydrochlorothiazide	1	
Diuretics, Loop		
bumetanide tablet	2	
furosemide tablet	1	
torsemide tablet	1	
Diuretics, Potassium-sparing		
spironolactone tablet	1	
Diuretics, Thiazide		
chlorthalidone tablet 25mg, 50mg	2	
hydrochlorothiazide capsule, tablet	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate tablet 145mg, 160mg, 48mg, 54mg	2	
Dyslipidemics, HMG CoA Reductase Inhibitors		
LIVALO	4	ST
lovastatin tablet	1	
pravastatin sodium	1	
rosuvastatin calcium	1	
simvastatin tablet	1	
Dyslipidemics, Other		
ezetimibe	2	
PRALUENT	3	QL(2 ML per 28 days); PA
REPATHA	3	QL(3 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 tablet sublingual 0.3mg, 0.4mg, 0.6mg	2	
VERQUVO	3	QL(30 EA per 30 days); PA
Vasodilators, Direct-acting Arterial		
hydralazine hcl tablet 10mg	1	
hydralazine hydrochloride tablet 25mg, 50mg	1	
hydralazine hydrochloride tablet 100mg	2	
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine/dextroamphetamine tablet	3	QL(90 EA per 30 days)
Central Nervous System, Other		
AUSTEDO	5	QL(120 EA per 30 days); PA
INGREZZA CAPSULE 60MG, 80MG	5	QL(30 EA per 30 days); PA
INGREZZA CAPSULE 40MG	5	QL(60 EA per 30 days); PA
NUEDEXTA	5	PA
Fibromyalgia Agents		
pregabalin capsule 300mg	2	QL(60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
pregabalin capsule 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg	2	QL(90 EA per 30 days)
Multiple Sclerosis Agents		
AVONEX PEN	5	QL(4 EA per 28 days); PA
AVONEX INJECTION 30MCG/0.5ML	5	QL(4 EA per 28 days); PA
BETASERON	5	QL(15 EA per 30 days); PA
KESIMPTA	5	QL(0.4 ML per 28 days); PA
MAYZENT TABLET 0.25MG	5	QL(120 EA per 30 days); PA
MAYZENT TABLET 1MG, 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
ZEPOSIA	5	QL(30 EA per 30 days); PA
Dental and Oral Agents		
Dental and Oral Agents		
chlorhexidine gluconate solution	1	
doxycycline hyclate tablet 20mg	3	
paroex	1	
Dermatological Agents		
Acne and Rosacea Agents		
FINACEA FOAM	3	QL(50 GM per 30 days)
Dermatitis and Pruitus Agents		
ALA-CORT CREAM 2.5%	2	
clobetasol propionate cream, ointment	2	
clobetasol propionate solution	3	
hydrocortisone cream 2.5%	2	
triamcinolone acetonide cream	2	
triamcinolone acetonide ointment 0.025%, 0.1%, 0.5%	2	
triderm	2	
Dermatological Agents, Other		
clotrimazole/betamethasone dipropionate cream	2	
fluorouracil cream 5%	2	QL(40 GM per 30 days)
OTEZLA TABLET 30MG	5	QL(60 EA per 30 days); PA
SANTYL	4	
Topical Anti-infectives		
ciclodan solution	2	PA
ciclopirox nail lacquer	2	PA
mupirocin ointment	2	QL(110 GM per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
klor-con 10	2	
klor-con 8	2	
klor-con m10	2	

Drug Name	Drug Tier	Requirements/Limits
klor-con m15	3	
klor-con m20	2	
klor-con sprinkle	2	
potassium chloride er capsule extended release	2	
potassium chloride er tablet extended release 10meq, 20meq, 8meq	2	
potassium chloride er tablet extended release 15meq	3	
potassium chloride sr tablet extended release 8meq	2	
Phosphate Binders		
VELPHORO	5	
Potassium Binders		
VELTASSA	4	
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose	2	
lactulose solution	2	
LINZESS	3	QL(30 EA per 30 days)
MOTEGRITY	3	QL(30 EA per 30 days)
Antispasmodics, Gastrointestinal		
dicyclomine hydrochloride capsule	2	
Gastrointestinal Agents, Other		
CLENPIQ	3	
gavilyte-c	2	
gavilyte-g	2	
peg 3350/electrolytes	2	
peg-3350/electrolytes	2	
XIFAXAN TABLET 550MG	5	PA
Histamine2 (H2) Receptor Antagonists		
famotidine tablet 20mg, 40mg	2	
Protectants		
sucralfate tablet	2	
Proton Pump Inhibitors		
esomeprazole magnesium capsule delayed release	2	QL(60 EA per 30 days)
lansoprazole capsule delayed release	2	QL(60 EA per 30 days)
omeprazole dr capsule delayed release 10mg	1	QL(60 EA per 30 days)
omeprazole capsule delayed release 10mg, 20mg, 40mg	1	QL(60 EA per 30 days)
pantoprazole sodium tablet delayed release	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 CAPSULE DELAYED RELEASE PARTICLES 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	3	
ZENPEP CAPSULE DELAYED RELEASE PARTICLES 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 TABLET EXTENDED RELEASE 24 HOUR	3	
oxybutynin chloride er	2	
oxybutynin chloride tablet 5mg	2	
solifenacin succinate	2	
trospium chloride	3	
Benign Prostatic Hypertrophy Agents		
doxazosin mesylate	2	
dutasteride capsule	2	
finasteride tablet	1	
tamsulosin hydrochloride	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
dexamethasone tablet 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	2	
methylprednisolone dose pack tablet therapy pack	2	
prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
GENOTROPIN	5	PA
GENOTROPIN MINIQUICK	5	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
Estrogens		
estradiol cream, oral tablet	2	
estradiol vaginal tablet	4	
PREMARIN CREAM	4	
PREMARIN TABLET 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	4	
PREMPHASE	4	

Drug Name	Drug Tier	Requirements/Limits
PREMPRO	4	
yuvafem	4	
Selective Estrogen Receptor Modifying Agents		
OSPHENA	3	QL(30 EA per 30 days); PA
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
ARMOUR THYROID	4	
EUTHYROX TABLET 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 25MCG, 50MCG, 75MCG, 88MCG	3	
LEVO-T	3	
levothyroxine sodium tablet	1	
LEVOXYL TABLET 100MCG, 112MCG, 125MCG, 137MCG, 150MCG, 175MCG, 200MCG, 25MCG, 50MCG, 75MCG, 88MCG	3	
np thyroid 120	4	
np thyroid 15	4	
np thyroid 30	4	
np thyroid 60	4	
np thyroid 90	4	
SYNTHROID TABLET	3	
THYROID TABLET 120MG, 15MG, 30MG, 60MG, 90MG	4	
UNITHROID	3	
Hormonal Agents, Suppressant (Pituitary)		
Hormonal Agents, Suppressant (Pituitary)		
LUPRON DEPOT (1-MONTH)	5	QL(1 EA per 28 days); PA
LUPRON DEPOT (3-MONTH)	5	QL(1 EA per 84 days); PA
LUPRON DEPOT (4-MONTH)	5	QL(1 EA per 112 days); PA
LUPRON DEPOT (6-MONTH)	5	QL(1 EA per 168 days); PA
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole tablet 10mg, 5mg	2	
Immunological Agents		
Immunological Agents, Other		
COSENTYX SENSOREADY PEN	5	QL(10 ML per 28 days); PA
COSENTYX INJECTION 150MG/ML, 75MG/0.5ML	5	QL(10 ML per 28 days); PA
DUPIXENT INJECTION 100MG/0.67ML	5	QL(1.34 ML per 28 days); PA
DUPIXENT INJECTION 200MG/1.14ML	5	QL(4.56 ML per 28 days); PA
DUPIXENT INJECTION 300MG/2ML	5	QL(8 ML per 28 days); PA
OTEZLA TABLET THERAPY PACK 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 INJECTION 75MG/0.83ML	5	PA
SKYRIZI INJECTION 150MG/ML	5	QL(1 ML per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI INJECTION 180MG/1.2ML	5	QL(1.2 ML per 56 days); PA
SKYRIZI INJECTION 360MG/2.4ML	5	QL(2.4 ML per 56 days); PA
STELARA INJECTION 130MG/26ML	5	PA
STELARA INJECTION 45MG/0.5ML, 90MG/ML	5	QL(3 ML per 84 days); PA
VYVGART HYTRULO	5	PA
XELJANZ XR	5	QL(30 EA per 30 days); PA
XELJANZ SOLUTION	5	QL(300 ML per 30 days); PA
XELJANZ TABLET	5	QL(60 EA per 30 days); PA
Immunosuppressants		
ASTAGRAF XL	4	B/D
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	5	QL(6 EA per 28 days); PA
CYLTEZO STARTER PACKAGE FOR PSORIASIS	5	QL(6 EA per 28 days); PA
CYLTEZO INJECTION 10MG/0.2ML, 20MG/0.4ML	5	QL(2 EA per 28 days); PA
CYLTEZO INJECTION 40MG/0.8ML	5	QL(6 EA per 28 days); PA
ENBREL MINI	5	QL(8 ML per 28 days); PA
ENBREL SURECLICK	5	QL(8 ML per 28 days); PA
ENBREL INJECTION 25MG	5	PA
ENBREL INJECTION 25MG/0.5ML	5	QL(4 ML per 28 days); PA
ENBREL INJECTION 50MG/ML	5	QL(8 ML per 28 days); PA
ENVARSUS XR TABLET EXTENDED RELEASE 24 HOUR 0.75MG, 1MG	4	B/D
ENVARSUS XR TABLET EXTENDED RELEASE 24 HOUR 4MG	5	B/D
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 0	5	QL(4 EA per 365 days); PA
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 80MG/0.8ML	5	QL(6 EA per 365 days); PA
HUMIRA PEN-CD/UC/HS STARTER INJECTION 80MG/0.8ML	5	QL(4 EA per 28 days); PA
HUMIRA PEN-CD/UC/HS STARTER INJECTION 40MG/0.8ML	5	QL(6 EA per 28 days); PA
HUMIRA PEN-PEDIATRIC UC STARTER PACK	5	QL(4 EA per 28 days); PA
HUMIRA PEN-PS/UV STARTER INJECTION 40MG/0.8ML	5	QL(6 EA per 28 days); PA
HUMIRA PEN-PS/UV STARTER INJECTION 0	5	QL(6 EA per 365 days); PA
HUMIRA PEN INJECTION 40MG/0.4ML, 80MG/0.8ML	5	QL(4 EA per 28 days); PA
HUMIRA PEN INJECTION 40MG/0.8ML	5	QL(6 EA per 28 days); PA
HUMIRA INJECTION 10MG/0.1ML, 20MG/0.2ML, 40MG/0.8ML	5	QL(2 EA per 28 days); PA
HUMIRA INJECTION 40MG/0.4ML	5	QL(4 EA per 28 days); PA
methotrexate sodium tablet	2	
YUFLYMA 1-PEN KIT	5	QL(6 EA per 28 days); PA
Vaccines		

Drug Name	Drug Tier	Requirements/Limits
ADACEL	3	
BOOSTRIX	3	
SHINGRIX	3	
Inflammatory Bowel Disease Agents		
Glucocorticoids		
procto-med hc	2	
proctosol hc	2	
proctozone-hc	2	
Metabolic Bone Disease Agents		
Metabolic Bone Disease Agents		
alendronate sodium tablet 10mg, 35mg, 5mg	1	
alendronate sodium tablet 70mg	1	QL(4 EA per 28 days)
calcitriol capsule	2	
FORTEO INJECTION 600MCG/2.4ML	5	PA
ibandronate sodium tablet	2	QL(1 EA per 28 days)
PROLIA	4	QL(2 ML per 365 days)
RAYALDEE	5	
TYMLOS	5	PA
Miscellaneous Therapeutic Agents		
Miscellaneous Therapeutic Agents		
B-D INSULIN SYRINGE ULTRAFINE II/0.3ML/31G X 5/16"	2	QL(200 EA per 30 days)
BD INSULIN SYRINGE SAFETYGLIDE/1ML/29G X 1/2"	2	QL(200 EA per 30 days)
BD INSULIN SYRINGE ULTRA-FINE/0.5ML/30G X 12.7MM	2	QL(200 EA per 30 days)
BD INSULIN SYRINGE ULTRA-FINE/1ML/31G X 8MM	2	QL(200 EA per 30 days)
BD PEN NEEDLE/ORIGINAL/ULTRA-FINE/29G X 12.7MM	2	QL(200 EA per 30 days)
bd veo insulin syringe ultra-fine/0.3ml/31g x 6mm	2	QL(200 EA per 30 days)
OMNIPOD 5 G6 INTRO KIT (GEN 5)	3	QL(1 EA per 365 days)
OMNIPOD 5 G6 PODS (GEN 5)	3	QL(30 EA per 30 days)
OMNIPOD CLASSIC PDM STARTER KIT (GEN 3)	3	QL(1 EA per 365 days)
OMNIPOD CLASSIC PODS (GEN 3)	3	QL(30 EA per 30 days)
OMNIPOD DASH INTRO KIT (GEN 4)	3	QL(1 EA per 365 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 TABLET THERAPY PACK 150MG; 100MG	3	QL(20 EA per 5 days); $0 Copay
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	3	QL(30 EA per 5 days); (300mg-100mg Pak) $0 Copay
ulticare micro pen needles/32g x 5/32"	2	QL(200 EA per 30 days)
unifine pentips 32gx6mm	2	QL(200 EA per 30 days)
V-GO 20	3	
V-GO 30	3	
V-GO 40	3	

Drug Name	Drug Tier	Requirements/Limits
Ophthalmic Agents		
Ophthalmic Agents, Other		
COMBIGAN	3	
cyclosporine	3	
dorzolamide hcl/timolol maleate	2	
neomycin/polymyxin/dexamethasone suspension	2	
polymyxin b sulfate/trimethoprim sulfate	1	
RESTASIS	3	
RESTASIS MULTIDOSE	3	
ROCKLATAN	3	QL(2.5 ML per 25 days)
SIMBRINZA	3	
XIIDRA	4	QL(60 EA per 30 days)
ZYLET	4	
Ophthalmic Anti-Infectives		
erythromycin	2	
ofloxacin	2	
ZIRGAN	4	
Ophthalmic Anti-inflammatories		
ILEVRO	3	QL(4 ML per 30 days)
ketorolac tromethamine solution 0.5%	2	
ketorolac tromethamine solution 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 solution	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
ALPHAGAN P SOLUTION 0.1%	3	
brimonidine tartrate solution 0.2%	2	
dorzolamide hydrochloride	2	
RHOPRESSA	3	QL(2.5 ML per 25 days)
Ophthalmic Prostaglandin and Prostamide Analogs		
latanoprost solution	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)
ASMANEX TWISTHALER 60 METERED DOSES	4	QL(1 EA per 30 days)
ASMANEX TWISTHALER 7 METERED DOSES	4	QL(1 EA per 30 days)
BREZTRI AEROSPHERE	3	QL(23.6 GM per 28 days)

Drug Name	Drug Tier	Requirements/Limits
fluticasone propionate	1	
Antihistamines		
azelastine hcl solution 0.15%	2	QL(60 ML per 30 days)
azelastine hydrochloride solution 0.1%	2	QL(60 ML per 30 days)
hydroxyzine hcl tablet 50mg	3	
hydroxyzine hydrochloride tablet 10mg, 25mg	3	
levocetirizine dihydrochloride tablet	2	
Antileukotrienes		
montelukast sodium tablet	1	
Bronchodilators, Anticholinergic		
ATROVENT HFA	4	QL(25.8 GM per 30 days)
INCRUSE ELLIPTA	3	QL(30 EA per 30 days)
ipratropium bromide solution	2	
LONHALA MAGNAIR REFILL KIT	5	QL(60 ML per 30 days)
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5MCG/ACT	3	
SPIRIVA RESPIMAT AEROSOL SOLUTION 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 aerosol solution 108mcg/act	2	QL(13.4 GM per 30 days)
albuterol sulfate hfa aerosol solution 108mcg/act	2	QL(17 GM per 30 days)
albuterol sulfate hfa aerosol solution 108mcg/act	2	QL(48 GM per 30 days)
SEREVENT DISKUS	3	QL(60 EA per 30 days)
Pulmonary Antihypertensives		
OPSUMIT	5	QL(30 EA per 30 days); PA
ORENITRAM TITRATION KIT MONTH 1	5	QL(336 EA per 365 days); PA
ORENITRAM TITRATION KIT MONTH 2	5	QL(672 EA per 365 days); PA
ORENITRAM TITRATION KIT MONTH 3	5	QL(504 EA per 365 days); PA
ORENITRAM TABLET EXTENDED RELEASE 0.25MG, 1MG, 2.5MG, 5MG	5	PA
Pulmonary Fibrosis Agents		
OFEV	5	PA
Respiratory Tract Agents, Other		
BREO ELLIPTA AEROSOL POWDER BREATH ACTIVATED 100MCG/ACT; 25MCG/ACT, 200MCG/INH; 25MCG/INH	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)
fluticasone propionate/salmeterol aerosol powder breath activated 500mcg/act; 50mcg/act	2	QL(60 EA per 30 days)
NUCALA INJECTION 40MG/0.4ML	5	QL(0.4 ML per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
NUCALA INJECTION 100MG	5	QL(3 EA per 28 days); PA
NUCALA INJECTION 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		
Skeletal Muscle Relaxants		
cyclobenzaprine hydrochloride tablet 10mg, 5mg	3	
methocarbamol tablet 500mg, 750mg	4	
Sleep Disorder Agents		
Sleep Promoting Agents		
BELSOMRA	3	QL(30 EA per 30 days)
temazepam capsule 15mg, 30mg	3	QL(30 EA per 30 days)
zolpidem tartrate tablet	2	QL(30 EA per 30 days)

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Email: **Optum_Civil_Rights@Optum.com**

If you need help filing a complaint, please call the number located on the back of your prescription ID card (TTY 711). Representatives are available 24 hours a day, 7 days a week. You can also file a complaint directly with the U.S. Department of Health and Human Services online, by phone, or by mail:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at:
https://www.hhs.gov/ocr/office/file/index.html

Phone: Toll-free **1-800-368-1019**, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

This information is available in other formats like large print. To ask for another format, please call the telephone number listed on your health plan ID card.

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 1-866-443-1095. 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 1-866-443-1095. 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 1-866-443-1095。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 1-866-443-1095。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 1-866-443-1095. 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 1-866-443-1095. 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 1-866-443-1095 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 1-866-443-1095. 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 1-866-443-1095 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 1-866-443-1095. 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 1-866-443-1095 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 1-866-443-1095 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 1-866-443-1095. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-866-443-1095. 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 1-866-443-1095. 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 1-866-443-1095. Ta usługa jest 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、1-866-443-1095 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。

This formulary was updated on March 1, 2024, and is a partial listing of drugs covered by our plan.

For a complete listing or if you have questions, please contact:

Optum Rx Member Services

Phone (toll-free)**:**	**1-866-443-1095**
TTY users:	**711**
Hours of operation:	24 hours a day, 7 days a week
Website:	**optumrx.com**

Optum Rx® **optumrx.com**

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Abridged Formulary