County of Orange Medicare Prescription Drug Plan

Your 2024 Abridged Formulary **(partial list of covered drugs)**

Administered by Optum Rx®

Effective January 1, 2024

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

This abridged formulary was updated on August 18, 2023, 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)**:**	**1-800-908-9097**
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 County of Orange.

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, 2025.

Last updated date: August 18, 2023
Formulary ID 24047
Version 6

What is the Abridged Formulary?

A formulary is a list of covered drugs selected by County of Orange 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 January 1, 2024. To get updated information about covered drugs, please contact Optum Rx. You may also visit our website at optumrx.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 31. 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 generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, and high-cost drugs.

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

* High-Cost (and some Specialty) drugs are those that cost $950 or more for up to a 30-day maximum supply. These types of drugs are in the Abridged Formulary as NDS under the Requirements/Limits column.

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.

This plan does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, we only cover drugs, vaccines, biological products, and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on our drug list (formulary).

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 page 31.

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		
CELEBREX	3	QL(60 EA per 30 days)
celecoxib capsule	1	QL(60 EA per 30 days)
diclofenac sodium dr	3	
diclofenac sodium gel	1	QL(1000 GM per 30 days)
ibu	1	
ibuprofen tablet 400mg, 600mg, 800mg	1	
meloxicam tablet	1	
nabumetone tablet	1	
naproxen tablet 250mg, 375mg, 500mg	1	
RELAFEN	4	
RELAFEN DS	4	
VOLTAREN GEL	3	QL(1000 GM per 30 days)
Opioid Analgesics, Long-acting		
DURAGESIC PATCH 72 HOUR 12MCG/HR, 25MCG/HR	3	NDS
DURAGESIC PATCH 72 HOUR 100MCG/HR, 50MCG/HR, 75MCG/HR	4	NDS
fentanyl patch 72 hour 100mcg/hr, 12mcg/hr, 25mcg/hr, 37.5mcg/hr, 50mcg/hr, 62.5mcg/hr, 75mcg/hr	1	NDS
fentanyl patch 72 hour 87.5mcg/hr	4	NDS
morphine sulfate er tablet extended release	1	NDS
MS CONTIN TABLET EXTENDED RELEASE 15MG, 30MG	3	NDS
MS CONTIN TABLET EXTENDED RELEASE 100MG, 200MG, 60MG	4	NDS
XTAMPZA ER	2	NDS
Opioid Analgesics, Short-acting		
acetaminophen/codeine tablet	1	NDS
DILAUDID TABLET 2MG, 4MG, 8MG	3	NDS
endocet tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	NDS
hydrocodone bitartrate/acetaminophen tablet 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg, 325mg; 10mg, 325mg; 5mg	1	NDS
hydrocodone/acetaminophen tablet 325mg; 7.5mg	1	NDS
hydromorphone hcl tablet	1	NDS
lorcet	1	NDS
lorcet hd	1	NDS
lorcet plus tablet 325mg; 7.5mg	1	NDS
lortab tablet 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg	1	NDS
NALOCET	4	NDS
NORCO	3	NDS
OXAYDO TABLET 5MG	3	NDS
OXAYDO TABLET 7.5MG	4	NDS

Drug Name	Drug Tier	Requirements/Limits
OXYCODONE AND ACETAMINOPHEN	4	NDS
oxycodone hydrochloride tablet	1	NDS
OXYCODONE/ACETAMINOPHEN TABLET 300MG; 10MG, 300MG; 2.5MG, 300MG; 5MG	4	NDS
oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	NDS
PERCOCET TABLET 325MG; 2.5MG	3	NDS
PERCOCET TABLET 325MG; 10MG, 325MG; 5MG, 325MG; 7.5MG	4	NDS
PRIMLEV	4	NDS
PROLATE TABLET	4	NDS
ROXICODONE TABLET 15MG, 5MG	3	NDS
ROXICODONE TABLET 30MG	4	NDS
tramadol hcl tablet	1	NDS
tramadol hydrochloride tablet 100mg	1	NDS
TYLENOL/CODEINE #3	3	NDS
TYLENOL/CODEINE #4	3	NDS
ULTRAM	3	NDS
vicodin es tablet 300mg; 7.5mg	1	NDS
vicodin hp tablet 300mg; 10mg	1	NDS
vicodin tablet 300mg; 5mg	1	NDS
Anti-Addiction/Substance Abuse Treatment Agents		
Opioid Dependence		
buprenorphine hydrochloride/naloxone hydrochloride film 12mg; 3mg, 4mg; 1mg	1	QL(60 EA per 30 days)
buprenorphine hydrochloride/naloxone hydrochloride film 2mg; 0.5mg, 8mg; 2mg	1	QL(90 EA per 30 days)
SUBOXONE FILM 12MG; 3MG, 4MG; 1MG	2	QL(60 EA per 30 days)
SUBOXONE FILM 2MG; 0.5MG, 8MG; 2MG	2	QL(90 EA per 30 days)
ZUBSOLV TABLET SUBLINGUAL 2.9MG; 0.71MG	3	QL(180 EA per 30 days); ST
ZUBSOLV TABLET SUBLINGUAL 11.4MG; 2.9MG	3	QL(30 EA per 30 days); ST
ZUBSOLV TABLET SUBLINGUAL 1.4MG; 0.36MG	3	QL(360 EA per 30 days); ST
ZUBSOLV TABLET SUBLINGUAL 8.6MG; 2.1MG	3	QL(60 EA per 30 days); ST
ZUBSOLV TABLET SUBLINGUAL 0.7MG; 0.18MG, 5.7MG; 1.4MG	3	QL(90 EA per 30 days); ST
Opioid Reversal Agents		
KLOXXADO	3	ST
naloxone hydrochloride liquid	1	
Antibacterials		
Antibacterials, Other		
clindamycin hcl capsule 150mg, 300mg	1	
clindamycin hydrochloride capsule	1	
metronidazole tablet	1	
nitrofurantoin monohydrate/macrocrystals	1	

Drug Name	Drug Tier	Requirements/Limits
nitrofurantoin monohydrate capsule	1	
Beta-lactam, Cephalosporins		
cefadroxil capsule	1	
cefdinir capsule	1	
cefpodoxime proxetil tablet	1	
cefuroxime axetil tablet	1	
cephalexin capsule	1	
Beta-lactam, Penicillins		
amoxicillin/clavulanate potassium tablet	1	
amoxicillin capsule, tablet	1	
AUGMENTIN TABLET 500MG; 125MG	3	
Macrolides		
azithromycin tablet	1	
DIFICID TABLET	4	
Quinolones		
ciprofloxacin hcl tablet 100mg, 750mg	1	
ciprofloxacin hydrochloride tablet 250mg, 500mg	1	
levofloxacin tablet	1	
Sulfonamides		
sulfamethoxazole/trimethoprim ds	1	
sulfamethoxazole/trimethoprim tablet	1	
Tetracyclines		
doxycycline hyclate capsule 100mg, 50mg	1	
doxycycline hyclate tablet 100mg	1	
doxycycline monohydrate tablet 100mg, 50mg	1	
LYMEPAK	4	
morgidox 1x100mg capsule	1	
morgidox 1x50mg	1	
morgidox 2x100mg capsule	1	
Anticonvulsants		
Anticonvulsants, Other		
KEPPRA TABLET 500MG	3	
KEPPRA TABLET 1000MG, 750MG	4	
LAMICTAL TABLET	4	
lamotrigine tablet	1	
levetiracetam tablet	1	
roweepra	1	
subvenite	1	
TOPAMAX TABLET 50MG	3	
TOPAMAX TABLET 100MG, 200MG	4	
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)

Drug Name	Drug Tier	Requirements/Limits
divalproex sodium dr	1	
gabapentin capsule 400mg	1	QL(270 EA per 30 days)
gabapentin capsule 100mg, 300mg	1	QL(360 EA per 30 days)
gabapentin tablet 800mg	1	QL(150 EA per 30 days)
gabapentin tablet 600mg	1	QL(180 EA per 30 days)
KLONOPIN TABLET 2MG	3	QL(300 EA per 30 days)
KLONOPIN TABLET 0.5MG, 1MG	3	QL(90 EA per 30 days)
MYSOLINE TABLET	4	
NEURONTIN CAPSULE 400MG	3	QL(270 EA per 30 days)
NEURONTIN CAPSULE 100MG, 300MG	3	QL(360 EA per 30 days)
NEURONTIN TABLET 800MG	4	QL(150 EA per 30 days)
NEURONTIN TABLET 600MG	4	QL(180 EA per 30 days)
primidone tablet	1	
Antidementia Agents		
Cholinesterase Inhibitors		
donepezil hcl tablet 10mg, 23mg	1	
donepezil hydrochloride tablet 5mg	1	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hcl titration pak	1	
memantine hydrochloride tablet	1	
Antidepressants		
Antidepressants, Other		
bupropion hydrochloride er (sr) tablet extended release 12 hour 150mg, 200mg	1	QL(60 EA per 30 days)
bupropion hydrochloride er (sr) tablet extended release 12 hour 100mg	1	QL(90 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 300mg	1	QL(30 EA per 30 days)
bupropion hydrochloride er (xl) tablet extended release 24 hour 150mg	1	QL(90 EA per 30 days)
mirtazapine tablet	1	
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 150MG, 200MG	3	QL(60 EA per 30 days)
WELLBUTRIN SR TABLET EXTENDED RELEASE 12 HOUR 100MG	3	QL(90 EA per 30 days)
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300MG	4	QL(30 EA per 30 days)
WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150MG	4	QL(90 EA per 30 days)
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		
citalopram hydrobromide tablet	1	
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 20MG, 60MG	3	QL(60 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
CYMBALTA CAPSULE DELAYED RELEASE PARTICLES 30MG	3	QL(90 EA per 30 days)
duloxetine hcl capsule delayed release particles 30mg, 40mg	1	QL(90 EA per 30 days)
duloxetine hydrochloride capsule delayed release particles 20mg, 60mg	1	QL(60 EA per 30 days)
duloxetine hydrochloride capsule delayed release particles 30mg	1	QL(90 EA per 30 days)
escitalopram oxalate tablet	1	
fluoxetine hcl capsule 20mg	1	
fluoxetine hydrochloride capsule 10mg, 40mg	1	
paroxetine hcl tablet 30mg, 40mg	1	
paroxetine hydrochloride tablet 10mg, 20mg	1	
PROZAC CAPSULE 20MG	3	
PROZAC CAPSULE 40MG	4	
sertraline hcl tablet 25mg, 50mg	1	
sertraline hydrochloride tablet 100mg	1	
trazodone hydrochloride tablet 100mg, 150mg, 50mg	1	
TRINTELLIX	3	QL(30 EA per 30 days)
venlafaxine hcl er capsule extended release 24 hour 150mg, 37.5mg	1	
venlafaxine hydrochloride er capsule extended release 24 hour 75mg	1	
Tricyclics		
amitriptyline hcl tablet 100mg, 150mg, 25mg, 75mg	1	
amitriptyline hydrochloride tablet 10mg, 25mg, 50mg	1	
nortriptyline hcl capsule 25mg, 75mg	1	
nortriptyline hydrochloride capsule 10mg, 50mg	1	
PAMELOR CAPSULE	4	
Antiemetics		
Antiemetics, Other		
meclizine hcl tablet	1	
meclizine hydrochloride tablet 25mg	1	
prochlorperazine maleate tablet	1	
Emetogenic Therapy Adjuncts		
ondansetron hcl tablet 24mg	1	QL(14 EA per 28 days); B/D
ondansetron hydrochloride tablet	1	B/D
ondansetron odt	1	B/D
ZOFRAN TABLET 4MG, 8MG	4	B/D
Antifungals		
Antifungals		
DIFLUCAN TABLET 200MG	4	
fluconazole tablet	1	
ketoconazole shampoo	1	
ketoconazole cream	1	QL(90 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
nyamyc	1	QL(120 GM per 30 days)
nyata powder	1	QL(120 GM per 30 days)
nystatin powder	1	QL(120 GM per 30 days)
nystop	1	QL(120 GM per 30 days)
Antigout Agents		
Antigout Agents		
allopurinol tablet 100mg, 300mg	1	
colchicine tablet 0.6mg	2	
Antimigraine Agents		
Prophylactic		
AIMOVIG INJECTION 140MG/ML	3	QL(1 ML per 30 days); PA
AIMOVIG INJECTION 70MG/ML	3	QL(2 ML per 30 days); PA
EMGALITY INJECTION 100MG/ML	3	QL(3 ML per 30 days); PA
NURTEC	4	QL(18 EA per 30 days); PA
Serotonin (5-HT) Receptor Agonist		
IMITREX TABLET	3	QL(9 EA per 30 days)
sumatriptan succinate tablet	1	QL(9 EA per 30 days)
Antineoplastics		
Antiandrogens		
ERLEADA	4	PA
NUBEQA	4	PA
XTANDI	4	PA
Aromatase Inhibitors, 3rd Generation		
anastrozole tablet	1	
ARIMIDEX	3	
letrozole	1	
Antiparasitics		
Antiprotozoals		
hydroxychloroquine sulfate tablet 100mg, 200mg	1	
Antiparkinson Agents		
Dopamine Agonists		
pramipexole dihydrochloride	1	
ropinirole hcl tablet 0.5mg, 1mg, 2mg, 4mg, 5mg	1	
ropinirole hydrochloride tablet 0.25mg, 3mg	1	
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	1	
DHIVY	3	ST
INBRIJA	4	PA
RYTARY	3	ST
Antipsychotics		
2nd Generation/Atypical		
ABILIFY MAINTENA	4	
ABILIFY TABLET	4	QL(30 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
aripiprazole tablet	1	QL(30 EA per 30 days)
ARISTADA	4	
ARISTADA INITIO	4	
INVEGA HAFYERA	4	ST
INVEGA SUSTENNA INJECTION 39MG/0.25ML	3	
INVEGA SUSTENNA INJECTION 117MG/0.75ML, 156MG/ML, 234MG/1.5ML, 78MG/0.5ML	4	
INVEGA TRINZA	4	
olanzapine tablet	1	QL(30 EA per 30 days)
PERSERIS	4	
quetiapine fumarate tablet 300mg, 400mg	1	QL(60 EA per 30 days)
quetiapine fumarate tablet 100mg, 150mg, 200mg, 25mg, 50mg	1	QL(90 EA per 30 days)
REXULTI	4	QL(30 EA per 30 days)
RISPERDAL CONSTA INJECTION 12.5MG	3	
RISPERDAL CONSTA INJECTION 25MG, 37.5MG, 50MG	4	
RISPERDAL TABLET 0.25MG, 0.5MG, 1MG, 4MG	3	QL(60 EA per 30 days)
RISPERDAL TABLET 2MG, 3MG	4	QL(60 EA per 30 days)
risperidone tablet	1	QL(60 EA per 30 days)
SEROQUEL TABLET 300MG, 400MG	3	QL(60 EA per 30 days)
SEROQUEL TABLET 100MG, 200MG, 25MG, 50MG	3	QL(90 EA per 30 days)
ZYPREXA TABLET 10MG, 2.5MG, 5MG, 7.5MG	3	QL(30 EA per 30 days)
ZYPREXA TABLET 15MG, 20MG	4	QL(30 EA per 30 days)
Antispasticity Agents		
Antispasticity Agents		
baclofen tablet	1	
DYSPORT	3	PA
tizanidine hcl tablet 2mg	1	
tizanidine hydrochloride tablet 4mg	1	
Antivirals		
Anti-hepatitis C (HCV) Agents		
EPCLUSA TABLET 400MG; 100MG	4	QL(84 EA per 365 days); PA
MAVYRET TABLET	4	QL(336 EA per 365 days); PA
MAVYRET PACKET	4	QL(560 EA per 365 days); PA
SOFOSBUVIR/VELPATASVIR	4	QL(84 EA per 365 days); PA
VOSEVI	4	QL(84 EA per 365 days); PA
Antiherpetic Agents		
acyclovir tablet	1	
SITAVIG	3	QL(2 EA per 30 days)
valacyclovir hcl tablet 1gm	1	QL(120 EA per 30 days)
valacyclovir hydrochloride tablet 500mg	1	QL(120 EA per 30 days)
VALTREX	3	QL(120 EA per 30 days)
Anxiolytics		
Anxiolytics, Other		

Drug Name	Drug Tier	Requirements/Limits
buspirone hcl tablet 15mg, 30mg	1	
buspirone hydrochloride tablet 10mg, 5mg, 7.5mg	1	
Benzodiazepines		
alprazolam tablet 0.25mg, 0.5mg, 1mg	1	QL(120 EA per 30 days)
alprazolam tablet 2mg	1	QL(150 EA per 30 days)
ATIVAN TABLET 2MG	4	QL(150 EA per 30 days)
ATIVAN TABLET 0.5MG, 1MG	4	QL(90 EA per 30 days)
diazepam tablet 10mg	1	QL(120 EA per 30 days)
diazepam tablet 5mg	1	QL(240 EA per 30 days)
diazepam tablet 2mg	1	QL(300 EA per 30 days)
lorazepam tablet 2mg	1	QL(150 EA per 30 days)
lorazepam tablet 0.5mg, 1mg	1	QL(90 EA per 30 days)
VALIUM TABLET 10MG	3	QL(120 EA per 30 days)
VALIUM TABLET 5MG	3	QL(240 EA per 30 days)
VALIUM TABLET 2MG	3	QL(300 EA per 30 days)
XANAX TABLET 0.25MG, 0.5MG, 1MG	3	QL(120 EA per 30 days)
XANAX TABLET 2MG	3	QL(150 EA per 30 days)
Blood Glucose Regulators		
Antidiabetic Agents		
BYDUREON BCISE	3	QL(3.4 ML per 28 days); PA
BYETTA INJECTION 10MCG/0.04ML	3	QL(2.4 ML per 28 days); PA
BYETTA INJECTION 5MCG/0.02ML	3	QL(4.8 ML per 28 days); PA
FARXIGA	2	
FORTAMET	4	
glimepiride	1	
glipizide er	1	
glipizide xl	1	
glipizide tablet	1	
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 500MG	3	PA
GLUMETZA TABLET EXTENDED RELEASE 24 HOUR 1000MG	4	PA
GLYXAMBI	2	
JANUMET	2	
JANUMET XR	2	
JANUVIA	2	QL(30 EA per 30 days)
JARDIANCE	2	
JENTADUETO	2	
JENTADUETO XR	2	
metformin hydrochloride er tablet extended release 24 hour 500mg, 750mg	1	
metformin hydrochloride er tablet extended release 24 hour 1000mg, 500mg	1	PA
metformin hydrochloride tablet 1000mg, 500mg, 850mg	1	

Drug Name	Drug Tier	Requirements/Limits
metformin hydrochloride tablet 625mg	4	PA
MOUNJARO	2	QL(2 ML per 28 days); PA
OZEMPIC INJECTION 2MG/1.5ML	2	QL(1.5 ML per 28 days); PA
OZEMPIC INJECTION 2MG/1.5ML, 2MG/3ML, 4MG/3ML, 5.5MG/ML; 14MG/ML; 8MG/3ML	2	QL(3 ML per 28 days); PA
pioglitazone hcl tablet 45mg	1	
pioglitazone hydrochloride tablet 15mg, 30mg	1	
RYBELSUS TABLET 14MG, 7MG	2	QL(30 EA per 30 days); PA
RYBELSUS TABLET 3MG	2	QL(60 EA per 365 days); PA
SOLIQUA 100/33	2	PA
SYNJARDY	2	
SYNJARDY XR	2	
TRADJENTA	2	QL(30 EA per 30 days)
TRIJARDY XR	2	
TRULICITY	2	QL(2 ML per 28 days); PA
XIGDUO XR	2	
Glycemic Agents		
BAQSIMI ONE PACK	2	
BAQSIMI TWO PACK	2	
GLUCAGON EMERGENCY KIT	2	
glucagon emergency kit for low blood sugar injection 1mg	2	
GVOKE HYPOPEN 1-PACK	2	
GVOKE HYPOPEN 2-PACK	2	
GVOKE KIT	2	
GVOKE PFS	2	
Insulins		
ADMELOG	3	ST
ADMELOG SOLOSTAR	3	ST
BASAGLAR KWIKPEN	3	ST
BASAGLAR TEMPO PEN	3	ST
HUMALOG	2	
HUMALOG JUNIOR KWIKPEN	2	
HUMALOG KWIKPEN	2	
HUMALOG MIX 50/50	2	
HUMALOG MIX 50/50 KWIKPEN	2	
HUMALOG MIX 75/25	2	
HUMALOG MIX 75/25 KWIKPEN	2	
HUMULIN 70/30	2	
HUMULIN 70/30 KWIKPEN	2	
HUMULIN N	2	
HUMULIN N KWIKPEN	2	
HUMULIN R	2	
HUMULIN R U-500 (CONCENTRATED)	2	
HUMULIN R U-500 KWIKPEN	2	

Drug Name	Drug Tier	Requirements/Limits
INSULIN LISPRO	2	
LANTUS	2	
LANTUS SOLOSTAR	2	
LEVEMIR	2	
LEVEMIR FLEXPEN	2	
LEVEMIR FLEXTOUCH	2	
LYUMJEV	2	
LYUMJEV KWIKPEN	2	
NOVOLIN 70/30	2	
NOVOLIN 70/30 FLEXPEN	2	
NOVOLIN 70/30 FLEXPEN RELION	2	
NOVOLIN 70/30 RELION	2	
NOVOLIN N	2	
NOVOLIN N FLEXPEN	2	
NOVOLIN N FLEXPEN RELION	2	
NOVOLIN N RELION	2	
NOVOLIN R	2	
NOVOLIN R FLEXPEN	2	
NOVOLIN R FLEXPEN RELION	2	
NOVOLIN R RELION	2	
NOVOLOG	2	
NOVOLOG FLEXPEN	2	
NOVOLOG FLEXPEN RELION	2	
NOVOLOG MIX 70/30	2	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	2	
NOVOLOG MIX 70/30 PREFILLED FLEXPEN RELION	2	
NOVOLOG MIX 70/30 RELION	2	
NOVOLOG PENFILL	2	
NOVOLOG RELION	2	
TOUJEO MAX SOLOSTAR	2	
TOUJEO SOLOSTAR	2	
TRESIBA	2	
TRESIBA FLEXTOUCH	2	
Blood Products and Modifiers		
Anticoagulants		
dabigatran etexilate	3	QL(60 EA per 30 days)
ELIQUIS STARTER PACK	2	QL(148 EA per 365 days)
ELIQUIS TABLET 2.5MG	2	QL(60 EA per 30 days)
ELIQUIS TABLET 5MG	2	QL(90 EA per 30 days)
FRAGMIN INJECTION 10000UNIT/4ML, 2500UNIT/0.2ML	3	

Drug Name	Drug Tier	Requirements/Limits
FRAGMIN INJECTION 10000UNIT/ML, 12500UNIT/0.5ML, 15000UNIT/0.6ML, 18000UNT/0.72ML, 5000UNIT/0.2ML, 7500UNIT/0.3ML, 95000UNIT/3.8ML	4	
jantoven	1	
warfarin sodium tablet	1	
XARELTO TABLET 10MG, 20MG	2	QL(30 EA per 30 days)
XARELTO TABLET 15MG, 2.5MG	2	QL(60 EA per 30 days)
Blood Products and Modifiers, Other		
ARANESP ALBUMIN FREE INJECTION 10MCG/0.4ML, 25MCG/0.42ML, 25MCG/ML, 40MCG/0.4ML, 40MCG/ML, 60MCG/0.3ML	3	PA
ARANESP ALBUMIN FREE INJECTION 100MCG/0.5ML, 100MCG/ML, 150MCG/0.3ML, 200MCG/0.4ML, 200MCG/ML, 300MCG/0.6ML, 500MCG/ML, 60MCG/ML	4	PA
EPOGEN INJECTION 10000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA
EPOGEN INJECTION 20000UNIT/ML	4	PA
NEULASTA	4	PA
NEULASTA ONPRO KIT	4	PA
PROCRIT INJECTION 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA
PROCRIT INJECTION 40000UNIT/ML	4	PA
RETACRIT INJECTION 10000UNIT/ML, 20000UNIT/2ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML	3	PA
RETACRIT INJECTION 40000UNIT/ML	4	PA
UDENYCA	4	PA
ZARXIO	4	
Platelet Modifying Agents		
BRILINTA	2	
clopidogrel	1	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hydrochloride tablet	1	
midodrine hcl	1	
Alpha-adrenergic Blocking Agents		
terazosin hcl capsule 10mg, 1mg, 5mg	1	
terazosin hydrochloride capsule 2mg	1	
Angiotensin II Receptor Antagonists		
EDARBI	3	
irbesartan	1	
losartan potassium tablet	1	
olmesartan medoxomil tablet	1	

Drug Name	Drug Tier	Requirements/Limits
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	
VASOTEC TABLET 20MG	4	
Antiarrhythmics		
amiodarone hydrochloride tablet	1	
BETAPACE TABLET 120MG, 160MG, 80MG	4	
digitek tablet 0.125mg, 0.25mg	1	
digox	1	
digoxin tablet 125mcg, 250mcg, 62.5mcg	1	
flecainide acetate	1	
pacerone tablet 100mg, 200mg, 400mg	1	
sorine	1	
sotalol hcl	1	
sotalol hydrochloride tablet 160mg, 80mg	1	
Beta-adrenergic Blocking Agents		
atenolol tablet	1	
bisoprolol fumarate	1	
carvedilol	1	
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 60MG, 80MG	3	
INDERAL LA CAPSULE EXTENDED RELEASE 24 HOUR 120MG, 160MG	4	
metoprolol succinate er	1	
metoprolol tartrate tablet	1	
nebivolol hydrochloride	1	
nebivolol tablet 10mg, 20mg, 5mg	1	
propranolol hcl er capsule extended release 24 hour 120mg, 160mg	1	
propranolol hcl tablet 40mg	1	
propranolol hydrochloride er capsule extended release 24 hour 60mg, 80mg	1	
propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg	1	
Calcium Channel Blocking Agents, Dihydropyridines		
afeditab cr	1	
amlodipine besylate tablet	1	
nifedical xl	1	
nifedipine er	1	
Calcium Channel Blocking Agents, Nondihydropyridines		

Drug Name	Drug Tier	Requirements/Limits
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 120MG, 180MG	3	
CARDIZEM CD CAPSULE EXTENDED RELEASE 24 HOUR 240MG, 300MG, 360MG	4	
cartia xt	1	
diltiazem hcl cd	1	
diltiazem hydrochloride er capsule extended release 24 hour	1	
verapamil hcl er tablet extended release	1	
verapamil hydrochloride er tablet extended release 180mg	1	
Cardiovascular Agents, Other		
amlodipine besylate/benazepril hydrochloride	1	
CORLANOR SOLUTION	3	QL(450 ML per 30 days); PA
CORLANOR TABLET	3	QL(60 EA per 30 days); PA
EDARBYCLOR	3	
ENTRESTO	2	QL(60 EA per 30 days)
lisinopril/hydrochlorothiazide	1	
losartan potassium/hydrochlorothiazide	1	
triamterene/hydrochlorothiazide capsule 25mg; 37.5mg	1	
triamterene/hydrochlorothiazide tablet	1	
valsartan/hydrochlorothiazide	1	
Diuretics, Loop		
bumetanide tablet	1	
furosemide tablet	1	
SOAANZ	3	ST
torsemide tablet	1	
Diuretics, Potassium-sparing		
spironolactone tablet	1	
Diuretics, Thiazide		
chlorthalidone tablet 25mg, 50mg	1	
hydrochlorothiazide capsule, tablet	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate tablet 145mg, 160mg, 48mg, 54mg	1	
FENOGLIDE TABLET 120MG	3	
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium	1	
lovastatin tablet	1	
pravastatin sodium	1	
rosuvastatin calcium	1	
simvastatin tablet	1	
Dyslipidemics, Other		
ezetimibe	1	
PRALUENT	2	QL(2 ML per 28 days); PA
REPATHA	2	QL(3 ML per 28 days); PA
REPATHA PUSHTRONEX SYSTEM	2	QL(7 ML per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
REPATHA SURECLICK	2	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	1	
VERQUVO	2	QL(30 EA per 30 days); PA
Vasodilators, Direct-acting Arterial		
hydralazine hcl tablet 10mg	1	
hydralazine hydrochloride tablet 100mg, 25mg, 50mg	1	
Central Nervous System Agents		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
ADDERALL	3	QL(90 EA per 30 days)
amphetamine/dextroamphetamine tablet	1	QL(90 EA per 30 days)
Central Nervous System, Other		
AUSTEDO	4	QL(120 EA per 30 days); PA
INGREZZA CAPSULE THERAPY PACK	4	QL(56 EA per 365 days); PA
INGREZZA CAPSULE 60MG, 80MG	4	QL(30 EA per 30 days); PA
INGREZZA CAPSULE 40MG	4	QL(60 EA per 30 days); PA
Fibromyalgia Agents		
LYRICA CAPSULE 300MG	3	QL(60 EA per 30 days)
LYRICA CAPSULE 100MG, 150MG, 200MG, 225MG, 25MG, 50MG, 75MG	3	QL(90 EA per 30 days)
pregabalin capsule 300mg	1	QL(60 EA per 30 days)
pregabalin capsule 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg	1	QL(90 EA per 30 days)
Multiple Sclerosis Agents		
AVONEX PEN	4	QL(4 EA per 28 days); PA
AVONEX INJECTION 30MCG/0.5ML	4	QL(4 EA per 28 days); PA
BETASERON	4	QL(15 EA per 30 days); PA
EXTAVIA	4	QL(15 EA per 30 days); PA
KESIMPTA	4	QL(0.4 ML per 28 days); PA
MAVENCLAD	4	PA
MAYZENT STARTER PACK TABLET THERAPY PACK 0.25MG	3	QL(14 EA per 365 days); PA
MAYZENT STARTER PACK TABLET THERAPY PACK 0.25MG	4	QL(24 EA per 365 days); PA
MAYZENT TABLET 0.25MG	4	QL(120 EA per 30 days); PA
MAYZENT TABLET 1MG, 2MG	4	QL(30 EA per 30 days); PA
OCREVUS	4	QL(40 ML per 365 days); PA
PLEGRIDY	4	QL(1 ML per 28 days); PA
REBIF	4	QL(6 ML per 28 days); PA
REBIF REBIDOSE	4	QL(6 ML per 28 days); PA
REBIF REBIDOSE TITRATION PACK	4	QL(8.4 ML per 365 days); PA
REBIF TITRATION PACK	4	QL(8.4 ML per 365 days); PA
VUMERITY	4	QL(120 EA per 30 days); PA

Drug Name	Drug Tier	Requirements/Limits
Dental and Oral Agents		
Dental and Oral Agents		
chlorhexidine gluconate oral rinse	1	
chlorhexidine gluconate solution	1	
doxycycline hyclate tablet 20mg	1	
paroex	1	
periogard	1	
Dermatological Agents		
Acne and Rosacea Agents		
FINACEA FOAM	2	QL(50 GM per 30 days)
Dermatitis and Pruitus Agents		
ala-cort cream 2.5%	1	
clobetasol propionate ointment, solution	1	
cormax scalp application	1	
hydrocortisone cream 2.5%	1	
IMPOYZ	4	
triamcinolone acetonide cream	1	
triamcinolone acetonide ointment 0.025%, 0.1%, 0.5%	1	
triderm cream 0.1%	1	
Dermatological Agents, Other		
CARAC	4	
clotrimazole/betamethasone dipropionate cream	1	
EFUDEX CREAM	3	QL(40 GM per 30 days)
FLUOROPLEX CREAM	4	
FLUOROURACIL CREAM 0.5%	4	
fluorouracil cream 5%	1	QL(40 GM per 30 days)
OTEZLA TABLET 30MG	4	QL(60 EA per 30 days); PA
Topical Anti-infectives		
CENTANY OINTMENT	3	QL(110 GM per 30 days)
ciclodan solution	1	PA
ciclopirox nail lacquer	1	PA
mupirocin ointment	1	QL(110 GM per 30 days)
PENLAC NAIL LACQUER	4	PA
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
klor-con 10	1	
klor-con 8	1	
klor-con m10	1	
klor-con m15	1	
klor-con m20	1	
klor-con sprinkle	1	
potassium chloride er	1	
potassium chloride sr tablet extended release 8meq	1	
Phosphate Binders		

Drug Name	Drug Tier	Requirements/Limits
VELPHORO	4	
Potassium Binders		
LOKELMA	3	QL(90 EA per 30 days)
VELTASSA	3	
Gastrointestinal Agents		
Anti-Constipation Agents		
constulose	1	
lactulose solution	1	
LINZESS	2	QL(30 EA per 30 days)
MOTEGRITY	2	QL(30 EA per 30 days)
Antispasmodics, Gastrointestinal		
dicyclomine hydrochloride capsule	1	
Gastrointestinal Agents, Other		
CLENPIQ	2	
gavilyte-c	1	
gavilyte-g	1	
peg 3350/electrolytes	1	
peg-3350/electrolytes	1	
SUTAB	2	
XIFAXAN TABLET 550MG	4	PA
Histamine2 (H2) Receptor Antagonists		
famotidine tablet 20mg, 40mg	1	
PEPCID TABLET 40MG	3	
Protectants		
sucralfate tablet	1	
Proton Pump Inhibitors		
esomeprazole magnesium capsule delayed release	1	QL(60 EA per 30 days)
lansoprazole capsule delayed release	1	QL(60 EA per 30 days)
NEXIUM CAPSULE DELAYED RELEASE	3	QL(60 EA per 30 days)
omeprazole dr capsule delayed release 10mg	1	QL(60 EA per 30 days)
omeprazole capsule delayed release 20mg, 40mg	1	QL(60 EA per 30 days)
pantoprazole sodium tablet delayed release	1	QL(60 EA per 30 days)
PREVACID CAPSULE DELAYED RELEASE	3	QL(60 EA per 30 days)
PROTONIX TABLET DELAYED RELEASE	3	QL(60 EA per 30 days)
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
CREON CAPSULE DELAYED RELEASE PARTICLES 120000UNIT; 24000UNIT; 76000UNIT, 15000UNIT; 3000UNIT; 9500UNIT, 180000UNIT; 36000UNIT; 114000UNIT, 30000UNIT; 6000UNIT; 19000UNIT, 60000UNIT; 12000UNIT; 38000UNIT	2	

Drug Name	Drug Tier	Requirements/Limits
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	2	
Genitourinary Agents		
Antispasmodics, Urinary		
GEMTESA	3	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR	2	
oxybutynin chloride er	1	
oxybutynin chloride tablet 5mg	1	
solifenacin succinate	1	
trospium chloride	1	
Benign Prostatic Hypertrophy Agents		
doxazosin mesylate	1	
dutasteride capsule	1	
finasteride tablet	1	
tamsulosin hydrochloride	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
ACTHAR	4	PA
CORTROPHIN	4	PA
deltasone tablet 20mg	1	
dexamethasone tablet 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg	1	
methylprednisolone dose pack tablet therapy pack	1	
prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
Estrogens		
estradiol cream, oral tablet, vaginal tablet	1	
IMVEXXY MAINTENANCE PACK	2	PA
IMVEXXY STARTER PACK	2	PA
PREMARIN CREAM	2	
PREMARIN TABLET 0.3MG, 0.45MG, 0.625MG, 0.9MG, 1.25MG	3	
PREMPHASE	3	
PREMPRO	3	
yuvafem	1	
Selective Estrogen Receptor Modifying Agents		
OSPHENA	2	QL(30 EA per 30 days); PA
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		

Drug Name	Drug Tier	Requirements/Limits
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
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	
SYNTHROID TABLET	3	
unithroid	3	
Hormonal Agents, Suppressant (Pituitary)		
Hormonal Agents, Suppressant (Pituitary)		
LUPRON DEPOT (1-MONTH)	4	QL(1 EA per 28 days); PA
LUPRON DEPOT (3-MONTH)	4	QL(1 EA per 84 days); PA
LUPRON DEPOT (4-MONTH)	4	QL(1 EA per 112 days); PA
LUPRON DEPOT (6-MONTH)	4	QL(1 EA per 168 days); PA
Hormonal Agents, Suppressant (Thyroid)		
Antithyroid Agents		
methimazole tablet 10mg, 5mg	1	
Immunological Agents		
Immunological Agents, Other		
COSENTYX	4	QL(10 ML per 28 days); PA
COSENTYX SENSOREADY PEN	4	QL(10 ML per 28 days); PA
DUPIXENT INJECTION 100MG/0.67ML	4	QL(1.34 ML per 28 days); PA
DUPIXENT INJECTION 200MG/1.14ML	4	QL(4.56 ML per 28 days); PA
DUPIXENT INJECTION 300MG/2ML	4	QL(8 ML per 28 days); PA
EMPAVELI	4	PA
OTEZLA TABLET THERAPY PACK 0	4	QL(110 EA per 365 days); PA
RINVOQ	4	QL(30 EA per 30 days); PA
SKYRIZI PEN	4	QL(1 ML per 28 days); PA
SKYRIZI INJECTION 600MG/10ML, 75MG/0.83ML	4	PA
SKYRIZI INJECTION 150MG/ML	4	QL(1 ML per 28 days); PA
SKYRIZI INJECTION 180MG/1.2ML	4	QL(1.2 ML per 56 days); PA
SKYRIZI INJECTION 360MG/2.4ML	4	QL(2.4 ML per 56 days); PA
SOLIRIS	4	PA
STELARA INJECTION 130MG/26ML	4	PA
STELARA INJECTION 45MG/0.5ML, 90MG/ML	4	QL(3 ML per 84 days); PA
ULTOMIRIS	4	PA
VYVGART	4	PA
VYVGART HYTRULO	4	PA
XELJANZ XR	4	QL(30 EA per 30 days); PA
XELJANZ SOLUTION	4	QL(300 ML per 30 days); PA
XELJANZ TABLET	4	QL(60 EA per 30 days); PA
Immunosuppressants		
ASTAGRAF XL	3	B/D

Drug Name	Drug Tier	Requirements/Limits
CYLTEZO STARTER PACKAGE FOR CROHNS DISEASE/UC/HS	4	QL(6 EA per 28 days); PA
CYLTEZO STARTER PACKAGE FOR PSORIASIS	4	QL(6 EA per 28 days); PA
CYLTEZO INJECTION 10MG/0.2ML, 20MG/0.4ML	4	QL(2 EA per 28 days); PA
CYLTEZO INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
ENBREL MINI	4	QL(8 ML per 28 days); PA
ENBREL SURECLICK	4	QL(8 ML per 28 days); PA
ENBREL INJECTION 25MG	4	PA
ENBREL INJECTION 25MG/0.5ML	4	QL(4 ML per 28 days); PA
ENBREL INJECTION 50MG/ML	4	QL(8 ML per 28 days); PA
ENVARSUS XR TABLET EXTENDED RELEASE 24 HOUR 0.75MG, 1MG	3	B/D
ENVARSUS XR TABLET EXTENDED RELEASE 24 HOUR 4MG	4	B/D
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 40MG/0.8ML	4	QL(2 EA per 28 days); PA
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 0	4	QL(4 EA per 365 days); PA
HUMIRA PEDIATRIC CROHNS DISEASE STARTER PACK INJECTION 80MG/0.8ML	4	QL(6 EA per 365 days); PA
HUMIRA PEN-CD/UC/HS STARTER INJECTION 80MG/0.8ML	4	QL(4 EA per 28 days); PA
HUMIRA PEN-CD/UC/HS STARTER INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
HUMIRA PEN-PEDIATRIC UC STARTER PACK	4	QL(4 EA per 28 days); PA
HUMIRA PEN-PS/UV STARTER INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
HUMIRA PEN-PS/UV STARTER INJECTION 0	4	QL(6 EA per 365 days); PA
HUMIRA PEN INJECTION 40MG/0.4ML, 80MG/0.8ML	4	QL(4 EA per 28 days); PA
HUMIRA PEN INJECTION 40MG/0.8ML	4	QL(6 EA per 28 days); PA
HUMIRA INJECTION 10MG/0.1ML, 20MG/0.2ML, 40MG/0.8ML	4	QL(2 EA per 28 days); PA
HUMIRA INJECTION 40MG/0.4ML	4	QL(4 EA per 28 days); PA
INFLECTRA	4	PA
methotrexate sodium tablet	1	
methotrexate tablet	1	
OTREXUP INJECTION 20MG/0.4ML	3	QL(1.6 ML per 28 days); PA
RASUVO INJECTION 7.5MG/0.15ML	3	QL(0.6 ML per 28 days); PA
RASUVO INJECTION 10MG/0.2ML	3	QL(0.8 ML per 28 days); PA
RASUVO INJECTION 12.5MG/0.25ML	3	QL(1 ML per 28 days); PA
RASUVO INJECTION 15MG/0.3ML	3	QL(1.2 ML per 28 days); PA
RASUVO INJECTION 17.5MG/0.35ML	3	QL(1.4 ML per 28 days); PA
RASUVO INJECTION 20MG/0.4ML	3	QL(1.6 ML per 28 days); PA
RASUVO INJECTION 22.5MG/0.45ML	3	QL(1.8 ML per 28 days); PA

Drug Name	Drug Tier	Requirements/Limits
RASUVO INJECTION 25MG/0.5ML	3	QL(2 ML per 28 days); PA
RASUVO INJECTION 30MG/0.6ML	3	QL(2.4 ML per 28 days); PA
YUFLYMA 1-PEN KIT	4	QL(6 EA per 28 days); PA
YUFLYMA 2-PEN KIT	4	QL(6 EA per 28 days); PA
Vaccines		
ADACEL	2	
BOOSTRIX	2	
SHINGRIX	2	
Inflammatory Bowel Disease Agents		
Glucocorticoids		
hydrocortisone cream 2.5%	1	
procto-med hc	1	
proctosol hc	1	
proctozone-hc	1	
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)
BONIVA TABLET 150MG	3	QL(1 EA per 28 days)
calcitriol capsule	1	
FORTEO INJECTION 600MCG/2.4ML	4	PA
FOSAMAX TABLET 70MG	3	QL(4 EA per 28 days)
ibandronate sodium tablet	1	QL(1 EA per 28 days)
PROLIA	3	QL(2 ML per 365 days)
RAYALDEE	4	
TERIPARATIDE	4	PA
TYMLOS	4	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)
EASY TOUCH SAFETY PEN NEEDLES/30G X 1/4"	2	QL(200 EA per 30 days)
OMNIPOD 10 PACK	2	QL(30 EA per 30 days)
OMNIPOD 5 G6 INTRO KIT (GEN 5)	2	QL(1 EA per 365 days)
OMNIPOD 5 G6 PODS (GEN 5)	2	QL(30 EA per 30 days)
OMNIPOD CLASSIC PDM STARTER KIT (GEN 3)	2	QL(1 EA per 365 days)
OMNIPOD CLASSIC PODS (GEN 3)	2	QL(30 EA per 30 days)
OMNIPOD DASH INTRO KIT (GEN 4)	2	QL(1 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD DASH PDM KIT (GEN 4)	2	QL(1 EA per 365 days)
OMNIPOD DASH PODS (GEN 4)	2	QL(30 EA per 30 days)
OMNIPOD GO 10 UNITS/DAY	2	QL(10 EA per 30 days)
OMNIPOD GO 15 UNITS/DAY	2	QL(10 EA per 30 days)
OMNIPOD GO 20 UNITS/DAY	2	QL(10 EA per 30 days)
OMNIPOD GO 25 UNITS/DAY	2	QL(10 EA per 30 days)
OMNIPOD GO 30 UNITS/DAY	2	QL(10 EA per 30 days)
OMNIPOD GO 35 UNITS/DAY	2	QL(10 EA per 30 days)
OMNIPOD GO 40 UNITS/DAY	2	QL(10 EA per 30 days)
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(20 EA per 5 days)
PAXLOVID TABLET THERAPY PACK 150MG; 100MG	2	QL(30 EA per 5 days)
TYRVAYA	3	QL(8.4 ML per 30 days); PA
V-GO 20	2	
V-GO 30	2	
V-GO 40	2	
Ophthalmic Agents		
Ophthalmic Agents, Other		
brimonidine tartrate/timolol maleate	2	
COMBIGAN	2	
cyclosporine	2	
CYCLOSPORINE IN KLARITY	4	QL(120 ML per 30 days); PA
dorzolamide hcl/timolol maleate	1	
neomycin/polymyxin/dexamethasone suspension	1	
polymyxin b sulfate/trimethoprim sulfate	1	
RESTASIS	2	
RESTASIS MULTIDOSE	2	
ROCKLATAN	2	QL(2.5 ML per 25 days)
SIMBRINZA	2	
VERKAZIA	4	QL(120 EA per 30 days); PA
XIIDRA	3	QL(60 EA per 30 days)
ZYLET	3	
Ophthalmic Anti-Infectives		
erythromycin	1	
ilotycin	1	
ofloxacin	1	
Ophthalmic Anti-inflammatories		
ACUVAIL	3	ST
ketorolac tromethamine	1	
LOTEMAX SM	3	QL(20 GM per 365 days)
LOTEMAX OINTMENT	3	QL(14 GM per 365 days)
PRED MILD	2	
prednisolone acetate	1	
Ophthalmic Beta-Adrenergic Blocking Agents		
timolol maleate solution	1	

Drug Name	Drug Tier	Requirements/Limits
Ophthalmic Intraocular Pressure Lowering Agents, Other		
ALPHAGAN P SOLUTION 0.1%	2	
brimonidine tartrate	1	
dorzolamide hydrochloride	1	
RHOPRESSA	2	QL(2.5 ML per 25 days)
Ophthalmic Prostaglandin and Prostamide Analogs		
bimatoprost	1	QL(5 ML per 30 days)
latanoprost solution	1	
LUMIGAN	2	QL(2.5 ML per 25 days)
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	2	QL(30 EA per 30 days)
ASMANEX HFA	3	QL(13 GM per 30 days)
ASMANEX TWISTHALER 120 METERED DOSES	3	QL(1 EA per 30 days)
ASMANEX TWISTHALER 14 METERED DOSES	3	QL(1 EA per 30 days)
ASMANEX TWISTHALER 30 METERED DOSES	3	QL(1 EA per 30 days)
ASMANEX TWISTHALER 60 METERED DOSES	3	QL(1 EA per 30 days)
ASMANEX TWISTHALER 7 METERED DOSES	3	QL(1 EA per 30 days)
BREZTRI AEROSPHERE	2	QL(23.6 GM per 28 days)
fluticasone propionate	1	
Antihistamines		
azelastine hcl solution 0.15%	1	QL(60 ML per 30 days)
azelastine hydrochloride	1	QL(60 ML per 30 days)
hydroxyzine hcl tablet 50mg	1	
hydroxyzine hydrochloride tablet 10mg, 25mg	1	
levocetirizine dihydrochloride tablet	1	
Antileukotrienes		
montelukast sodium tablet	1	
Bronchodilators, Anticholinergic		
ATROVENT HFA	3	QL(25.8 GM per 30 days)
INCRUSE ELLIPTA	2	QL(30 EA per 30 days)
ipratropium bromide solution	1	
SPIRIVA RESPIMAT AEROSOL SOLUTION 2.5MCG/ACT	2	
SPIRIVA RESPIMAT AEROSOL SOLUTION 1.25MCG/ACT	2	QL(8 GM per 30 days)
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(13.4 GM per 30 days)
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(17 GM per 30 days)
albuterol sulfate hfa aerosol solution 108mcg/act	1	QL(48 GM per 30 days)
PROAIR HFA	3	QL(17 GM per 30 days)
PROVENTIL HFA	3	QL(13.4 GM per 30 days)
SEREVENT DISKUS	2	QL(60 EA per 30 days)
STRIVERDI RESPIMAT	3	QL(4 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
VENTOLIN HFA	3	QL(48 GM per 30 days); ST
Pulmonary Antihypertensives		
OPSUMIT	4	QL(30 EA per 30 days); PA
ORENITRAM TITRATION KIT MONTH 1	4	QL(336 EA per 365 days); PA
ORENITRAM TITRATION KIT MONTH 2	4	QL(672 EA per 365 days); PA
ORENITRAM TITRATION KIT MONTH 3	4	QL(504 EA per 365 days); PA
ORENITRAM TABLET EXTENDED RELEASE 0.125MG	3	PA
ORENITRAM TABLET EXTENDED RELEASE 0.25MG, 1MG, 2.5MG, 5MG	4	PA
Pulmonary Fibrosis Agents		
OFEV	4	PA
Respiratory Tract Agents, Other		
ADVAIR DISKUS	3	QL(60 EA per 30 days)
AIRDUO RESPICLICK 113/14	3	QL(1 EA per 30 days)
AIRDUO RESPICLICK 232/14	3	QL(1 EA per 30 days)
AIRDUO RESPICLICK 55/14	3	QL(1 EA per 30 days)
BEVESPI AEROSPHERE	2	QL(10.7 GM per 30 days)
BREO ELLIPTA	2	QL(60 EA per 30 days)
COMBIVENT RESPIMAT	2	QL(8 GM per 30 days)
FASENRA	4	PA
FASENRA PEN	4	PA
fluticasone propionate/salmeterol diskus	1	QL(60 EA per 30 days)
FLUTICASONE PROPIONATE/SALMETEROL AEROSOL POWDER BREATH ACTIVATED 113MCG/ACT; 14MCG/ACT, 232MCG/ACT; 14MCG/ACT, 55MCG/ACT; 14MCG/ACT	3	QL(1 EA per 30 days)
NUCALA INJECTION 40MG/0.4ML	4	QL(0.4 ML per 28 days); PA
NUCALA INJECTION 100MG	4	QL(3 EA per 28 days); PA
NUCALA INJECTION 100MG/ML	4	QL(3 ML per 28 days); PA
STIOLTO RESPIMAT	3	QL(24 GM per 30 days); ST
TRELEGY ELLIPTA	2	QL(60 EA per 30 days)
wixela inhub	1	QL(60 EA per 30 days)
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
cyclobenzaprine hydrochloride tablet	1	
FEXMID	3	
methocarbamol tablet 500mg, 750mg	1	
methocarbamol tablet 1000mg	4	
ROBAXIN-750	3	
Sleep Disorder Agents		
Sleep Promoting Agents		
AMBIEN	3	QL(30 EA per 30 days)
BELSOMRA	2	QL(30 EA per 30 days)
RESTORIL	3	QL(30 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
temazepam	1	QL(30 EA per 30 days)
zolpidem tartrate tablet	1	QL(30 EA per 30 days)
Wakefulness Promoting Agents		
SODIUM OXYBATE	4	QL(540 ML per 30 days); PA
SUNOSI	3	QL(30 EA per 30 days); PA
XYREM	4	QL(540 ML per 30 days); PA

Index of Drugs

Optum Rx®

Nondiscrimination notice and access to communication services

Optum Rx and its family of affiliated Optum companies do not discriminate on the basis of race, color, national origin, age, disability, or sex in its health programs or activities.

We provide assistance free of charge to people with disabilities or whose primary language is not English. To request a document in another format, such as large print, or to get language assistance such as a qualified interpreter, 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.

If you believe we have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can send a complaint to:

Optum Rx Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344

Phone: **1-800-562-6223 (TTY 711)**
Fax: 1-855-351-5495
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/complaints/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 1-800-908-9097. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-908-9097. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-908-9097。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-908-9097。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-908-9097. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-908-9097. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-908-9097 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-908-9097. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-908-9097 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-908-9097. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على **1-800-908-9097** . 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 1-800-908-9097 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-908-9097. 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 1-800-908-9097. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-908-9097. 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 1-800-908-9097. 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、1-800-908-9097 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 August 18, 2023, and is not complete list of drugs covered by our plan.

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

Optum Rx Member Services

Phone (toll-free):	1-800-908-9097
TTY users:	**711**
Hours of operation:	24 hours a day, 7 days a week
Website:	**optumrx.com**

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Abridged Formulary