County of Orange Medicare Prescription Drug Plan

Your 2025 Abridged Formulary **(partial list of covered drugs or "Drug List")**

Administered by Optum Rx®

Effective January 1, 2025

Please read: this document contains information about the drugs we cover in this plan.
This abridged formulary was updated on 08/26/2024 and is not a complete Drug List 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, 2026.

Formulary ID 25307
S8841_25_MC-DS10_COO_C
Last updated date: 08/26/2024

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?

Most changes in drug coverage happen on January 1, but we, County of Orange Part D Prescription Drug Plan, we may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: optumrx.com.

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

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

  When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

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

  If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more information, see the section below titled “How do I request an exception to the Formulary?

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

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier. We must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug and notice of the change.

  If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the Formulary?"

Changes that will not affect you if you are currently taking the drug.

- Generally, if you are taking a drug on our 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above.
- This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year.
- You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 01/01/2025. To get updated information about the drugs covered by County of Orange Medicare Part D Prescription Drug Plan please contact us. Our contact information appears on the front and back cover pages.

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 8. 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 8. 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 18. 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.
Tier 4	Specialty or high-cost drugs listed under Tier 4 cost $950 or more for up to a 30-day maximum supply.

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

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

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

- For discussion of drug types, please see the Evidence of Coverage, Chapter 3*,* Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

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. This may be in addition to a standard one-month or three-month supply.
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 8. 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 5 for additional information.

What are over the counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. County of Orange pays for certain OTC drugs. The cost to County of Orange of these OTC drugs will not count toward your total Part D drug costs.

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 prescriber and ask them 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 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.

- 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.

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 alternative drug is included on the plan's formulary, applying the restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You or your prescriber should contact Optum Rx for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request an exception, your prescriber will need to explain the medical reasons why you need the exception.**

Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your prescriber 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 prescriber.

What do I do before I can talk to my prescriber 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 prescriber to decide if you should switch to an appropriate drug that we cover or request a formulary exception. While you talk to your 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 18.

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. This may be in addition to a standard one-month or three-month supply.
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	1	QL(60 EA per 30 days)
diclofenac sodium dr	3	
diclofenac sodium gel	1	QL(1000 GM per 30 days)
FLECTOR	3	QL(60 EA per 30 days); PA
ibuprofen tablet 400mg, 600mg, 800mg	1	
meloxicam tablet	1	
naproxen tablet 250mg, 375mg, 500mg	1	
Opioid Analgesics, Short-acting		
acetaminophen/codeine tablet	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
oxycodone hydrochloride tablet	1	NDS
OXYCODONE/ACETAMINOPHEN TABLET 300MG; 10MG, 300MG; 5MG	4	NDS
oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg	1	NDS
tramadol hydrochloride tablet	1	NDS
Anesthetics		
Local Anesthetics		
lidocaine patch 5%	1	PA
Anti-Addiction/Substance Abuse Treatment Agents		
Opioid Reversal Agents		
naloxone hydrochloride liquid	1	
Antibacterials		
Antibacterials, Other		
clindamycin hcl capsule 300mg	1	
clindamycin hydrochloride capsule	1	
metronidazole tablet	1	
nitrofurantoin monohydrate/macrocrystals	1	
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	
penicillin v potassium tablet	1	
Macrolides		

Drug Name	Drug Tier	Requirements/Limits
azithromycin tablet	1	
Quinolones		
ciprofloxacin hcl tablet 100mg, 750mg	1	
ciprofloxacin hydrochloride tablet 250mg, 500mg	1	
levofloxacin tablet	1	
Sulfonamides		
sulfamethoxazole/trimethoprim ds	1	
Tetracyclines		
doxycycline hyclate capsule	1	
doxycycline hyclate tablet 100mg	1	
doxycycline monohydrate capsule 100mg, 50mg, 75mg	1	
doxycycline monohydrate tablet	1	
Anticonvulsants		
Anticonvulsants, Other		
lamotrigine tablet	1	
levetiracetam tablet	1	
Gamma-aminobutyric Acid (GABA) Modulating 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	1	
divalproex sodium er	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)
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)
Antidementia Agents		
Cholinesterase Inhibitors		
donepezil hcl tablet 10mg, 23mg	1	
donepezil hydrochloride tablet 5mg	1	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
memantine hydrochloride tablet	1	
Antidepressants		
Antidepressants, Other		
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	
quetiapine fumarate tablet 150mg	1	QL(90 EA per 30 days)
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor		

Drug Name	Drug Tier	Requirements/Limits
citalopram hydrobromide tablet	1	
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 hydrochloride capsule	1	
sertraline hcl tablet 50mg	1	
sertraline hydrochloride tablet 100mg, 25mg	1	
trazodone hydrochloride tablet 100mg, 150mg, 50mg	1	
venlafaxine hydrochloride er capsule extended release 24 hour	1	
Tricyclics		
amitriptyline hcl tablet 100mg, 150mg, 25mg, 75mg	1	
amitriptyline hydrochloride tablet 100mg, 10mg, 25mg, 50mg	1	
Antiemetics		
Antiemetics, Other		
meclizine hcl tablet	1	
meclizine hydrochloride tablet 25mg, 50mg	1	
scopolamine	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 tablet disintegrating 4mg, 8mg	1	B/D
Antifungals		
Antifungals		
clotrimazole cream	1	QL(90 GM per 30 days)
fluconazole tablet	1	
ketoconazole shampoo	1	
ketoconazole cream	1	QL(90 GM per 30 days)
nystatin cream	1	
nystatin powder	1	QL(120 GM per 30 days)
Antigout Agents		
Antigout Agents		
allopurinol tablet 100mg, 300mg	1	
COLCHICINE TABLET 0.6MG	2	
Antineoplastics		
Aromatase Inhibitors, 3rd Generation		
anastrozole tablet	1	
Antiparasitics		
Antiprotozoals		
hydroxychloroquine sulfate tablet	1	
Antiparkinson Agents		

Drug Name	Drug Tier	Requirements/Limits
Anticholinergics		
benztropine mesylate tablet	1	
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa/levodopa	1	
Antipsychotics		
2nd Generation/Atypical		
aripiprazole tablet	1	QL(30 EA per 30 days)
olanzapine tablet	1	QL(30 EA per 30 days)
quetiapine fumarate tablet 300mg, 400mg	1	QL(60 EA per 30 days)
quetiapine fumarate tablet 100mg, 200mg, 25mg, 50mg	1	QL(90 EA per 30 days)
risperidone tablet	1	QL(60 EA per 30 days)
Antispasticity Agents		
Antispasticity Agents		
baclofen tablet	1	
tizanidine hcl tablet 2mg	1	
tizanidine hydrochloride tablet 4mg	1	
Antivirals		
Anti-influenza Agents		
oseltamivir phosphate capsule 75mg	1	QL(110 EA per 365 days)
oseltamivir phosphate capsule 30mg	1	QL(168 EA per 365 days)
oseltamivir phosphate capsule 45mg	1	QL(84 EA per 365 days)
Antiherpetic Agents		
acyclovir tablet	1	
valacyclovir hydrochloride	1	QL(120 EA per 30 days)
Antiviral, Coronavirus Agents		
LAGEVRIO	2	QL(40 EA per 5 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); (300mg-100mg Pak)
Anxiolytics		
Anxiolytics, Other		
buspirone hcl tablet 15mg	1	
buspirone hydrochloride tablet 10mg, 30mg, 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)
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)
Blood Glucose Regulators		
Antidiabetic Agents		

Drug Name	Drug Tier	Requirements/Limits
glimepiride	1	
glipizide tablet	1	
JANUVIA	2	QL(30 EA per 30 days)
metformin hydrochloride er tablet extended release 24 hour 1000mg, 500mg, 750mg	1	
metformin hydrochloride er tablet extended release 24 hour 1000mg, 500mg	1	PA
metformin hydrochloride tablet 1000mg, 500mg, 850mg	1	
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/3ML, 4MG/3ML, 8MG/3ML	2	QL(3 ML per 28 days); PA
TRADJENTA	2	QL(30 EA per 30 days)
TRULICITY	2	QL(2 ML per 28 days); PA
Insulins		
HUMALOG KWIKPEN	2	
LANTUS	2	
LANTUS SOLOSTAR	2	
NOVOLOG FLEXPEN	2	
NOVOLOG FLEXPEN RELION	2	
Blood Products and Modifiers		
Anticoagulants		
dabigatran etexilate	3	QL(60 EA per 30 days)
ELIQUIS TABLET 2.5MG	2	QL(60 EA per 30 days)
ELIQUIS TABLET 5MG	2	QL(90 EA per 30 days)
XARELTO TABLET 10MG, 20MG	2	QL(30 EA per 30 days)
XARELTO TABLET 15MG, 2.5MG	2	QL(60 EA per 30 days)
Platelet Modifying Agents		
clopidogrel	1	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
clonidine hydrochloride tablet	1	
Angiotensin II Receptor Antagonists		
irbesartan	1	
losartan potassium tablet	1	
olmesartan medoxomil tablet	1	
valsartan tablet	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
lisinopril tablet	1	
ramipril	1	
Antiarrhythmics		
amiodarone hydrochloride tablet	1	
Beta-adrenergic Blocking Agents		
atenolol tablet	1	

Drug Name	Drug Tier	Requirements/Limits
carvedilol	1	
metoprolol succinate er	1	
metoprolol tartrate tablet	1	
nebivolol	1	
nebivolol hydrochloride	1	
propranolol hcl tablet 40mg	1	
propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg	1	
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine besylate tablet	1	
Calcium Channel Blocking Agents, Nondihydropyridines		
diltiazem hcl cd	1	
diltiazem hydrochloride er capsule extended release 24 hour	1	
Cardiovascular Agents, Other		
ENTRESTO TABLET	2	QL(60 EA per 30 days)
lisinopril/hydrochlorothiazide	1	
losartan potassium/hydrochlorothiazide	1	
triamterene/hydrochlorothiazide capsule 25mg; 37.5mg	1	
Diuretics, Loop		
bumetanide tablet	1	
furosemide tablet	1	
torsemide tablet	1	
Diuretics, Thiazide		
chlorthalidone tablet 25mg, 50mg	1	
hydrochlorothiazide capsule, tablet	1	
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate tablet 120mg, 145mg, 160mg, 48mg, 54mg	1	
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin calcium	1	
pravastatin sodium	1	
rosuvastatin calcium tablet	1	
simvastatin tablet	1	
Dyslipidemics, Other		
ezetimibe	1	
icosapent ethyl	1	
omega-3-acid ethyl esters	1	
REPATHA SURECLICK	2	QL(3 ML per 28 days); PA
Mineralocorticoid Receptor Antagonists		
spironolactone tablet	1	
Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)		
FARXIGA	2	QL(30 EA per 30 days)
JARDIANCE	2	QL(30 EA per 30 days)
Vasodilators, Direct-acting Arterial/Venous		
isosorbide mononitrate er	1	
nitroglycerin tablet sublingual 0.3mg, 0.4mg, 0.6mg	1	

Drug Name	Drug Tier	Requirements/Limits
Vasodilators, Direct-acting Arterial		
hydralazine hcl tablet 10mg	1	
hydralazine hydrochloride tablet 100mg, 25mg, 50mg	1	
Dental and Oral Agents		
Dental and Oral Agents		
chlorhexidine gluconate solution	1	
Dermatological Agents		
Dermatitis and Pruritus Agents		
clobetasol propionate ointment, solution	1	
hydrocortisone cream 2.5%	1	
mometasone furoate cream 0.1%	1	
triamcinolone acetonide cream	1	
triamcinolone acetonide ointment 0.025%, 0.1%, 0.5%	1	
Dermatological Agents, Other		
clotrimazole/betamethasone dipropionate cream	1	QL(90 GM per 30 days)
FLUOROURACIL CREAM 0.5%	4	
fluorouracil cream 5%	1	QL(40 GM per 30 days)
Topical Anti-infectives		
ciclopirox olamine	1	
mupirocin ointment	1	QL(110 GM per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
Electrolyte/Mineral Replacement		
potassium chloride er	1	
Phosphate Binders		
sevelamer carbonate tablet	1	
Gastrointestinal Agents		
Anti-Constipation Agents		
lactulose solution 10gm/15ml	1	
Anti-Diarrheal Agents		
loperamide hcl capsule	1	
VIBERZI	4	QL(60 EA per 30 days); PA
Antispasmodics, Gastrointestinal		
dicyclomine hydrochloride capsule, tablet	1	
Gastrointestinal Agents, Other		
CLENPIQ	2	
gavilyte-c	1	
peg-3350/nacl/na bicarbonate/kcl	1	
sodium sulfate/potassium sulfate/magnesium sulfate	1	
SUTAB	2	
Histamine2 (H2) Receptor Antagonists		
famotidine tablet 20mg, 40mg	1	
Protectants		
sucralfate tablet	1	
Proton Pump Inhibitors		

Drug Name	Drug Tier	Requirements/Limits
dexlansoprazole	1	QL(30 EA per 30 days)
esomeprazole magnesium capsule delayed release	1	QL(60 EA per 30 days)
lansoprazole capsule delayed release	1	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)
Genitourinary Agents		
Antispasmodics, Urinary		
GEMTESA	3	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR	2	
oxybutynin chloride er	1	
oxybutynin chloride tablet	1	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er	1	
dutasteride capsule	1	
finasteride tablet	1	
tadalafil tablet 2.5mg, 5mg	1	QL(30 EA per 30 days); PA
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	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	1	
PREMARIN CREAM	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
levothyroxine sodium tablet	1	
Immunological Agents		
Immunosuppressants		
methotrexate sodium tablet	1	
Vaccines		
abrysvo	1	QL(1 EA per 252 days)
adacel	1	
arexvy	1	QL(1 EA per 999 days)
BOOSTRIX	2	
shingrix	1	
Inflammatory Bowel Disease Agents		
Aminosalicylates		
mesalamine er capsule extended release	1	

Drug Name	Drug Tier	Requirements/Limits
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)
ibandronate sodium tablet	1	QL(1 EA per 28 days)
PROLIA	3	QL(2 ML per 365 days)
Ophthalmic Agents		
Ophthalmic Agents, Other		
CYCLOSPORINE	2	
dorzolamide hcl/timolol maleate	1	
neomycin/polymyxin/dexamethasone	1	
polymyxin b sulfate/trimethoprim sulfate	1	
tobramycin/dexamethasone	1	
XIIDRA	3	QL(60 EA per 30 days)
Ophthalmic Anti-allergy Agents		
azelastine hcl ophthalmic solution 0.05%	1	
Ophthalmic Anti-Infectives		
ciprofloxacin hydrochloride solution 0.3%	1	
erythromycin	1	
moxifloxacin hydrochloride solution	1	
ofloxacin	1	
Ophthalmic Anti-inflammatories		
ketorolac tromethamine	1	
prednisolone acetate	1	
Ophthalmic Beta-Adrenergic Blocking Agents		
timolol maleate solution	1	
Ophthalmic Intraocular Pressure Lowering Agents, Other		
brimonidine tartrate	1	
Ophthalmic Prostaglandin and Prostamide Analogs		
latanoprost solution	1	
LUMIGAN	2	QL(2.5 ML per 25 days)
Respiratory Tract/Pulmonary Agents		
Anti-inflammatories, Inhaled Corticosteroids		
fluticasone propionate	1	
mometasone furoate suspension 50mcg/act	1	QL(34 GM per 30 days)
Antihistamines		
azelastine hcl nasal solution 0.15%	1	QL(60 ML per 30 days)
azelastine hydrochloride	1	QL(60 ML per 30 days)
azelastine hydrochloride/fluticasone propionate	3	QL(23 GM per 30 days)
hydroxyzine hcl tablet 50mg	1	
hydroxyzine hydrochloride tablet 10mg, 25mg	1	
hydroxyzine pamoate capsule	1	
levocetirizine dihydrochloride tablet	1	
Antileukotrienes		

Drug Name	Drug Tier	Requirements/Limits
montelukast sodium tablet	1	
Bronchodilators, Anticholinergic		
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)
albuterol sulfate nebulization solution 2.5mg/0.5ml	1	QL(100 EA per 30 days); B/D
albuterol sulfate nebulization solution 0.63mg/3ml, 1.25mg/3ml	1	QL(375 ML per 30 days); B/D
albuterol sulfate nebulization solution 0.083%	1	QL(525 ML per 30 days); B/D
EPINEPHRINE INJECTION 0.15MG/0.15ML, 0.15MG/0.3ML, 0.3MG/0.3ML	2	
VENTOLIN HFA	3	QL(48 GM per 30 days); ST
Pulmonary Fibrosis Agents		
ESBRIET	4	PA
pirfenidone	4	PA
Respiratory Tract Agents, Other		
ADVAIR DISKUS	3	QL(60 EA per 30 days)
BREO ELLIPTA	2	QL(60 EA per 30 days)
CINQAIR	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)
fluticasone propionate/salmeterol aerosol powder breath activated 500mcg/act; 50mcg/act	1	QL(60 EA per 30 days)
ipratropium bromide/albuterol sulfate	1	QL(540 ML per 30 days); B/D
TRELEGY ELLIPTA	2	QL(60 EA per 30 days)
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
cyclobenzaprine hydrochloride tablet	1	PA
methocarbamol tablet 500mg, 750mg	1	
methocarbamol tablet 1000mg	4	
Sleep Disorder Agents		
Sleep Promoting Agents		
zolpidem tartrate tablet	1	QL(30 EA per 30 days)

Index of Drugs

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.

Português: 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 08/26/2024, 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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County of Orange
Abridged Formulary