Your prescription benefit updates

Utilization Management changes

Effective July 1, 2026

We use utilization management (UM) strategies—tools and reviews that help make sure you get medications that are effective, appropriate for your needs, and help make the best use of your pharmacy benefit dollar.

This is a list of UM changes made to your formulary.

In this update, brand-name medications are shown in UPPERCASE (for example, CLOBEX). Generic medications are shown in lowercase (for example, clobetasol).

New Prior Authorization (PA)^

The following medication requires a PA review for coverage. This means we need more information from your doctor to see if this medication is covered by your plan.

Therapeutic use	Medication name
Cardiology: Antihypertensive	ARBLI SUSP 10 MG/ML (losartan) LOPRESSOR SOLN 10 MG/ML (metoprolol)
Miscellaneous: Chelating Agents	DEPEN TAB 250 MG (penicillamine)

Step Therapy (ST)

The following medications have been added to a step therapy program. This means you must try a lower-cost medication (step 1) before a higher-cost medication (step 2) is covered.

Therapeutic use	Requested medication	New or revised trial medications (step requirement)
Central Nervous System: Amyotrophic Lateral Sclerosis (ALS) Agents	TIGLUTIK, TEGLUTIK SUSP (riluzole)	Generic riluzole
Dermatology: Topical Acne Treatments	ACANYA GEL 1.2-2.5%* (clindamycin/benzoyl peroxide) BENZAMYCIN GEL 5-3%* (benzoyl peroxide/erythromycin) ONEXTON GEL 1.2-3.75% (clindamycin/benzoyl peroxide) ZIANA GEL 1.2-0.025%* (clindamycin/tretinoin)	Any one of the following: EPIDUO FORTE, generic clindamycin/benzoyl peroxide gel 1.2/3.75%
	TWYNEO CREAM 0.1-3%* (tretinoin/benzoyl peroxide)	Any one of the following: EPIDUO FORTE, generic clindamycin/benzoyl peroxide gel 1.2/3.75%, (only for ages 9-11 years) generic adapalene/benzoyl peroxide gel 0.1/2.5%
Dermatology: Topical Immunomodulators	ZORYVE FOAM 0.3% (roflumilast)	One topical generic: alclometasone, amcinonide, betamethasone, clobetasol, clocortolone, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide, flurandrenolide, fluticasone, halcinonide, halobetasol, hydrocortisone, mometasone, prednicarbate, triamcinolone, pramoxine-HC, calcipotriene-betamethasone, tacrolimus, pimecrolimus, calcipotrine, calcitrol, tazarotene, clotrimazole, econazole, ketoconazole, luliconazole, miconazole, oxiconazole, sertaconazole, sulconazole, selenium sulfide
Generic First: Various	DYMISTA NASAL SPRAY* (fluticasone/azelastine) NUVARING* (etonogestrel/ethinyl estradiol)	Generic equivalent

*Excluded on premium

^Can apply to both brand and generic

Therapeutic use	Requested medication	New or revised trial medications (step requirement)
Miscellaneous: Phosphate Binders/ Iron Replacement	AURYXIA TAB*, FERRIC CITRATE TAB* (ferric citrate)	Any two of the following generics: calcium acetate, calcium carbonate, sevelamer carbonate, sevelamer HCl OR any one of the following generics: ferrous fumarate, ferrous gluconate, ferrous sulfate
Miscellaneous: Phosphate Binders	VELPHORO CHEW TAB* (sucroferric oxyhydroxide) XPHOZAH TAB* (tenapanor)	Any two of the following generics: calcium acetate, calcium carbonate, sevelamer carbonate, sevelamer HCl
Respiratory: Long-Acting Bronchodilators (COPD)	INCRUSE ELLIPTA* (umeclidinium) TUDORZA PRESSAIR* (aclidinium)	Generic tiotropium inhalation capsules

Quantity Limits (QL)^

The following medications have a new or revised quantity limit. Your plan provides coverage for quantities up to the amount shown. A prior authorization review may be required to determine if your plan covers additional quantities of these medications.

Therapeutic use	Medication name	New or revised quantity limit
Anti-infectives: Anthelmintics	albendazole tab 200 mg	120 tablets per 180 days
	BILTRICIDE TAB 600 MG, praziquantel tab 600 mg	105 tablets per 180 days
	EMVERM TAB 100 MG	6 tablets per 180 days
	ivermectin 6 mg tab	9 tablets per 180 days
	STROMECTOL TAB 3 MG, ivermectin 3 mg tab	18 tablets per 180 days
Central Nervous System: Alzheimer's Agents	LEQEMBI IV SOLN 200 MG/2 ML*	10 vials per 28 days
	LEQEMBI IV SOLN 500 MG/5 ML*	4 vials per 28 days
Miscellaneous: Viscosupplements	DUROLANE INJ 60 MG/3 ML	2 syringes per 180 days
	EUFLEXXA INJ 20 MG/2 ML	6 syringes per 180 days
	GEL-ONE INJ 30 MG/3 ML*	2 syringes per 180 days
	GELSYN-3 INJ 16.8 MG/2 ML	6 syringes per 180 days
	GENVISC 850 INJ 25 MG/2.5 ML*	6 syringes per 180 days
	HYALGAN INJ 20 MG/2 ML*	6 syringes or 10 vials per 180 days
	HYMOVIS INJ 24 MG/3 ML*	4 syringes per 180 days
	HYMOVIS ONE INJ 32 MG/4 ML*	2 syringes per 180 days
	MONOVISC INJ 88 MG/4 ML*	2 syringes per 180 days
	ORTHOVISC INJ 30 MG/2 ML*	8 syringes per 180 days
	SUPARTZ FX INJ 25 MG/2.5 ML*	6 syringes per 180 days
	SYNOJOYNT INJ 20 MG/2 ML*	6 syringes per 180 days
	SYNVISC INJ 8 MG/ML*	6 syringes per 180 days

*Excluded on premium

^Can apply to both brand and generic

Therapeutic use	Medication name	New or revised quantity limit
	SYNVISC ONE INJ 8 MG/ML*	2 syringes per 180 days
	TRILURON INJ 20 MG/2 ML*	6 syringes per 180 days
	TRIVISC INJ 25 MG/2.5 ML*	6 syringes per 180 days
	VISCO-3 INJ 25 MG/2.5 ML*	6 syringes per 180 days
Ophthalmology: Anti-Inflammatory	XDEMVY SOLN 0.25%*	2 bottles per 180 days
Respiratory: Pulmonary Fibrosis	ESBRIET TAB/CAP 267 MG*, pirfenidone tab/ cap 267 mg	9 tablets per day
	ESBRIET TAB 801 MG*, pirfenidone tab 801 mg	3 tablets per day
	OFEV CAP	2 capsules per day

When differences between this list and your benefit plan documents exist, please refer to the information included in your benefit plan documents. This is not a complete list of your covered medications. Please review your benefit plan documents for information on what medications are covered by your plan.

Questions?

Call the number on your member ID card.

Visit your plan's website on your member ID card or log on to your plan's app to:

- Find a participating retail pharmacy by zip code.
- Look up possible lower-cost medication alternatives.
- Compare medication pricing and options.

*Excluded on premium

^Can apply to both brand and generic