Your Prescription Benefit Updates

Utilization Management Changes

Effective
January 1, 2027

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
Central Nervous System: Non-Narcotic Analgesics	ZYBIC*, MELOXICAM SUSP 7.5 MG/5 ML* (meloxicam)

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)
Cardiology: Heart Failure	CORLANOR TAB* (ivabradine)	Generic ivabradine
Cardiology: Renin-Angiotensin System Agents	BENICAR TAB* (olmesartan)	Any one of the following generics: amlodipine/benazepril, amlodipine/olmesartan, benazepril, benazepril/HCTZ, candesartan, candesartan/HCTZ, captopril, captopril/HCTZ, enalapril, enalapril/HCTZ, fosinopril, fosinopril/HCTZ, irbesartan, irbesartan/HCTZ, lisinopril, lisinopril/HCTZ, losartan, losartan/HCTZ, moexipril, olmesartan, olmesartan/HCTZ, olmesartan/amlodipine/HCTZ, perindopril, quinapril, quinapril/HCTZ, ramipril, telmisartan, telmisartan/HCTZ, trandolapril, trandolapril/verapamil
Central Nervous System: Neurologic Agents	SAVELLA TAB* (milnacipran) SAVELLA STARTER PACK* (milnacipran)	Generic milnacipran and any one of the following generics: amitriptyline, cyclobenzaprine, duloxetine, gabapentin IR, pregabalin
Central Nervous System: Anticonvulsants	BRIVIACT SOLN 10 MG/ML* (brivaracetam) BRIVIACT TAB* (brivaracetam)	Generic brivaracetam and any one of the following generics: lamotrigine IR, levetiracetam IR/ER, oxcarbazepine IR, topiramate IR
Endocrinology: Diabetes Supplies	V-GO 20 KIT V-GO 30 KIT V-GO 40 KIT	Any one of the following: OMNIPOD or TWIIST

*Excluded on premium

^Can apply to both brand and generic

Therapeutic use	Requested medication	New or revised trial medications (step requirement)
Endocrinology: DPP4 Inhibitors	ALOGLIPTIN TAB* (alogliptin) ALOGLIPTIN/METFORMIN TAB* (alogliptin/metformin) ALOGLIPTIN/PIOGLITAZONE TAB* (alogliptin/pioglitazone) BRYNOVIN SOLN 25 MG/ML* (sitagliptin) JANUVIA TAB* (sitagliptin) JANUMET TAB* (sitagliptin/metformin) JANUMET XR TAB* (sitagliptin/metformin) ONGLYZA TAB* (saxagliptin) ZITUVIMET*, SITAGLIPTIN/METFORMIN TAB* (sitagliptin/metformin) ZITUVIMET XR TAB* (sitagliptin/metformin) ZITUVIO*, SITAGLIPTIN TAB* (sitagliptin)	Any one of the following generics: metformin IR/ER, glipizide/metformin, glyburide/metformin, pioglitazone/metformin AND any one of the following generics: sitagliptin, sitagliptin/metformin AND any one of the following: Jentadueto, Jentadueto XR, Tradjenta
Endocrinology: SGLT-2 Inhibitors	BRENZAVVY TAB*, BEXAGLIFLOZIN TAB* (bexagliflozin) FARXIGA TAB* (dapagliflozin) INVOKAMET TAB* (canagliflozin/metformin) INVOKAMET XR TAB* (canagliflozin/metformin) INVOKANA TAB* (canagliflozin) QTERN*, DAPAGLIFLOZIN/SAXAGLIPTIN TAB* (dapagliflozin/saxagliptin) STEGLATRO TAB* (ertugliflozin) STEGLUJAN TAB* (ertugliflozin/sitagliptin) SEGLUROMET TAB* (ertugliflozin/metformin) XIGDUO XR TAB* (dapagliflozin/metformin ER)	Any one of the following generics: metformin IR/ER, glipizide/metformin, glyburide/metformin, pioglitazone/metformin AND any one of the following generics: dapagliflozin, dapagliflozin/metformin AND any one of the following: GLYXAMBI, TRIJARDY XR, JARDIANCE, SYNJARDY, SYNJARDY XR
Endocrinology: SGLT-2 Inhibitors	INPEFA TAB* (sotagliflozin)	Both of the following: generic dapagliflozin and JARDIANCE
Gastroenterology: Irritable Bowel Syndrome	DELZICOL CAP* (mesalamine) LIALDA TAB 1.2 GM* (mesalamine)	Both of the following: generic mesalamine and APRISO
Miscellaneous: Smoking Cessation Products	CHANTIX* (varenicline)	Generic varenicline

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Therapeutic use	Requested medication	New or revised trial medications (step requirement)
Ophthalmology: Antiglaucoma Agents	IYUZEH SOLN 0.005%* (latanoprost) LUMIGAN SOLN* (bimatoprost) OMLONTI SOLN 0.002%* (omidenepag) XELPROS EMULSION (latanoprost) VYZULTA SOLN* (latanoprostene bunod)	All of the following generic ophthalmic solutions: latanoprost, travoprost, bimatoprost
Respiratory: Short-Acting Bronchodilator	ATROVENT HFA 17 MCG	Generic ipratropium HFA
Urology: Overactive Bladder	GELNIQUE GEL (oxybutynin) GEMTESA TAB* (vibegron) MYRBETRIQ TAB* (mirabegron) MYRBETRIQ SUSP 8 MG/ML* (mirabegron) OXYTROL PATCH (oxybutynin) TOVIAZ TAB* (fesoterodine)	Any two of the following: darifenacin ER, fesoterodine ER, oxybutynin IR/ER, solifenacin, tolterodine IR/ER, trospium IR/ER, mirabegron

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: Antiretrovirals, HIV	CABENUVA SUSP 400 MG-600 MG	1 kit per 28 days
	CABENUVA SUSP 600 MG-900 MG	1 kit per 28 days
Cardiology: Antilipemic	JUXTAPID 5 MG	56 caps per 365 days
	JUXTAPID 10 MG	56 caps per 365 days
Endocrinology & Metabolism: Diabetic Supplies	GLUCOSE TEST STRIPS (ALL BRANDS)	Plan covers 100 strips per 30 days without insulin use; or 300 strips per 30 days with insulin use
	OMNIPOD DASH PODS (GEN 4), OMNIPOD 5 DEXCOM G7G6 PODS (GEN 5), OMNIPOD 5 LIBRE2 PLUS G6 PODS	10 pods per 30 days
	MODD1 SUPPLY KIT, TWIIST REFILL KIT/INFUSION SET	1 kit per 30 days
	TWIIST REFILL KIT	1 kit per 30 days
	V-GO KIT	1 kit per 30 days
Gastroenterology: Bowel Prep Agents	MOVIPREP*	2 kits per 365 days

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^Can apply to both brand and generic

Therapeutic use	Medication name	New or revised quantity limit
Oncology (Oral): Kinase and Molecular Target Inhibitors	PIQRAY THERAPY PACK	2 tablets per day
	PIQRAY 200 MG THERAPY PACK	1 tablet per day
	ZYDELIG TAB	2 tablets per day
	ITOVEBI TAB 9 MG	1 tablet per day
	COPIKTRA 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

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