

Optum Rx Medicare Prescription Drug Plan

Your 2025 Abridged Formulary (partial list of covered drugs or “Drug List”)

Administered for the Michigan Public School Employees’ Retirement System
by Optum Rx[®]

Effective January 1, 2025



Please read: this document contains information about covered drugs. This abridged formulary (“Drug List”) was updated on August 5, 2024, and is not a complete Drug List covered by your plan. For more recent information or if you have questions, please contact Optum Rx.

Optum Rx Member Services

Phone (toll-free): 1-855-577-6517
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,” “your plan,” or “our plan,” it means the Optum Rx Medicare Prescription Drug Plan offered by the Michigan Public School Employees’ Retirement System.

In most instances, you must use network pharmacies to use your prescription drug benefit. The benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2026.

What is the Abridged Formulary (“Drug List”)?

A formulary is a list of covered drugs selected by Optum Rx and a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We call it the “Drug List.” This plan will generally cover the drugs listed in the Drug List 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 drug listing 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 Drug List, appears on the front and back cover pages.

Can the Drug List change?

Most changes in drug coverage happen on January 1, but the Optum Rx Medicare Prescription Drug Plan 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](https://www.optumrx.com).

Changes that can affect you this year: In the below cases, 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 versions of an original biological product, that was already on the formulary (for example, adding an interchangeable biosimilar 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 for you and continue to cover the drug you have been taking. For more information, see the section below titled “How do I request an exception to Optum Rx’s 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 if the Food and Drug Administration determines the drug is to be withdrawn due to 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 Optum Rx’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug in the beginning of the 2025 year, it will not be discontinued or reduced in coverage except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions 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, 2026, such changes would affect you. It is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of January 1, 2025. To get updated information about the drugs covered by Optum Rx Medicare 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 visit optumrx.com where you will find the most up-to-date information by using the “Drug Information” tool (found under the “Member Tools” tab). You may also call Optum Rx Member Services. Our contact information is shown on the front and back cover pages.

How do I use the Drug List?

There are 2 ways to find your drug:

- **Medical Condition**

Beginning on page 8, the drugs 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.

How does cost-sharing work?

The Drug List includes generic drugs, preferred brand-name drugs, non-preferred brand-name drugs, and preferred and non-preferred high-cost drugs. Each drug is in one of 5 cost-sharing tiers.

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, as well as some preferred specialty drugs.

Tier 3	Drugs listed under Tier 3 include non-preferred brand name drugs that generally have higher copayments than preferred brand-name drugs.
Tier 4	Drugs listed in Tier 4 include preferred specialty or high-cost drugs. These drugs cost \$950 or more for up to a 30-day maximum supply, and generally have a lower copayment than drugs in non-preferred tier below.
Tier 5	Drugs listed in Tier 5 include non-preferred specialty or high-cost drugs. These drugs cost \$950 or more for up to a 30-day maximum supply, and generally have a higher copayment than drugs in the preferred tier above.

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

What are 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 additional coverage requirements?

Yes. Some covered drugs may have additional requirements or limits. 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. You must renew your prior authorization annually.

Quantity Limits (QL) For certain drugs, there is a limit on the amount of the drug you can get each time you fill your prescription. This may be in addition to a standard one-month or three-month supply.

Step Therapy (ST) In some cases, you must first try certain drugs to treat your medical condition before another drug for that condition will be covered. For example, if Drug A and Drug B both treat your medical condition, Drug B may not be covered unless you try Drug A first. If Drug A does not work for you, Drug B will be covered.

To find out if your drug has any additional requirements or limits, look in the Drug List that begins on page 8. You can also get information about requirements 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 Drug List, is shown on the front and back cover pages. You can ask Optum Rx to make an exception to these requirements 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. Optum Rx pays for certain OTC drugs. The cost to Optum Rx of these OTC drugs will not count toward your total Part D drug costs.

What if my drug is not on the Drug List?

If your drug is not included in this Drug List, you should first contact Optum Rx and ask if your drug is covered. You can also view a full list of covered drugs at [optumrx.com](https://www.optumrx.com). This document includes only a partial list of covered drugs. Our contact information, along with the date we last updated the Drug List, 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. See below for information about how to request an exception.

How do I request an exception?

Ask Optum Rx to make an exception before you fill your prescription.

- You can ask for a drug to be covered even if it is not on the Drug List. 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 for coverage requirements or limits to be waived on your drug. For example, if your drug has a limit on the amount of the drug you can get each time you fill your prescription, you can ask for a greater quantity.
- You can ask for a drug on the Drug List to be covered at a lower cost-sharing level if the drug is not in Tier 4. If approved, this would lower the amount you must pay for your drug.

Generally, we will only approve your request for an exception if the alternative drug is included on the Drug List, or applying the restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You must submit a statement from your prescriber supporting your request for an exception. When you request an exception, your prescriber will need to explain the medical reasons why you need the exception. Generally, we will 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 will 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?

If your drugs are not on the Drug List, or if your ability to get your drugs is limited, your drugs may be covered while you talk to your prescriber to determine the right course of action for you.

During the first 90 days you are a member of this plan, you may receive a temporary 31-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. If you are a resident of a long-term care facility, you may receive more than one refill during the first 90 days you are a member of this plan or, if you are past the first 90 days of membership, you may receive a 31-day emergency supply of your drugs (unless you have a prescription for fewer days).

If you are a current enrollee with a level-of-care change you can receive a temporary 31-day transition supply (unless you have a prescription written for fewer days). If you are in the process of seeking an exception, you may be allowed continued coverage until a decision is made.

For more information

For more detailed information about your prescription drug coverage, please review your *Evidence of Coverage*. 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.

Drug List (Formulary)

The abridged drug listing below provides 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 additional requirements for coverage of your drug.

Requirements/Limits	Helpful Tips
B/D	<p>This prescription drug has a Part B versus Part D administrative prior authorization requirement. This drug may be covered under Medicare Part B (your Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO Plan) or D (your Optum Rx Medicare Prescription Drug Plan) depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.</p>
NDS	<p>Non-Extended Days' Supply. This prescription drug is not available for an extended days' supply.</p>
PA	<p>Prior Authorization. You or your physician must 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.</p>
QL	<p>Quantity Limit. Certain drugs have limits on the amount of the drug you can get each time you fill your prescription. This may be in addition to a standard one-month or three-month supply.</p>
ST	<p>Step Therapy. In some cases, you must first try certain drugs to treat your medical condition before another drug is covered for that condition. For example, if Drug A and Drug B both treat your medical condition, Drug B may not be covered unless you try Drug A first. If Drug A does not work for you, Drug B will be covered.</p>

Drug Name	Drug Tier	Requirements/Limits
Analgesics		
<i>Nonsteroidal Anti-inflammatory Drugs</i>		
<i>celecoxib capsule</i>	1	QL(60 EA per 30 days)
<i>diclofenac sodium gel</i>	1	QL(1000 GM per 30 days)
<i>ibuprofen tablet 400mg, 600mg, 800mg</i>	1	
<i>meloxicam tablet</i>	1	
<i>naproxen tablet 250mg, 375mg, 500mg</i>	1	
<i>Opioid Analgesics, Short-acting</i>		
<i>acetaminophen/codeine tablet</i>	1	NDS
<i>hydrocodone bitartrate/acetaminophen tablet 300mg; 10mg, 300mg; 5mg, 300mg; 7.5mg, 325mg; 10mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	NDS
<i>hydrocodone/acetaminophen tablet 325mg; 7.5mg</i>	1	NDS
<i>oxycodone hydrochloride tablet</i>	1	NDS
<i>oxycodone/acetaminophen tablet 325mg; 10mg, 325mg; 2.5mg, 325mg; 5mg, 325mg; 7.5mg</i>	1	NDS
<i>tramadol hydrochloride tablet 100mg, 50mg</i>	1	NDS
Anesthetics		
<i>Local Anesthetics</i>		
<i>lidocaine patch 5%</i>	1	PA
Anti-Addiction/Substance Abuse Treatment Agents		
<i>Opioid Reversal Agents</i>		
<i>naloxone hydrochloride liquid</i>	1	
Antibacterials		
<i>Antibacterials, Other</i>		
<i>clindamycin hcl capsule 300mg</i>	1	
<i>clindamycin hydrochloride capsule 150mg, 75mg</i>	1	
<i>metronidazole tablet</i>	1	
<i>nitrofurantoin monohydrate/macrocrystals</i>	1	
<i>nitrofurantoin monohydrate capsule</i>	1	
<i>Beta-lactam, Cephalosporins</i>		
<i>cefadroxil capsule</i>	1	
<i>cefdinir capsule</i>	1	
<i>cefpodoxime proxetil tablet</i>	1	
<i>cefuroxime axetil tablet</i>	1	
<i>cephalexin capsule</i>	1	
<i>Beta-lactam, Penicillins</i>		
<i>amoxicillin/clavulanate potassium tablet</i>	1	
<i>amoxicillin capsule, tablet</i>	1	
<i>penicillin v potassium tablet</i>	1	
<i>Macrolides</i>		
<i>azithromycin tablet</i>	1	

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You can find information on what the symbols and abbreviations in this table mean by going to the introduction pages of this document.

Drug Name	Drug Tier	Requirements/Limits
Quinolones		
<i>ciprofloxacin hcl tablet 100mg, 750mg</i>	1	
<i>ciprofloxacin hydrochloride tablet 250mg, 500mg</i>	1	
<i>levofloxacin tablet</i>	1	
Sulfonamides		
<i>sulfamethoxazole/trimethoprim ds</i>	1	
Tetracyclines		
<i>doxycycline hyclate capsule</i>	1	
<i>doxycycline hyclate tablet 100mg, 50mg</i>	1	
<i>doxycycline monohydrate capsule, tablet</i>	1	
Anticonvulsants		
Anticonvulsants, Other		
<i>lamotrigine tablet</i>	1	
<i>levetiracetam tablet</i>	1	
Gamma-aminobutyric Acid (GABA) Modulating Agents		
<i>clonazepam tablet 2mg</i>	1	QL(300 EA per 30 days)
<i>clonazepam tablet 0.5mg, 1mg</i>	1	QL(90 EA per 30 days)
<i>divalproex sodium dr</i>	1	
<i>divalproex sodium er</i>	1	
<i>gabapentin capsule 400mg</i>	1	QL(270 EA per 30 days)
<i>gabapentin capsule 100mg, 300mg</i>	1	QL(360 EA per 30 days)
<i>gabapentin tablet 800mg</i>	1	QL(150 EA per 30 days)
<i>gabapentin tablet 600mg</i>	1	QL(180 EA per 30 days)
<i>pregabalin capsule 300mg</i>	1	QL(60 EA per 30 days)
<i>pregabalin capsule 100mg, 150mg, 200mg, 225mg, 25mg, 50mg, 75mg</i>	1	QL(90 EA per 30 days)
Antidementia Agents		
Cholinesterase Inhibitors		
<i>donepezil hcl tablet 10mg, 23mg</i>	1	
<i>donepezil hydrochloride tablet 10mg, 5mg</i>	1	
N-methyl-D-aspartate (NMDA) Receptor Antagonist		
<i>memantine hydrochloride tablet</i>	1	
Antidepressants		
Antidepressants, Other		
BUPROPION HYDROCHLORIDE ER (XL) TABLET EXTENDED RELEASE 24 HOUR 450MG	3	QL(30 EA per 30 days)
<i>bupropion hydrochloride er (xl) tablet extended release 24 hour 300mg</i>	1	QL(30 EA per 30 days)
<i>bupropion hydrochloride er (xl) tablet extended release 24 hour 150mg</i>	1	QL(90 EA per 30 days)
<i>mirtazapine tablet</i>	1	
<i>quetiapine fumarate tablet 150mg</i>	1	QL(90 EA per 30 days)
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin and Norepinephrine Reuptake Inhibitor)		

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Drug Name	Drug Tier	Requirements/Limits
<i>citalopram hydrobromide tablet</i>	1	
<i>duloxetine hcl capsule delayed release particles 40mg</i>	1	QL(90 EA per 30 days)
<i>duloxetine hydrochloride capsule delayed release particles 20mg, 60mg</i>	1	QL(60 EA per 30 days)
<i>duloxetine hydrochloride capsule delayed release particles 30mg, 40mg</i>	1	QL(90 EA per 30 days)
<i>escitalopram oxalate tablet</i>	1	
<i>fluoxetine hydrochloride capsule</i>	1	
<i>sertraline hcl tablet 50mg</i>	1	
<i>sertraline hydrochloride tablet 100mg, 25mg</i>	1	
<i>trazodone hydrochloride</i>	1	
<i>venlafaxine hydrochloride er capsule extended release 24 hour</i>	1	
Tricyclics		
<i>amitriptyline hcl tablet 100mg, 150mg, 25mg, 75mg</i>	1	
<i>amitriptyline hydrochloride tablet 100mg, 10mg, 50mg</i>	1	
Antiemetics		
<i>Antiemetics, Other</i>		
<i>meclizine hcl tablet</i>	1	
<i>scopolamine</i>	1	
<i>Emetogenic Therapy Adjuncts</i>		
<i>ondansetron hcl tablet 24mg</i>	1	QL(14 EA per 28 days); B/D
<i>ondansetron hydrochloride tablet</i>	1	B/D
<i>ondansetron odt tablet disintegrating 4mg, 8mg</i>	1	B/D
Antifungals		
<i>Antifungals</i>		
<i>clotrimazole cream</i>	1	QL(90 GM per 30 days)
<i>fluconazole tablet</i>	1	
<i>ketoconazole shampoo</i>	1	
<i>ketoconazole cream</i>	1	QL(90 GM per 30 days)
<i>nystatin cream</i>	1	
<i>nystatin powder</i>	1	QL(120 GM per 30 days)
Antigout Agents		
<i>Antigout Agents</i>		
<i>allopurinol tablet 100mg, 300mg</i>	1	
<i>colchicine tablet 0.6mg</i>	1	
Antimigraine Agents		
<i>Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists</i>		
NURTEC	5	QL(18 EA per 30 days); PA; NDS
Antineoplastics		
<i>Aromatase Inhibitors, 3rd Generation</i>		
<i>anastrozole tablet</i>	1	
Antiparasitics		
<i>Antiprotozoals</i>		

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Drug Name	Drug Tier	Requirements/Limits
<i>hydroxychloroquine sulfate tablet</i>	1	
Antiparkinson Agents		
<i>Anticholinergics</i>		
<i>benztropine mesylate tablet</i>	1	
<i>Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors</i>		
<i>carbidopa/levodopa</i>	1	
Antipsychotics		
<i>2nd Generation/Atypical</i>		
<i>aripiprazole tablet</i>	1	QL(30 EA per 30 days)
<i>olanzapine tablet</i>	1	QL(30 EA per 30 days)
<i>quetiapine fumarate tablet 300mg, 400mg</i>	1	QL(60 EA per 30 days)
<i>quetiapine fumarate tablet 100mg, 200mg, 25mg, 50mg</i>	1	QL(90 EA per 30 days)
<i>risperidone tablet</i>	1	QL(60 EA per 30 days)
Antispasticity Agents		
<i>Antispasticity Agents</i>		
<i>baclofen tablet 10mg, 20mg, 5mg</i>	1	
<i>tizanidine hcl tablet 2mg</i>	1	
<i>tizanidine hydrochloride tablet 4mg</i>	1	
Antivirals		
<i>Anti-influenza Agents</i>		
<i>oseltamivir phosphate capsule 75mg</i>	1	QL(110 EA per 365 days)
<i>oseltamivir phosphate capsule 30mg</i>	1	QL(168 EA per 365 days)
<i>oseltamivir phosphate capsule 45mg</i>	1	QL(84 EA per 365 days)
<i>Antiherpetic Agents</i>		
<i>acyclovir tablet</i>	1	
<i>valacyclovir hydrochloride</i>	1	QL(120 EA per 30 days)
<i>Antiviral, Coronavirus Agents</i>		
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)
Anxiolytics		
<i>Anxiolytics, Other</i>		
<i>bupirone hcl tablet 15mg</i>	1	
<i>bupirone hydrochloride tablet 10mg, 30mg, 5mg, 7.5mg</i>	1	
<i>Benzodiazepines</i>		
<i>alprazolam tablet 0.25mg, 0.5mg, 1mg</i>	1	QL(120 EA per 30 days)
<i>alprazolam tablet 2mg</i>	1	QL(150 EA per 30 days)
<i>diazepam tablet 10mg</i>	1	QL(120 EA per 30 days)
<i>diazepam tablet 5mg</i>	1	QL(240 EA per 30 days)
<i>diazepam tablet 2mg</i>	1	QL(300 EA per 30 days)
<i>lorazepam tablet 2mg</i>	1	QL(150 EA per 30 days)
<i>lorazepam tablet 0.5mg, 1mg</i>	1	QL(90 EA per 30 days)
Blood Glucose Regulators		

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Drug Name	Drug Tier	Requirements/Limits
Antidiabetic Agents		
<i>glimepiride tablet 1mg, 2mg, 4mg</i>	1	
<i>glipizide tablet</i>	1	
JANUVIA	2	QL(30 EA per 30 days)
<i>metformin hydrochloride er</i>	1	
<i>metformin hydrochloride tablet 1000mg, 500mg, 850mg</i>	1	
MOUNJARO	4	QL(2 ML per 28 days); PA; NDS
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
VICTOZA	3	QL(9 ML per 30 days); PA
Insulins		
HUMALOG KWIKPEN	3	
LANTUS	2	
LANTUS SOLOSTAR	2	
NOVOLOG FLEXPEN	2	
NOVOLOG FLEXPEN RELION	2	
Blood Products and Modifiers		
Anticoagulants		
<i>dabigatran etexilate</i>	1	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		
<i>clopidogrel</i>	1	
Cardiovascular Agents		
Alpha-adrenergic Agonists		
<i>clonidine hydrochloride tablet</i>	1	
Angiotensin II Receptor Antagonists		
<i>irbesartan</i>	1	
<i>losartan potassium tablet</i>	1	
<i>olmesartan medoxomil tablet</i>	1	
<i>valsartan tablet</i>	1	
Angiotensin-converting Enzyme (ACE) Inhibitors		
<i>lisinopril tablet</i>	1	
<i>ramipril</i>	1	
Antiarrhythmics		
<i>amiodarone hydrochloride tablet</i>	1	
Beta-adrenergic Blocking Agents		
<i>atenolol tablet</i>	1	
<i>carvedilol</i>	1	
<i>metoprolol succinate er</i>	1	

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Drug Name	Drug Tier	Requirements/Limits
<i>metoprolol tartrate tablet</i>	1	
<i>nebivolol hydrochloride</i>	1	
<i>nebivolol tablet 5mg</i>	1	
<i>propranolol hcl tablet 40mg</i>	1	
<i>propranolol hydrochloride tablet 10mg, 20mg, 60mg, 80mg</i>	1	
Calcium Channel Blocking Agents, Dihydropyridines		
<i>amlodipine besylate tablet</i>	1	
Calcium Channel Blocking Agents, Nondihydropyridines		
<i>diltiazem hcl cd</i>	1	
<i>diltiazem hydrochloride er capsule extended release 24 hour</i>	1	
Cardiovascular Agents, Other		
ENTRESTO TABLET	3	QL(60 EA per 30 days)
<i>lisinopril/hydrochlorothiazide</i>	1	
<i>losartan potassium/hydrochlorothiazide</i>	1	
<i>triamterene/hydrochlorothiazide capsule 25mg; 37.5mg</i>	1	
Diuretics, Loop		
<i>bumetanide tablet</i>	1	
<i>furosemide tablet</i>	1	
<i>toremide tablet</i>	1	
Diuretics, Thiazide		
<i>chlorthalidone tablet 25mg, 50mg</i>	1	
<i>hydrochlorothiazide capsule, tablet</i>	1	
Dyslipidemics, Fibrin Acid Derivatives		
<i>fenofibrate tablet</i>	1	
Dyslipidemics, HMG CoA Reductase Inhibitors		
<i>atorvastatin calcium</i>	1	
<i>pravastatin sodium</i>	1	
<i>rosuvastatin calcium tablet</i>	1	
<i>simvastatin tablet</i>	1	
Dyslipidemics, Other		
<i>ezetimibe</i>	1	
<i>icosapent ethyl</i>	1	
<i>omega-3-acid ethyl esters</i>	1	
REPATHA SURECLICK	2	QL(3 ML per 28 days); PA
Mineralocorticoid Receptor Antagonists		
<i>spironolactone tablet</i>	1	
Sodium-Glucose Co-Transporter 2 Inhibitors (SGLT2i)		
JARDIANCE	2	QL(30 EA per 30 days)
Vasodilators, Direct-acting Arterial/Venous		
<i>isosorbide mononitrate er</i>	1	
<i>nitroglycerin tablet sublingual 0.3mg, 0.4mg, 0.6mg</i>	1	
Vasodilators, Direct-acting Arterial		
<i>hydralazine hcl tablet 10mg</i>	1	
<i>hydralazine hydrochloride tablet 100mg, 25mg, 50mg</i>	1	

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Dental and Oral Agents		
<i>Dental and Oral Agents</i>		
<i>chlorhexidine gluconate solution</i>	1	
Dermatological Agents		
<i>Dermatitis and Pruritus Agents</i>		
<i>clobetasol propionate cream, ointment, solution</i>	1	
<i>hydrocortisone cream 1%, 2.5%</i>	1	
<i>mometasone furoate cream 0.1%</i>	1	
<i>triamcinolone acetonide cream, ointment</i>	1	
<i>Dermatological Agents, Other</i>		
<i>clotrimazole/betamethasone dipropionate cream</i>	1	QL(90 GM per 30 days)
FLUOROURACIL CREAM 0.5%	4	NDS
<i>fluorouracil cream 5%</i>	1	QL(40 GM per 30 days)
<i>Topical Anti-infectives</i>		
<i>ciclopirox olamine</i>	1	
<i>mupirocin ointment</i>	1	QL(110 GM per 30 days)
Electrolytes/Minerals/Metals/Vitamins		
<i>Electrolyte/Mineral Replacement</i>		
<i>potassium chloride er</i>	1	
<i>Phosphate Binders</i>		
<i>sevelamer carbonate tablet</i>	1	
Gastrointestinal Agents		
<i>Anti-Constipation Agents</i>		
<i>lactulose solution 10gm/15ml</i>	1	
<i>Anti-Diarrheal Agents</i>		
<i>loperamide hcl capsule</i>	1	
VIBERZI	5	QL(60 EA per 30 days); PA; NDS
<i>Antispasmodics, Gastrointestinal</i>		
<i>dicyclomine hydrochloride capsule, tablet</i>	1	
<i>Gastrointestinal Agents, Other</i>		
CLENPIQ	3	
<i>gavilyte-c</i>	1	
<i>peg-3350/nacl/na bicarbonate/kcl</i>	1	
<i>sodium sulfate/potassium sulfate/magnesium sulfate</i>	1	
<i>Histamine2 (H2) Receptor Antagonists</i>		
<i>famotidine tablet 20mg, 40mg</i>	1	
<i>Protectants</i>		
<i>sucrafate tablet</i>	1	
<i>Proton Pump Inhibitors</i>		
<i>esomeprazole magnesium capsule delayed release</i>	1	QL(60 EA per 30 days)
<i>lansoprazole capsule delayed release</i>	1	QL(60 EA per 30 days)
<i>omeprazole dr capsule delayed release 10mg, 40mg</i>	1	QL(60 EA per 30 days)
<i>omeprazole capsule delayed release 10mg, 20mg, 40mg</i>	1	QL(60 EA per 30 days)
<i>pantoprazole sodium tablet delayed release</i>	1	QL(60 EA per 30 days)

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Genitourinary Agents		
<i>Antispasmodics, Urinary</i>		
GEMTESA	3	
<i>mirabegron er</i>	1	
MYRBETRIQ TABLET EXTENDED RELEASE 24 HOUR	2	
<i>oxybutynin chloride er</i>	1	
<i>oxybutynin chloride tablet 5mg</i>	1	
<i>Benign Prostatic Hypertrophy Agents</i>		
<i>alfuzosin hcl er</i>	1	
<i>dutasteride capsule</i>	1	
<i>finasteride tablet</i>	1	
<i>tadalafil tablet 2.5mg, 5mg</i>	1	QL(30 EA per 30 days); PA
<i>tamsulosin hydrochloride</i>	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</i>		
<i>dexamethasone tablet 0.5mg, 0.75mg, 1.5mg, 1mg, 2mg, 4mg, 6mg</i>	1	
<i>methylprednisolone dose pack tablet therapy pack</i>	1	
<i>prednisone tablet 10mg, 1mg, 2.5mg, 20mg, 50mg, 5mg</i>	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
<i>Estrogens</i>		
<i>estradiol cream</i>	1	
PREMARIN CREAM	2	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)</i>		
<i>levothyroxine sodium tablet</i>	1	
Immunological Agents		
<i>Immunosuppressants</i>		
<i>methotrexate sodium tablet</i>	1	
<i>Vaccines</i>		
ABRYSVO	2	QL(1 EA per 252 days)
ADACEL	2	
AREXVY	2	QL(1 EA per 999 days)
BOOSTRIX	2	
SHINGRIX	2	
Inflammatory Bowel Disease Agents		
<i>Aminosalicylates</i>		
<i>mesalamine er capsule extended release</i>	1	
PENTASA CAPSULE EXTENDED RELEASE 250MG	2	
Metabolic Bone Disease Agents		
<i>Metabolic Bone Disease Agents</i>		
<i>alendronate sodium tablet 10mg, 35mg, 5mg</i>	1	
<i>alendronate sodium tablet 70mg</i>	1	QL(4 EA per 28 days)

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

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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	3	QL(48 GM per 30 days)
<i>albuterol sulfate hfa aerosol solution 108mcg/act</i>	1	QL(13.4 GM per 30 days)
<i>albuterol sulfate hfa aerosol solution 108mcg/act</i>	1	QL(17 GM per 30 days)
<i>albuterol sulfate nebulization solution 2.5mg/0.5ml</i>	1	QL(100 EA per 30 days); B/D
<i>albuterol sulfate nebulization solution 0.63mg/3ml, 1.25mg/3ml</i>	1	QL(375 ML per 30 days); B/D
<i>albuterol sulfate nebulization solution 0.083%</i>	1	QL(525 ML per 30 days); B/D
<i>epinephrine injection 0.15mg/0.15ml, 0.15mg/0.3ml, 0.3mg/0.3ml</i>	1	
VENTOLIN HFA	3	QL(48 GM per 30 days); ST
Pulmonary Fibrosis Agents		
<i>pirfenidone</i>	4	PA; NDS
Respiratory Tract Agents, Other		
BREO ELLIPTA	2	QL(60 EA per 30 days)
CINQAIR	5	PA; NDS
<i>fluticasone propionate/salmeterol diskus</i>	1	QL(60 EA per 30 days)
<i>fluticasone propionate/salmeterol aerosol powder breath activated 500mcg/act; 50mcg/act</i>	1	QL(60 EA per 30 days)
<i>ipratropium bromide/albuterol sulfate</i>	1	QL(540 ML per 30 days); B/D
TRELEGY ELLIPTA	2	QL(60 EA per 30 days)
Skeletal Muscle Relaxants		
Skeletal Muscle Relaxants		
<i>cyclobenzaprine hydrochloride tablet</i>	1	PA
<i>methocarbamol tablet 500mg, 750mg</i>	1	
Sleep Disorder Agents		
Sleep Promoting Agents		
<i>zolpidem tartrate tablet</i>	1	QL(30 EA per 30 days)

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<i>spironolactone</i>	13		
<i>sucrafate</i>	14		
<i>sulfamethoxazole/trimethoprim ds</i>	9		
<i>tadalafil</i>	15		
<i>tamsulosin hydrochloride</i>	15		

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 1-855-577-6517. 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 1-855-577-6517. 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 1-855-577-6517。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 1-855-577-6517。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 1-855-577-6517. 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 1-855-577-6517. 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 quý vị cần thông dịch viên xin gọi 1-855-577-6517 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-577-6517. 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 1-855-577-6517 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 1-855-577-6517. 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 . سيقوم شخص ما يتحدث العربية 1-855-577-6517 على مترجم فوري، ليس عليك سوى الاتصال بنا على . 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 1-855-577-6517 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 1-855-577-6517. 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 1-855-577-6517. 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 1-855-577-6517. 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 1-855-577-6517. 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。通訳をご用命になるには、1-855-577-6517 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 5, 2024, and is not a 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): 1-855-577-6517
TTY users: 711
Hours of operation: 24 hours a day, 7 days a week
Website: optumrx.com

Optum Rx[®] optumrx.com

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