

**Humana Group Medicare**  
Humana Inc.  
P.O. Box 669  
Louisville, KY 40201-0669

**Important plan information**



**2025 Humana Group Medicare**  
Your journey to better health, for better retirement





# Humana®

A more human way  
to healthcare™



## We're here for you

Humana Group Medicare Customer Care

**800-585-7417 (TTY: 711)**

Monday – Friday, 7 a.m. – 8 p.m., Central time

Humana is a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal. Call **800-585-7417 (TTY: 711)** for more information.

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# Humana<sup>®</sup>

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## Welcome to a more human way to healthcare

Dear North Dakota Public Employees Retirement System (NDPERS) Member,

We're excited to let you know that **North Dakota Public Employees Retirement System (NDPERS)** has asked Humana to offer you a prescription drug plan that gives you prescription drug coverage to add to your Original Medicare plan.

Your health is more important than ever. That's why Humana has a variety of tools, programs and resources to help you stay on track. At Humana, helping you achieve lifelong well-being is our mission. During our over 30 years of experience with Medicare, we've learned how to be a better partner in health.

### Get to know your plan

Review the enclosed materials. This packet includes information on your Group Medicare prescription drug plan option along with extra services Humana provides.

- If you have questions about your premium, please call **North Dakota Public Employees Retirement System (NDPERS) at 800-803-7377 or 701-328-3900 (TTY: 711)**.
- Please see your enclosed prescription drug guide (PDG) to determine if your medications have quantity limits, require a prior authorization or step therapy. You can also visit **Humana.com/Pharmacy** or call Group Medicare Customer Care for assistance.

We look forward to serving you now and for many years to come.

Sincerely,  
Group Medicare Operations

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## What to expect after you enroll

- **Enrollment confirmation**

You'll receive a letter from Humana once the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment.

- **Humana member ID card**

Your Humana member ID card will arrive in the mail shortly after you enroll.

- **Evidence of Coverage (EOC)**

You will receive information on how to view or request a copy of an Evidence of Coverage document (also known as a member contract or subscriber agreement). Please read the document to learn about the plan's coverage and services. This will also include your privacy notice.

## We're here for you

If you have questions or need help, call Humana Group Medicare Customer Care,

**800-585-7417 (TTY: 711),**

Monday – Friday, 7 a.m. – 8 p.m., Central time

# Get the hassle-free care you deserve



## Humana Prescription Drug Plan offers you:

### A large network

There are more than 62,000 participating pharmacies in our network.

### Almost no claims paperwork

The plan works with your pharmacist to handle claims for you.

### Pharmacy finder

An online tool that helps you find in-network pharmacies. It also tells you how far they are from you, the hours they're open, if they have a drive-through available, if they offer emergency Rx, delivery options and if they have bilingual employees.

### Details you need to know

North Dakota Public Employees Retirement System (NDPERS) partners with Humana Group Medicare for your prescription drug plan (PDP). If you have already enrolled, no further action is needed as your enrollment has been processed. If you would like to enroll in this plan, please contact the NDPERS office to verify eligibility and to request application materials. Enrollment in this plan will end your enrollment in any Medicare prescription drug plan or Medicare Advantage prescription drug plan that you are currently enrolled in.

# Humana®

## Going beyond your expectations

At Humana, what we do is more than health insurance. It's human care—care that works harder, goes farther and digs deeper. **All for you.**

## Your Group Medicare prescription drug plan guide

Understanding your Medicare plan and how it works is important. Humana believes everyone should have access to the tools and support needed to have a fair and just opportunity to be as healthy as possible.

### Inside this guide you'll find

How your plan works.....	8
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### Plan specific information

- Prescription Summary of Benefits
- Prescription Drug Guide



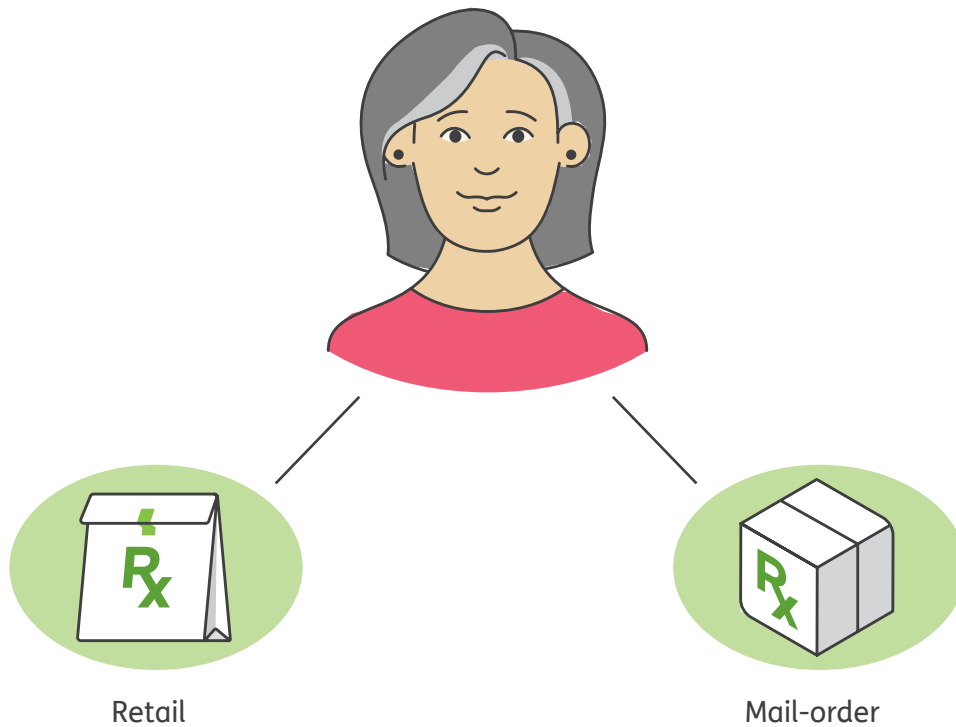
## How your prescription drug plan (PDP) works

You must use network pharmacies to enjoy the benefits of our plan except in an emergency. Pharmacies in the network have agreed to work with Humana to fill prescriptions for our members. If you use a pharmacy outside the network, your costs may be higher.

Our pharmacy network includes access to mail delivery, specialty, retail, long-term care, home infusion, and Indian, tribal and urban pharmacies.

### Is your pharmacy in Humana's network?

You can find a complete list of network pharmacies at MyHumana, your personal, secure online account at **Humana.com** and the MyHumana Mobile app.\* Get printable maps and directions, along with many more details to find a pharmacy that fits your needs. Other information at **Humana.com/pharmacy/medicare/tools** includes printable drug lists and prior authorization information.



\*Standard data rates may apply.

## MyHumana and MyHumana mobile app

### Get your personalized health information on MyHumana

A valuable part of your Humana plan is a secure online account called MyHumana where you can keep track of your claims and benefits, find pharmacies, view important plan documents and more.

Whether you prefer using a desktop, laptop, tablet, or smartphone, you can access your account anytime by visiting [Humana.com/registration](https://www.humana.com/registration) to create your MyHumana account.\*

- Review your plan benefits
- Find in-network pharmacies
- Look up and compare medication prices
- View your Humana member ID card
- Check claims
- View your SmartSummary



### MyHumana mobile app

Download the MyHumana mobile app on your smartphone or tablet.\* You'll have your plan details with you at all times.

Visit [Humana.com/mobile-apps](https://www.humana.com/mobile-apps) to learn about our many mobile apps, the app features and how to use them.

### Have questions?

If you need help using MyHumana, call Customer Care at the number listed on the back of your Humana member ID card.

\*Standard data rates may apply

### Use Humana's Find care tool on the MyHumana mobile app

Once your plan begins you can use the MyHumana mobile app to find a pharmacy near you, wherever you are. Select "Find care" at the bottom of the app.

## Prescription drug coverage

Some medications covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, quantity limits or step therapy. You can visit [Humana.com/Pharmacy](https://www.humana.com/Pharmacy) to view your prescription drug guide, it will provide information on quantity limits, step therapy or if a prior authorization is required. If you have additional questions, please call our Customer Care number on the back of your Humana member ID card.

### Prior authorization

The Humana Group Medicare Plan requires you or your provider to get prior authorization for certain medications. This means that you will need to get approval from the Humana Group Medicare Plan before you fill your prescriptions. The reason a prior authorization is required can vary depending on the medication. Humana will work with your provider when a prior authorization is required. The Centers for Medicare & Medicaid Services (CMS) requires a turnaround time of 72 hours for a prior authorization. However, an expedited review can be requested by your provider if waiting 72 hours may be harmful to you.

### Quantity limits

For some medications, the Humana Group Medicare Plan limits the quantity of the medication that is covered. The Humana Group Medicare Plan might limit how many refills you can get or quantity of a medication you can get each time you fill your prescription. Specialty medications are limited to a 30-day supply regardless of tier placement.

### One-time transition fill

For certain medications typically requiring prior authorization or step therapy, Humana will cover a one-time, 30-day supply of your Part D covered medication during the first 90 days of your enrollment. Once you have received the transition fill\* for your prescription requiring a prior authorization or step therapy, you'll receive a letter from Humana telling you about the requirements or limits on the prescription. The letter will also advise that you will need to get approval before future refills will be covered. A prior authorization will need to be approved or other alternative medications should be tried if the medication requires step therapy.

### Step therapy

In some cases, the Humana Group Medicare Plan requires that you first try certain medications to treat your medical condition before coverage is available for a more expensive medication prescribed to treat your medical condition.

\*Some medications do not qualify for a transition fill, such as medications that require a Part B vs D determination, CMS Excluded medications, or those that require a diagnosis review to determine coverage.

**Talk to your provider about your medications to see if they require prior authorization, have quantity limits or if step therapy is needed.**

## Medicare Part D prescription medication tiers

### Tier 1 – Generic or preferred generic

#### **Essentially the same medications, usually priced differently**

Have the same active ingredients as brand-name medications and are prescribed for the same reasons. The Food and Drug Administration (FDA) requires generic medications to have the same quality, strength, purity and stability as brand-name medications. Your cost for generic medications is usually lower than your cost for brand-name medications.

### Tier 2 – Preferred brand

#### **A medication available to you for less than a nonpreferred**

Generic or brand-name medications that Humana offers at a lower cost to you than nonpreferred medications.

### Tier 3 – Nonpreferred medication

#### **A more expensive medication than a preferred**

More expensive generic or brand-name prescription medications that Humana offers at a higher cost to you than preferred medications.

### Tier 4 – Specialty

#### **Medications for specific uses**

Some injectable and other high-cost medications to treat chronic or complex illnesses like rheumatoid arthritis and cancer.



## Pharmacy options

Comprehensive pharmacy support for retirees.

### Retail pharmacy network

With Humana plans you have a variety of retail and mail-order options to fill your prescription.

- Robust network of retail national and independent pharmacies
- Offers flexibility and convenience

### CenterWell Pharmacy™

You have the choice of pharmacies for prescription retail and mail order services, CenterWell Pharmacy is one option.\*

CenterWell Pharmacy offers:

- Comprehensive pharmacy services
- Convenient mail-order solutions, refill reminders and patient support
- Safe and secure delivery backed by multiple checks by pharmacists

### CenterWell Specialty Pharmacy™

CenterWell Specialty Pharmacy offers a variety of specialty therapies that can help treat your condition.

CenterWell Specialty Pharmacy offers:

- Outstanding care & patient experience
- Specially-trained associates to provide patient support
- Enhanced experience for cancer, neuromuscular disorders and certain pulmonary conditions

\*Other pharmacies are available in the Humana network.







### Online

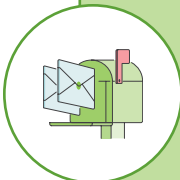
After you become a Humana member, you can sign in to **CenterWellPharmacy.com** with your MyHumana identification number and start a new prescription, order refills or check on an order.\*



### Phone

For maintenance medication(s), call CenterWell Pharmacy at **800-379-0092 (TTY: 711)**, Mon. – Fri., 7 a.m. – 10 p.m., and Sat., 7 a.m. – 5:30 p.m., Central time.

For specialty medication(s), call CenterWell Specialty Pharmacy at **800-486-2668 (TTY: 711)**, Mon. – Fri., 7 a.m. – 10 p.m., and Sat., 7 a.m. – 5:30 p.m., Central time.



### Mail

Download the “Registration & Prescription Order Form” from **CenterWellPharmacy.com/forms** and mail your paper prescriptions to: CenterWell Pharmacy, P.O. Box 745099, Cincinnati, OH 45274-5099



### Provider

Your provider can send prescriptions electronically through e-prescribe or by downloading the fax form from **CenterWellPharmacy.com/forms** and faxing the prescription to CenterWell Pharmacy at **800-379-7617** or CenterWell Specialty Pharmacy at **877-405-7940**.

\*Other pharmacies are available in the network.

## Where you get your vaccines may determine how they are covered

The Medicare Part D portion of your plan covers vaccines that are considered necessary to help prevent illness. Member cost share of all Part D vaccines listed on the Advisory Committee on Immunization Practices (ACIP) list<sup>1</sup> will be \$0.

### Get vaccines like the ones listed below at a network pharmacy

You can find a complete list of network pharmacies at [finder.humana.com/finder/pharmacy](https://finder.humana.com/finder/pharmacy).

Here are some common vaccines that you should get at your pharmacy, not from your provider's office.

- **Shingles:** This vaccine protects against shingles, a virus that causes a painful rash in people who have previously had chickenpox.
- **Tdap:** This booster vaccine protects against tetanus, diphtheria and pertussis (whooping cough). (Medicare Part B coverage will apply when a tetanus shot is related to injury and administered at your provider's office.)
- **RSV:** This vaccine protects against Respiratory Syncytial Virus, a lung and lower airway infection.

### Got questions?

Because vaccines are covered differently at the provider's office and the pharmacy, you may want to call first to understand how your insurance covers a specific vaccine. Call the Customer Care number on the back of your Humana member ID card or sign in to [MyHumana.com](https://MyHumana.com).

### Diabetes prescriptions and supplies covered under Part D

Part D typically covers diabetes supplies used to administer insulin. You must be enrolled in a Medicare drug plan to get the supplies Part D covers, like:

- diabetes medications
- insulin administered (or used) with syringes or pens
- syringes, pen needles or other insulin administration devices that are not durable medical equipment (e.g., Omnipod or VGO)

<sup>1</sup>For more information regarding the Centers for Disease Control and Prevention's ACIP vaccine recommendations, please go to [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html](https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/index.html).

### Important information for your pharmacist

Let your pharmacist know to use **BIN 015581** and **PCN 03200000** when filling your prescription for items covered under Part D.

## Your personalized benefits statement

Humana’s SmartSummary provides a comprehensive overview of your Part D benefits and prescription drug spending. **You’ll receive this statement after each month you’ve had a prescription claim processed.** You can also sign-in to MyHumana and see your past SmartSummary statements anytime.

### SmartSummary includes:

- **Numbers to watch.** SmartSummary shows your total drug costs for the month and year-to-date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- **Personalized messages.** SmartSummary gives you tips on saving money on the prescription drugs you take, information about changes in prescription copayments and how to plan ahead.
- **Your prescription details.** A personalized prescription section tells you more about your prescription medications, including information about dosage and the pharmacy provider. This page can be useful to take to your provider appointments or to your pharmacist.

**SmartSummary**<sup>®</sup>

Your Part D Pharmacy claims processed in February 2023

**THIS IS NOT A BILL**

This summary is your "Explanation of Benefits" (EOB) and claim payments for your Medicare prescription drug coverage (Part D). Please review this summary and keep it for your records. **This is not a bill.**

**Humana.**

**FIRSTNAME A LASTNAME**  
 Member ID: H12345678  
 Plan name: Humana Group Medicare PDP  
 Rx PCN or Rx Group number: 03200000

**OVERVIEW OF YOUR FEBRUARY CLAIMS**

	<b>Part D prescription drug claims</b> (see page 5)	
	Total cost this month	\$64.46
	Other payments	- \$0.00
	<b>Amount Humana paid</b>	<b>- \$19.13</b>
	<b>Your share</b>	<b>\$45.33</b>

You are currently in **Stage One** of your Part D Drug Payment Plan. (see page 2)

**CONTACT US IF YOU HAVE QUESTIONS OR NEED HELP.**

**Questions**  
 Login to MyHumana at [Humana.com](http://Humana.com) to see your benefits, drug lists, prescriptions and claims.

**Call us**  
 Call 866-396-8810 (TTY: 711)  
 Monday to Friday 8 a.m.- 9 p.m. EST. Calls to these numbers are free.

**For large print or another format**

## Frequently asked questions

### **Do I need to show my red, white and blue Medicare card when I visit the pharmacy?**

No. You'll get a Humana member ID card. Keep your Medicare ID card in a safe place.

### **What should I do if I move or have a temporary address change?**

If you move to another area or state, it may affect your plan. It's important to contact your group benefits administrator for details.

### **What should I do if I need prescriptions filled before I receive my Humana member ID card?**

If you need to fill a prescription after your coverage begins but before you receive your Humana member ID card, take a copy of your temporary proof of membership to any in-network pharmacy.

### **How can I get help with my drug plan costs?**

People with limited incomes may qualify for assistance from the Extra Help program to pay for their prescription drug costs. To see if you qualify for Extra Help, call **800-MEDICARE (800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **877-486-2048**. You can also call the Social Security Administration at **800-772-1213**. If you use a TTY, call **800-325-0778**. Your state's Medical Assistance (Medicaid) Office may also be able to help, or you can apply for Extra Help online at **www.ssa.gov**.

### **What should I do if I have to file a claim?**

To request reimbursement for a charge you paid for a prescription drug, send the provider's itemized receipt and the Prescription Drug Claim Form (available at **Humana.com** or by calling Customer Care) to the claims address on the back of your Humana member ID card. Make sure the receipt includes your name and Humana member ID number. Call Humana Group Medicare Customer Care for more information and assistance.

### **When does my coverage begin?**

Your former employer or union decides how and when you enroll. Check with your benefits administrator for the proposed effective date of your enrollment. Be sure to keep your current pharmacy coverage until your Humana Group Medicare PDP plan enrollment is confirmed.

## Pharmacy terms

### **Deductible (if applicable)**

#### **Your cost for Part D prescription medications before the plan pays**

The amount you pay for Part D prescription medications before the plan begins to pay its share.

### **Coinsurance**

#### **Your share of your prescription's cost**

This is a percentage of the total cost of a medication you pay each time you fill a prescription.

### **Copayment**

#### **What you pay at the pharmacy for your prescription**

The set dollar amount you pay when you fill a prescription.

### **Exclusions and limitations**

#### **Anything not covered**

Specific conditions or circumstances that aren't covered under a plan.

### **Formulary**

#### **Medications covered under your plan**

A list of medications approved for coverage under the plan. Also called a Drug List.

### **Maximum out-of-pocket**

#### **The most you'll spend before your plan pays 100% of the cost**

The most you would have to pay for prescriptions covered by a health plan, including deductibles, copays and coinsurance. Once your annual out-of-pocket limit has been reached, the Humana Group Medicare plan pays 100% for most pharmacy charges.

## Know your numbers

Find important numbers anytime you need them\*

### **Humana Group Medicare Customer Care**

**800-585-7417 (TTY: 711),**

Monday – Friday, 7 a.m. – 8 p.m., Central time

### **MyHumana**

Sign in to or register for MyHumana to access your personal and secure plan information at **Humana.com**

### **MyHumana mobile app**

**Humana.com/mobile-apps**

### **Pharmacies in your network**

**Humana.com/FindaPharmacy**

### **CenterWell Pharmacy™**

**800-379-0092 (TTY: 711),**

Mon. – Fri., 7 a.m. – 10 p.m., and Sat., 7 a.m. – 5:30 p.m., Central time

**CenterWellPharmacy.com**

### **CenterWell Specialty Pharmacy™**

**800-486-2668 (TTY: 711),**

Mon. – Fri., 7 a.m. – 10 p.m., and Sat., 7 a.m. – 5:30 p.m., Central time

**CenterWellSpecialtyPharmacy.com**

### **Humana Clinical Pharmacy Review Team**

**800-555-2546 (TTY: 711),**

Monday – Friday, 7 a.m. – 7 p.m., Central time

### **State health insurance program offices**

**800-633-4227 (TTY: 711),** daily

**www.cms.gov/apps/contacts/#**

\*You must be a Humana member to use these services.

## Important

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### At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618. If you need help filing a grievance, call **800-585-7417 (TTY: 711)**.

### Auxiliary aids and services, free of charge, are available to you.

#### **800-585-7417 (TTY: 711)**

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

### This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

**Español (Spanish):** Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711)**. Horas de operación: 8 a.m. a 8 p.m. hora del este.

**繁體中文 (Chinese):** 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235 (聽障專線：711)**。辦公時間：東部時間上午 8 時至晚上 8 時。

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# Summary of Benefits

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**Humana Group Medicare PDP Plan  
PDP 037/161**

**North Dakota Public Employees Retirement System (NDPERS)**



**Humana®**

Our service area includes the United States and Puerto Rico.



# Let's talk about the **Humana Group Medicare PDP Plan.**

Find out more about the Humana Group Medicare PDP plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

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## **To be eligible**

To join the Humana Group Medicare PDP plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

## **Plan name:**

Humana Group Medicare PDP plan

## **How to reach us:**

Members should call toll-free  
**1-800-585-7417** for questions  
**(TTY/TDD 711)**

Call Monday – Friday, 7 a.m. – 8 p.m.  
Central Time.

Or visit our website: **Humana.com**



## Deductible

### Pharmacy (Part D) deductible

This plan does not have a deductible.



## Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)

You pay the following until your total out-of-pocket drug costs reach **\$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Tier	Standard Retail Pharmacy	Standard Mail Order
<b>30-day supply</b>		
<b>1 (Generic or Preferred Generic)</b>	<b>\$5</b> copay and you pay <b>15%</b> of the remaining cost share	<b>\$5</b> copay and you pay <b>15%</b> of the remaining cost share
<b>2 (Preferred Brand)</b>	<b>\$15</b> copay and you pay <b>25%</b> of the remaining cost share	<b>\$15</b> copay and you pay <b>25%</b> of the remaining cost share
<b>3 (Non-Preferred Drug)</b>	<b>\$25</b> copay and you pay <b>50%</b> of the remaining cost share	<b>\$25</b> copay and you pay <b>50%</b> of the remaining cost share
<b>4 (Specialty Tier)</b>	<b>\$25</b> copay and you pay <b>50%</b> of the remaining cost share	<b>\$25</b> copay and you pay <b>50%</b> of the remaining cost share
<b>90-day supply</b>		
<b>1 (Generic or Preferred Generic)</b>	<b>\$5</b> copay and you pay <b>15%</b> of the remaining cost share	<b>\$5</b> copay and you pay <b>15%</b> of the remaining cost share
<b>2 (Preferred Brand)</b>	<b>\$15</b> copay and you pay <b>25%</b> of the remaining cost share	<b>\$15</b> copay and you pay <b>25%</b> of the remaining cost share
<b>3 (Non-Preferred Drug)</b>	<b>\$25</b> copay and you pay <b>50%</b> of the remaining cost share	<b>\$25</b> copay and you pay <b>50%</b> of the remaining cost share
<b>4 (Specialty Tier)</b>	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit [www.humana.com/SearchResources](http://www.humana.com/SearchResources), locate Prescription Drug section, select [www.humana.com/MedicareDrugList](http://www.humana.com/MedicareDrugList) link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP50.

**Important Message About What You Pay for Vaccines** – This plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Humana Group Medicare Customer Care 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 this plan, no matter what cost-sharing tier it's on.

## ADDITIONAL DRUG COVERAGE

### Original Medicare excluded drugs

Certain drugs excluded by Original Medicare are covered under this plan. You pay the cost share associated with the tier level for certain Cough/Cold, Erectile Dysfunction drugs. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage stage.

Contact Humana Group Medicare Customer Care at the phone number on the back of your membership card for more details.

## Catastrophic Coverage

After your total out-of-pocket costs reach **\$2,000**, you pay **\$0** for plan-covered Part D and excluded drugs.









## Notice of Non-Discrimination

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Humana Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **1-877-320-1235 (TTY: 711)**. Hours of operation: 8 a.m. – 8 p.m., Eastern time. If you believe that Humana Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with Humana Inc.'s Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **1-877-320-1235 (TTY: 711)**, or **accessibility@humana.com**. If you need help filing a grievance, Humana Inc.'s Non-Discrimination Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD)**.

### California members:

You can also file a civil rights complaint with the California Dept. of Health Care Services, Office of Civil rights by calling **916-440-7370 (TTY: 711)**, emailing **Civilrights@dhcs.ca.gov**, or by mail at: Deputy Director, Office of Civil Rights, Department of Health Care Services, P.O. Box 997413, MS 0009, Sacramento, CA 95899-7413. Complaint forms available at: **[http://www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)**.

This notice is available at **[www.humana.com/legal/non-discrimination-disclosure](http://www.humana.com/legal/non-discrimination-disclosure)**.

## 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 1-877-320-1235 (TTY: 711). Someone who speaks English 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (听障专线：711)。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 1-877-320-1235 (聽障專線：711)。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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. 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 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康保険と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をご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。



## Find out **more**

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You can see this plan's pharmacy directory at <https://www.Humana.com/finder/pharmacy/> or call us at the number listed at the beginning of this booklet and we will send you one.



You can see this plan's drug formulary at [www.Humana.com/medicaredruglist](http://www.Humana.com/medicaredruglist) or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare this plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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2025

# Prescription Drug Guide

## Humana Medicare Employer Plan Abbreviated Formulary

Partial List of covered drugs or "Drug List"

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN.

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Formulary 25800

This abridged formulary was updated on 09/28/2024 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the Humana Medicare Employer Plan with any questions at the number on the back of your membership card or for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m., Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day, 7 days a week, by visiting [Humana.com](https://www.humana.com).

Instructions for getting information about all covered drugs are inside.

# Humana®



# Welcome to The Humana Medicare Employer Plan!

**Note to existing members:** This Formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take. When this Drug List (Formulary) refers to “we,” “us”, or “our,” it means Humana. When it refers to “plan” or “our plan”, it means the Humana Medicare Employer Plan. This document includes a partial Drug List (formulary) for our plan which is current as of January 1, 2025. For a complete, updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1 of each year, and from time to time during the year.

## What is the Humana Medicare Employer abridged formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is the entire list of covered drugs or medicines selected by the Humana Medicare Employer Plan. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. The Humana Medicare Employer Plan worked with a team of doctors and pharmacists to make a formulary that represents the prescription drugs we think you need for a quality treatment program. The Humana Medicare Employer Plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Humana Medicare Employer Plan network pharmacy, and other plan rules are followed. For more information on how to fill your medicines, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by Humana Medicare Employer Plan. For a complete listing of all prescription drugs covered by Humana Medicare Employer Plan, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you are thinking about enrolling in a Humana Medicare Employer Plan and need help or a complete list of covered drugs, please contact Group Medicare Customer Care number listed in your enrollment materials. If you are a current member, call the number or visit the website listed in your Annual Notice of Change (ANOC) or Evidence of Coverage (EOC), or call the number on the back of your Humana member identification card. Our live representatives are available Monday through Friday from 8 a.m. - 9 p.m., Eastern time. Our automated phone system is available after hours, weekends, and holidays.

## Can the formulary change?

Most changes in drug coverage happen on January 1, but 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 Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here:

**[Humana.com/medicaredruglist](https://www.humana.com/medicaredruglist).**

**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 on 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 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 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 Humana 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 remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product, or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, or 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 a notice of the change.

We will notify members who are affected by the following changes to the formulary:

- When a drug is removed from the formulary.
- When prior authorization, quantity limits, or step-therapy restrictions are added to a drug or made more restrictive.
- When a drug is moved to a higher cost sharing tier.

If we make these other changes, you or your prescriber can ask us to make an exception 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 titled “How do I request an exception to the Humana 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.

### **What if you are affected by a Drug List change?**

We will notify you by mail at least 30 days before one of these changes happen or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of January 1, 2025. To get updated information about the drugs covered by Humana please contact us. Our contact information appears on the front and back cover pages.



## How do I use the Formulary?

There are two ways to find your drug in the formulary:

### Medical condition

The formulary starts on page 11. We have put the drugs into groups depending on the type of medical conditions that they are used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 11. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 6 for more information on Utilization Management Requirements).

### 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 32. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to each drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

### **What are generic drugs?**

Humana 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 5, Section 3.1, "The 'Drug List' tells which Part D drugs are covered" if you have a Medicare Advantage plan. If you have a Prescription Drug Plan (PDP), please see the Evidence of Coverage, Chapter 3, Section 3.1, "The 'Drug List' tells which Part D drugs are covered". The type of plan can be found at the top of your Evidence of Coverage.

Prescription drugs are grouped into one of four tiers.

The Humana Medicare Employer Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

- **Tier 1 - Generic or Preferred Generic:** Generic or brand drugs that are available at the lowest cost share for the plan
- **Tier 2 - Preferred Brand:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 1 Generic or Preferred Generic, and at a lower cost to you than Tier 3 Non-Preferred Drug
- **Tier 3 - Non-Preferred Drug:** Generic or brand drugs that the plan offers at a higher cost to you than Tier 2 Preferred Brand drug
- **Tier 4 - Specialty Tier:** Some injectables and other high-cost drugs

## How much will I pay for covered drugs?

The Humana Medicare Employer Plan pays part of the costs for your covered drugs and you pay part of the costs, too.

### The amount of money you pay depends on:

- Which tier your drug is on
- Whether you fill your prescription at a network pharmacy
- Your current drug payment stage - please read your Evidence of Coverage (EOC) for more information

**If you qualified for extra help with your drug costs, your costs may be different from those described above. Please refer to your Evidence of Coverage (EOC) or call Group Medicare Customer Care to find out what your costs are.**

### 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):** The Humana Medicare Employer Plan requires you to get prior authorization for certain drugs. This means that you will need to get approval from the Humana Medicare Employer Plan before you fill your prescriptions. If you do not get approval, the Humana Medicare Employer Plan may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, the Humana Medicare Employer Plan limits the amount of the drug that is covered. The Humana Medicare Employer Plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. Some drugs are limited to a 30-day supply regardless of tier placement.
- **Step Therapy (ST):** In some cases, the Humana Medicare Employer Plan requires 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, the Humana Medicare Employer Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Humana Medicare Employer Plan will then cover Drug B.
- **Part B versus Part D (BvsD):** Some drugs may be covered under Medicare Part B or Part D, depending upon the circumstances. Information may need to be submitted to the Humana Medicare Employer Plan that describes the use and the place where you receive and take the drug so a determination can be made.

For drugs that need prior authorization or step therapy, or drugs that fall outside of quantity limits, your health care provider can fax information about your condition and need for those drugs to the Humana Medicare Employer Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m. (EST).

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 11.

You can also get more information about the restrictions applied to specific covered drugs by visiting **[Humana.com/medicaredruglist](https://www.humana.com/medicaredruglist)**. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask the Humana Medicare Employer Plan to make an exception to these restrictions, 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 Humana Formulary?**" on page 7 for information about how to request an exception.

## 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 Humana Medicare Employer Plan Customer Care and ask if your drug is covered. This document includes only a partial list of covered drugs, so Humana Group Medicare Plan may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that Humana Medicare Employer Plan does not cover your drug, you have two options:

- You can ask Group Medicare Customer Care for a list of similar drugs that are covered by Humana Medicare Employer Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by the Humana Medicare Employer Plan.
- You can ask the Humana Medicare Employer Plan to make an exception and cover your drug. See below for information about how to request an exception.

## How do I request an exception to the Humana Formulary?

You can ask the Humana Medicare Employer Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask us to make.

- **Formulary exception:** You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- **Utilization restriction exception:** You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Humana Group Medicare Plan limits 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.
- **Tier exception:** You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.

Generally, the Humana Medicare Employer Plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost sharing drug, or applying the restriction would not be as effective for you and/or would cause you to have adverse effects.

You or your prescriber should contact us to ask for a tiering or formulary exception, including an exception to a coverage restriction. **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 ask for an expedited (fast) decision if you believe, and we agree, that your health could be seriously harmed by waiting up to 72 hours for a decision. If we agree, or if your prescriber asks for a fast decision, we must give you a decision no later than 24 hours after we get your prescriber's supporting statement.

## What can I do if my drug is not on the formulary or has a restriction?

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 has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor 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 that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30 day supply of

medication. If coverage is not approved, 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 and 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 written for fewer days. (in which case we will allow multiple fills to provide up to a total of 31 days of a drug) while you pursue a formulary exception.

Throughout the plan year, your treatment setting (the place where you receive and take your medicine) may change. These changes include:

- Members who are discharged from a hospital or skilled-nursing facility to a home setting
- Members who are admitted to a hospital or skilled-nursing facility from a home setting
- Members who transfer from one skilled-nursing facility to another and use a different pharmacy
- Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
- Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
- Members discharged from chronic psychiatric hospitals with highly individualized drug regimens

For these changes in treatment settings, the Humana Medicare Employer Plan will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. The Humana Medicare Employer Plan will review requests for continuation of therapy on a case-by-case basis understanding when you are on a stabilized drug regimen that, if changed, is known to have risks.

### **Transition extension**

The Humana Medicare Employer Plan will consider on a case-by-case basis an extension of the transition period if your exception request or appeal has not been processed by the end of your initial transition period. We will continue to provide necessary drugs to you if your transition period is extended.

A Transition Policy is available on Humana's Medicare website, **Humana.com**, in the same area where the Prescription Drug Guides are displayed.

### **CenterWell Pharmacy™**

You may fill your medicines at any network pharmacy. CenterWell Pharmacy – Humana's mail-delivery pharmacy is one option. To get started or learn more, visit **CenterWellPharmacy.com**. You can also call CenterWell Pharmacy at **1-844-222-2151 (TTY: 711)** Monday – Friday, 8 a.m. to 11 p.m. (EST), and Saturday, 8 a.m. to 6:30 p.m. (EST).

Other pharmacies are available in our network.

## For More Information

For more detailed information about your Humana Medicare Employer Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Humana Group Medicare Plan, please contact us. Our contact information, along with the date we last updated the formulary, appears 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)** 24 hours a day, seven days a week. **TTY** users should call **1-877-486-2048**. You can also visit **[www.medicare.gov](http://www.medicare.gov)**.

# Humana Medicare Employer Plan Formulary

The abridged formulary that begins on the next page provides coverage information about some of the drugs covered by the Humana Medicare Employer Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 32.

**Remember: This is only a partial list of drugs covered by Humana.** If your prescription drug is not listed in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Your plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D and are not subject to the Medicare appeals process. These drugs are listed separately on page 30.

## How to read your formulary

The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. Brand-name drugs are CAPITALIZED and generic drugs are listed in lower-case italics. Next to the drug name or Utilization Management column, you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:

**DL** - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.

**MO** - Drugs that are typically available through mail-order. Please contact your mail-order pharmacy to make sure your drug is available.

**LA** - Limited Access; The health plan has authorized certain pharmacies to dispense this medicine, as it requires extra handling, doctor coordination or patient education. Please call the number on the back of your ID card for additional information.

**CI** - Covered insulin products; Part D insulin products covered by your plan. For more information on cost sharing for your covered insulin products, please refer to your Evidence of Coverage.

**AV** - Advisory Committee on Immunization Practices (ACIP) Covered Part D vaccines; Part D vaccines recommended by ACIP for adults that may be available at no cost to you; additional restrictions may apply. For more information, please refer to your Evidence of Coverage.

**PDS** - Preferred Diabetic Supplies; BD and HTL- Droplet are the preferred diabetic syringe and pen needle brands for the plan.

The second column lists the tier of the drug. See page 5 for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. The Humana Medicare Employer Plan may have special requirements for covering that drug. If the column is blank, then there are no utilization requirements for that drug. The supply for each drug is based on benefits and whether your health care provider prescribes a supply for 30, 60, or 90 days. The amount of any quantity limits will also be in this column (Example: "QL - 30 for 30 days" means you can only get 30 doses every 30 days). See page 6 for more information about these requirements.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<b>ANALGESICS</b>		
celecoxib 100 mg, 200 mg CAPSULE <b>MO</b>	1	QL(60 per 30 days)
diclofenac sodium 1 % GEL <b>MO</b>	1	QL(1000 per 30 days)
diclofenac sodium 75 mg TABLET, DR/EC <b>MO</b>	1	
hydrocodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET <b>DL</b>	1	QL(360 per 30 days)
ibuprofen 600 mg, 800 mg TABLET <b>MO</b>	1	
meloxicam 15 mg TABLET <b>MO</b>	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET <b>MO</b>	1	QL(60 per 30 days)
naproxen 500 mg TABLET <b>MO</b>	1	
oxycodone 10 mg, 15 mg, 5 mg TABLET <b>DL</b>	1	QL(360 per 30 days)
oxycodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET <b>DL</b>	1	QL(360 per 30 days)
tramadol 50 mg TABLET <b>DL</b>	1	QL(240 per 30 days)
<b>ANESTHETICS</b>		
lidocaine 5 % ADHESIVE PATCH, MEDICATED <b>MO</b>	1	PA,QL(90 per 30 days)
<b>ANTIBACTERIALS</b>		
amoxicillin 500 mg CAPSULE <b>MO</b>	1	
amoxicillin 500 mg TABLET <b>MO</b>	1	
amoxicillin-pot clavulanate 875-125 mg TABLET <b>MO</b>	1	
azithromycin 250 mg TABLET <b>MO</b>	1	
cefdinir 300 mg CAPSULE <b>MO</b>	1	
cephalexin 500 mg CAPSULE <b>MO</b>	1	
ciprofloxacin hcl 500 mg TABLET <b>MO</b>	1	
DIFICID 200 MG TABLET <b>DL</b>	4	
DIFICID 40 MG/ML SUSPENSION FOR RECONSTITUTION <b>DL</b>	4	
doxycycline hyclate 100 mg CAPSULE <b>MO</b>	1	
doxycycline hyclate 100 mg TABLET <b>MO</b>	1	
levofloxacin 500 mg TABLET <b>MO</b>	1	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE <b>MO</b>	1	
sulfamethoxazole-trimethoprim 800-160 mg TABLET <b>MO</b>	1	
<b>ANTICONVULSANTS</b>		
EPIDIOLEX 100 MG/ML SOLUTION <b>DL</b>	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<i>gabapentin 100 mg, 300 mg, 400 mg CAPSULE MO</i>	1	QL(270 per 30 days)
<i>gabapentin 600 mg, 800 mg TABLET MO</i>	1	QL(180 per 30 days)
<i>levetiracetam 500 mg TABLET MO</i>	1	
NAYZILAM 5 MG/SPRAY (0.1 ML) SPRAY, NON-AEROSOL DL	3	QL(10 per 30 days)
<b>ANTIDEMENTIA AGENTS</b>		
<i>donepezil 10 mg TABLET MO</i>	1	QL(60 per 30 days)
<i>donepezil 5 mg TABLET MO</i>	1	QL(30 per 30 days)
<i>memantine 10 mg, 5 mg TABLET MO</i>	1	PA,QL(60 per 30 days)
NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. MO	2	QL(30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE ER SPRINKLE 24 HR. MO	2	QL(28 per 28 days)
<b>ANTIDEPRESSANTS</b>		
<i>amitriptyline 25 mg TABLET MO</i>	1	
<i>bupropion hcl 150 mg TABLET, ER 24 HR. MO</i>	1	QL(90 per 30 days)
<i>bupropion hcl 150 mg TABLET, SR 12 HR. MO</i>	1	QL(90 per 30 days)
<i>bupropion hcl 300 mg TABLET, ER 24 HR. MO</i>	1	QL(60 per 30 days)
<i>citalopram 10 mg, 40 mg TABLET MO</i>	1	QL(30 per 30 days)
<i>citalopram 20 mg TABLET MO</i>	1	QL(60 per 30 days)
<i>escitalopram oxalate 10 mg TABLET MO</i>	1	QL(45 per 30 days)
<i>escitalopram oxalate 20 mg, 5 mg TABLET MO</i>	1	QL(30 per 30 days)
<i>fluoxetine 20 mg CAPSULE MO</i>	1	QL(120 per 30 days)
<i>fluoxetine 40 mg CAPSULE MO</i>	1	QL(60 per 30 days)
<i>mirtazapine 15 mg, 30 mg, 7.5 mg TABLET MO</i>	1	
<i>sertraline 100 mg TABLET MO</i>	1	QL(60 per 30 days)
<i>sertraline 25 mg, 50 mg TABLET MO</i>	1	QL(90 per 30 days)
<i>trazodone 100 mg, 150 mg, 50 mg TABLET MO</i>	1	
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET MO	3	ST,QL(30 per 30 days)
<i>venlafaxine 150 mg CAPSULE, ER 24 HR. MO</i>	1	QL(60 per 30 days)
<i>venlafaxine 75 mg CAPSULE, ER 24 HR. MO</i>	1	QL(90 per 30 days)
<b>ANTIEMETICS</b>		
<i>meclizine 25 mg TABLET MO</i>	1	
<i>ondansetron 4 mg TABLET, DISINTEGRATING MO</i>	1	BvsD

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ondansetron hcl 4 mg TABLET <b>MO</b>	1	BvsD
promethazine 25 mg TABLET <b>MO</b>	1	
<b>ANTIFUNGALS</b>		
clotrimazole-betamethasone 1-0.05 % CREAM <b>MO</b>	1	QL(180 per 30 days)
fluconazole 150 mg TABLET <b>MO</b>	1	
ketoconazole 2 % CREAM <b>MO</b>	1	QL(60 per 30 days)
ketoconazole 2 % SHAMPOO <b>MO</b>	1	QL(120 per 30 days)
<b>ANTIGOUT AGENTS</b>		
allopurinol 100 mg, 300 mg TABLET <b>MO</b>	1	
<b>ANTIMIGRAINE AGENTS</b>		
EMGALITY PEN 120 MG/ML PEN INJECTOR <b>MO</b>	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 120 MG/ML SYRINGE <b>MO</b>	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 300 MG/3 ML (100 MG/ML X 3) SYRINGE <b>MO</b>	3	PA,QL(3 per 30 days)
QULIPTA 10 MG, 30 MG, 60 MG TABLET <b>MO</b>	3	PA,QL(30 per 30 days)
UBRELVY 100 MG, 50 MG TABLET <b>MO</b>	2	PA,QL(16 per 30 days)
<b>ANTIMYASTHENIC AGENTS</b>		
VYVGART 20 MG/ML SOLUTION <b>DL</b>	4	PA
VYVGART HYTRULO 1,008 MG-11,200 UNIT/5.6 ML SOLUTION <b>DL</b>	4	PA,QL(22.4 per 28 days)
<b>ANTINEOPLASTICS</b>		
ALECENSA 150 MG CAPSULE <b>DL</b>	4	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET <b>DL</b>	4	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK <b>DL</b>	4	PA,QL(30 per 30 days)
anastrozole 1 mg TABLET <b>MO</b>	1	QL(30 per 30 days)
BRUKINSA 80 MG CAPSULE <b>DL</b>	4	PA,QL(120 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
CALQUENCE 100 MG CAPSULE <b>DL</b>	4	PA,QL(60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) 100 MG TABLET <b>DL</b>	4	PA,QL(60 per 30 days)
ERIVEDGE 150 MG CAPSULE <b>DL</b>	4	PA,QL(28 per 28 days)
ERLEADA 240 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
ERLEADA 60 MG TABLET <b>DL</b>	4	PA,QL(120 per 30 days)
IMBRUVICA 140 MG CAPSULE <b>DL</b>	4	PA,QL(120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
IMBRUVICA 420 MG TABLET <b>DL</b>	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE <b>DL</b>	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG/ML SUSPENSION <b>DL</b>	4	PA
KISQALI 200 MG/DAY (200 MG X 1) TABLET <b>DL</b>	4	PA,QL(21 per 28 days)
KISQALI 400 MG/DAY (200 MG X 2) TABLET <b>DL</b>	4	PA,QL(42 per 28 days)
KISQALI 600 MG/DAY (200 MG X 3) TABLET <b>DL</b>	4	PA,QL(63 per 28 days)
KISQALI FEMARA CO-PACK 200 MG/DAY(200 MG X 1)-2.5 MG TABLET <b>DL</b>	4	PA,QL(49 per 28 days)
KISQALI FEMARA CO-PACK 400 MG/DAY(200 MG X 2)-2.5 MG TABLET <b>DL</b>	4	PA,QL(70 per 28 days)
KISQALI FEMARA CO-PACK 600 MG/DAY(200 MG X 3)-2.5 MG TABLET <b>DL</b>	4	PA,QL(91 per 28 days)
LYNPARZA 100 MG, 150 MG TABLET <b>DL</b>	4	PA,QL(120 per 30 days)
NUBEQA 300 MG TABLET <b>DL</b>	4	PA,QL(120 per 30 days)
ORGOVYX 120 MG TABLET <b>DL</b>	4	PA,QL(32 per 30 days)
RUXIENCE 10 MG/ML SOLUTION <b>DL</b>	4	PA
TRAZIMERA 420 MG RECON SOLUTION <b>DL</b>	4	PA
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET <b>DL</b>	4	PA,QL(60 per 30 days)
XTANDI 40 MG CAPSULE <b>DL</b>	4	PA,QL(120 per 30 days)
XTANDI 40 MG TABLET <b>DL</b>	4	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET <b>DL</b>	4	PA,QL(60 per 30 days)
ZEJULA 100 MG CAPSULE <b>DL</b>	4	PA,QL(90 per 30 days)
ZEJULA 100 MG, 200 MG, 300 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
ZIRABEV 25 MG/ML SOLUTION <b>DL</b>	4	PA
<b>ANTIPARASITICS</b>		
<i>hydroxychloroquine 200 mg TABLET <b>MO</b></i>	1	
<b>ANTIPARKINSON AGENTS</b>		
<i>carbidopa-levodopa 25-100 mg TABLET <b>MO</b></i>	1	
INBRIJA 42 MG CAPSULE, W/INHALATION DEVICE <b>DL</b>	4	PA,QL(300 per 30 days)
RYTARY 23.75-95 MG, 48.75-195 MG CAPSULE, ER <b>MO</b>	3	ST,QL(360 per 30 days)
RYTARY 36.25-145 MG CAPSULE, ER <b>MO</b>	3	ST,QL(270 per 30 days)
RYTARY 61.25-245 MG CAPSULE, ER <b>MO</b>	3	ST,QL(300 per 30 days)
<b>ANTIPSYCHOTICS</b>		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET <b>MO</b>	3	PA
ABILIFY ASIMTUFII 720 MG/2.4 ML SUSPENSION, ER, SYRINGE	4	QL(2.4 per 56 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ABILIFY ASIMTUFII 960 MG/3.2 ML SUSPENSION, ER, SYRINGE	4	QL(3.2 per 56 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON <b>DL</b>	4	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE <b>DL</b>	4	QL(1 per 28 days)
ABILIFY MYCITE MAINTENANCE KIT 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET WITH SENSOR AND STRIP <b>DL</b>	4	PA,QL(30 per 30 days)
ABILIFY MYCITE STARTER KIT 10 MG TABLET W/SENSOR AND STRIP, POD <b>DL</b>	4	PA,QL(30 per 30 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	4	QL(3.9 per 56 days)
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE <b>DL</b>	4	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE <b>DL</b>	4	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE <b>DL</b>	4	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE <b>DL</b>	4	QL(2.4 per 42 days)
INVEGA 3 MG, 9 MG TABLET, ER 24 HR. <b>DL</b>	4	PA,QL(30 per 30 days)
INVEGA 6 MG TABLET, ER 24 HR. <b>DL</b>	4	PA,QL(60 per 30 days)
INVEGA HAFYERA 1,092 MG/3.5 ML SYRINGE	4	QL(3.5 per 180 days)
INVEGA HAFYERA 1,560 MG/5 ML SYRINGE	4	QL(5 per 180 days)
INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML SYRINGE <b>DL</b>	4	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML SYRINGE <b>DL</b>	4	QL(1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML SYRINGE <b>MO</b>	3	QL(1.5 per 28 days)
INVEGA TRINZA 273 MG/0.88 ML SYRINGE	4	QL(0.88 per 90 days)
INVEGA TRINZA 410 MG/1.32 ML SYRINGE	4	QL(1.32 per 90 days)
INVEGA TRINZA 546 MG/1.75 ML SYRINGE	4	QL(1.75 per 90 days)
INVEGA TRINZA 819 MG/2.63 ML SYRINGE	4	QL(2.63 per 90 days)
LYBALVI 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
quetiapine 100 mg TABLET <b>MO</b>	1	QL(90 per 30 days)
quetiapine 25 mg, 50 mg TABLET <b>MO</b>	1	QL(120 per 30 days)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
RISPERDAL 0.5 MG TABLET <b>MO</b>	3	QL(120 per 30 days)
RISPERDAL 1 MG, 2 MG TABLET <b>MO</b>	3	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION <b>DL</b>	4	
RISPERDAL 3 MG, 4 MG TABLET <b>DL</b>	4	QL(60 per 30 days)
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML SUSPENSION, ER, RECON <b>MO</b>	3	QL(2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML SUSPENSION, ER, RECON <b>DL</b>	4	QL(2 per 28 days)

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<b>ANTISPASTICITY AGENTS</b>		
<i>baclofen 10 mg TABLET</i> <b>MO</b>	1	
<i>tizanidine 2 mg, 4 mg TABLET</i> <b>MO</b>	1	
<b>ANTIVIRALS</b>		
BIKTARVY 30-120-15 MG, 50-200-25 MG TABLET <b>DL</b>	4	QL(30 per 30 days)
DESCOVY 120-15 MG, 200-25 MG TABLET <b>DL</b>	4	QL(30 per 30 days)
EPCLUSA 150-37.5 MG PELLETS IN PACKET <b>DL</b>	4	PA,QL(28 per 28 days)
EPCLUSA 200-50 MG PELLETS IN PACKET <b>DL</b>	4	PA,QL(56 per 28 days)
EPCLUSA 200-50 MG, 400-100 MG TABLET <b>DL</b>	4	PA,QL(28 per 28 days)
GENVOYA 150-150-200-10 MG TABLET <b>DL</b>	4	QL(30 per 30 days)
LAGEVRIO (EUA) 200 MG CAPSULE <b>MO</b>	2	QL(40 per 5 days)
ODEFSEY 200-25-25 MG TABLET <b>DL</b>	4	QL(30 per 30 days)
PAXLOVID 150-100 MG TABLET, DOSE PACK <b>MO</b>	2	QL(40 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLET, DOSE PACK <b>MO</b>	2	QL(60 per 10 days)
<i>valacyclovir 1 gram, 500 mg TABLET</i> <b>MO</b>	1	
VEMLIDY 25 MG TABLET <b>DL</b>	4	QL(30 per 30 days)
VOSEVI 400-100-100 MG TABLET <b>DL</b>	4	PA,QL(28 per 28 days)
<b>ANXIOLYTICS</b>		
<i>alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET</i> <b>DL</b>	1	QL(120 per 30 days)
<i>buspirone 10 mg, 5 mg TABLET</i> <b>MO</b>	1	
<i>clonazepam 0.5 mg, 1 mg TABLET</i> <b>DL</b>	1	
<i>diazepam 5 mg TABLET</i> <b>DL</b>	1	QL(90 per 30 days)
<i>hydroxyzine hcl 25 mg TABLET</i> <b>MO</b>	1	
<i>lorazepam 0.5 mg, 1 mg TABLET</i> <b>DL</b>	1	QL(90 per 30 days)
<b>BLOOD GLUCOSE REGULATORS</b>		
FARXIGA 10 MG, 5 MG TABLET <b>MO</b>	3	QL(30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE <b>CI,MO</b>	2	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
<i>glimepiride 2 mg, 4 mg TABLET</i> <b>MO</b>	1	
<i>glipizide 10 mg, 5 mg TABLET</i> <b>MO</b>	1	
GLYXAMBI 10-5 MG, 25-5 MG TABLET <b>MO</b>	2	QL(30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMALOG JUNIOR KWIKPEN U-100 100 UNIT/ML INSULIN PEN, HALF-UNIT <b>CI,MO</b>	2	
HUMALOG KWIKPEN INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML (50-50) INSULIN PEN <b>CI,MO</b>	2	
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML (75-25) INSULIN PEN <b>CI,MO</b>	2	
HUMALOG MIX 75-25(U-100)INSULN 100 UNIT/ML (75-25) SUSPENSION <b>CI,MO</b>	2	
HUMALOG TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR <b>CI,MO</b>	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML CARTRIDGE <b>CI,MO</b>	2	
HUMALOG U-100 INSULIN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION <b>CI,MO</b>	2	
HUMULIN 70/30 U-100 KWIKPEN 100 UNIT/ML (70-30) INSULIN PEN <b>CI,MO</b>	2	
HUMULIN N NPH INSULIN KWIKPEN 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
HUMULIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION <b>CI,MO</b>	2	
HUMULIN R REGULAR U-100 INSULN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
HUMULIN R U-500 (CONC) INSULIN 500 UNIT/ML SOLUTION <b>CI,DL</b>	4	
HUMULIN R U-500 (CONC) KWIKPEN 500 UNIT/ML (3 ML) INSULIN PEN <b>CI,DL</b>	4	
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
INVOKAMET XR 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
JANUMET 50-1,000 MG, 50-500 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE <b>MO</b>	2	QL(30 per 30 days)
JANUMET XR 50-1,000 MG, 50-500 MG TABLET, ER 24 HR., MULTIPHASE <b>MO</b>	2	QL(60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
JARDIANCE 10 MG, 25 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
JENTADUETO 2.5-1,000 MG, 2.5-500 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML INSULIN PEN <b>CI,MO</b>	2	
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
LYUMJEV TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR <b>CI,MO</b>	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
<i>metformin 1,000 mg, 500 mg TABLET</i> <b>MO</b>	1	
<i>metformin 500 mg TABLET, ER 24 HR.</i> <b>MO</b>	1	QL(120 per 30 days)
MOUNJARO 10 MG/0.5 ML, 12.5 MG/0.5 ML, 15 MG/0.5 ML, 2.5 MG/0.5 ML, 5 MG/0.5 ML, 7.5 MG/0.5 ML PEN INJECTOR <b>MO</b>	2	PA,QL(2 per 28 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN <b>CI,MO</b>	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION <b>CI,MO</b>	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION <b>CI,MO</b>	2	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
NOVOLIN R REGULAR U100 INSULIN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
NOVOLOG MIX 70-30 U-100 INSULN 100 UNIT/ML (70-30) SOLUTION <b>CI,MO</b>	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN <b>CI,MO</b>	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE <b>CI,MO</b>	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
OZEMPIC 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML) PEN INJECTOR <b>MO</b>	2	PA,QL(3 per 28 days)
<i>pioglitazone 30 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET <b>MO</b>	2	PA,QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN <b>CI,MO</b>	2	QL(15 per 24 days)
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN <b>CI,MO</b>	2	
TRADJENTA 5 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
TRESIBA FLEXTOUCH U-200 200 UNIT/ML (3 ML) INSULIN PEN <b>CI,MO</b>	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION <b>CI,MO</b>	2	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(30 per 30 days)
TRIJARDY XR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	2	QL(60 per 30 days)
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML, 3 MG/0.5 ML, 4.5 MG/0.5 ML PEN INJECTOR <b>MO</b>	2	PA,QL(2 per 28 days)
XIGDUO XR 10-1,000 MG, 10-500 MG, 5-500 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	3	QL(30 per 30 days)
XIGDUO XR 2.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC <b>MO</b>	3	QL(60 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR <b>MO</b>	2	
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE <b>MO</b>	2	
<b>BLOOD PRODUCTS AND MODIFIERS</b>		
BRILINTA 60 MG, 90 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
clopidogrel 75 mg TABLET <b>MO</b>	1	QL(30 per 30 days)
ELIQUIS 2.5 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
ELIQUIS 5 MG TABLET <b>MO</b>	2	QL(74 per 30 days)
ELIQUIS DVT-PE TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK <b>MO</b>	2	QL(74 per 30 days)
NIVESTYM 300 MCG/0.5 ML SYRINGE <b>DL</b>	4	PA,QL(7 per 30 days)
NIVESTYM 300 MCG/ML SOLUTION <b>DL</b>	4	PA,QL(14 per 30 days)
NIVESTYM 480 MCG/0.8 ML SYRINGE <b>DL</b>	4	PA,QL(11.2 per 30 days)
NIVESTYM 480 MCG/1.6 ML SOLUTION <b>DL</b>	4	PA,QL(22.4 per 30 days)
PROMACTA 12.5 MG POWDER IN PACKET <b>DL,LA</b>	4	PA,QL(360 per 30 days)
PROMACTA 12.5 MG, 25 MG TABLET <b>DL,LA</b>	4	PA,QL(30 per 30 days)
PROMACTA 25 MG POWDER IN PACKET <b>DL,LA</b>	4	PA,QL(180 per 30 days)
PROMACTA 50 MG TABLET <b>DL,LA</b>	4	PA,QL(90 per 30 days)
PROMACTA 75 MG TABLET <b>DL,LA</b>	4	PA,QL(60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML SOLUTION <b>MO</b>	3	PA,QL(14 per 30 days)
RETACRIT 40,000 UNIT/ML SOLUTION <b>DL</b>	4	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE <b>DL</b>	4	PA,QL(1.2 per 28 days)
UDENYCA AUTOINJECTOR 6 MG/0.6 ML AUTO-INJECTOR <b>DL</b>	4	PA,QL(1.2 per 28 days)
<i>warfarin 5 mg TABLET</i> <b>MO</b>	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION <b>MO</b>	2	ST,QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
XARELTO DVT-PE TREAT 30D START 15 MG (42)- 20 MG (9) TABLET, DOSE PACK <b>MO</b>	2	QL(51 per 30 days)
ZARXIO 300 MCG/0.5 ML SYRINGE <b>DL</b>	4	PA,QL(7 per 30 days)
ZARXIO 480 MCG/0.8 ML SYRINGE <b>DL</b>	4	PA,QL(11.2 per 30 days)
<b>CARDIOVASCULAR AGENTS</b>		
<i>amiodarone 200 mg TABLET</i> <b>MO</b>	1	
<i>amlodipine 10 mg, 2.5 mg, 5 mg TABLET</i> <b>MO</b>	1	
<i>atenolol 25 mg, 50 mg TABLET</i> <b>MO</b>	1	
<i>atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET</i> <b>MO</b>	1	
<i>bumetanide 1 mg TABLET</i> <b>MO</b>	1	
<i>carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET</i> <b>MO</b>	1	
<i>chlorthalidone 25 mg TABLET</i> <b>MO</b>	1	
<i>clonidine hcl 0.1 mg TABLET</i> <b>MO</b>	1	
ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
<i>ezetimibe 10 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
<i>fenofibrate 160 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
<i>fenofibrate nanocrystallized 145 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
<i>furosemide 20 mg, 40 mg TABLET</i> <b>MO</b>	1	
<i>hydralazine 25 mg, 50 mg TABLET</i> <b>MO</b>	1	
<i>hydrochlorothiazide 12.5 mg CAPSULE</i> <b>MO</b>	1	
<i>hydrochlorothiazide 12.5 mg, 25 mg TABLET</i> <b>MO</b>	1	
<i>isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR.</i> <b>MO</b>	1	
KERENDIA 10 MG, 20 MG TABLET <b>MO</b>	2	PA,QL(30 per 30 days)

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lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET <b>MO</b>	1	
lisinopril-hydrochlorothiazide 10-12.5 mg, 20-12.5 mg, 20-25 mg TABLET <b>MO</b>	1	
losartan 100 mg, 25 mg, 50 mg TABLET <b>MO</b>	1	QL(60 per 30 days)
losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET <b>MO</b>	1	QL(60 per 30 days)
metoprolol succinate 100 mg, 25 mg, 50 mg TABLET, ER 24 HR. <b>MO</b>	1	
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET <b>MO</b>	1	
MULTAQ 400 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET <b>MO</b>	1	
olmesartan 40 mg TABLET <b>MO</b>	1	QL(30 per 30 days)
pravastatin 20 mg, 40 mg TABLET <b>MO</b>	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR <b>MO</b>	2	PA,QL(3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML PEN INJECTOR <b>MO</b>	2	PA,QL(3 per 28 days)
REPATHA SYRINGE 140 MG/ML SYRINGE <b>MO</b>	2	PA,QL(3 per 28 days)
rosuvastatin 10 mg, 20 mg, 40 mg, 5 mg TABLET <b>MO</b>	1	
simvastatin 10 mg, 20 mg, 40 mg TABLET <b>MO</b>	1	
spironolactone 25 mg, 50 mg TABLET <b>MO</b>	1	
torseamide 20 mg TABLET <b>MO</b>	1	
triamterene-hydrochlorothiazid 37.5-25 mg TABLET <b>MO</b>	1	
valsartan 160 mg TABLET <b>MO</b>	1	QL(60 per 30 days)
VASCEPA 0.5 GRAM CAPSULE <b>MO</b>	2	QL(240 per 30 days)
VASCEPA 1 GRAM CAPSULE <b>MO</b>	2	QL(120 per 30 days)
VERQUVO 10 MG, 2.5 MG, 5 MG TABLET <b>MO</b>	2	PA,QL(30 per 30 days)
ZYPITAMAG 2 MG, 4 MG TABLET <b>MO</b>	2	ST,QL(30 per 30 days)
<b>CENTRAL NERVOUS SYSTEM AGENTS</b>		
AUSTEDO 12 MG, 9 MG TABLET <b>DL</b>	4	PA,QL(120 per 30 days)
AUSTEDO 6 MG TABLET <b>DL</b>	4	PA,QL(60 per 30 days)
AUSTEDO XR 12 MG, 6 MG TABLET, ER 24 HR. <b>DL</b>	4	PA,QL(90 per 30 days)
AUSTEDO XR 24 MG TABLET, ER 24 HR. <b>DL</b>	4	PA,QL(60 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) 6 MG (14)-12 MG (14)-24 MG (14) TABLET, ER 24 HR., DOSE PACK <b>DL</b>	4	PA,QL(42 per 28 days)
BETASERON 0.3 MG KIT <b>DL</b>	4	PA,QL(15 per 30 days)
COPAXONE 20 MG/ML SYRINGE <b>DL</b>	4	PA,QL(30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
COPAXONE 40 MG/ML SYRINGE <b>DL</b>	4	PA,QL(12 per 28 days)
<i>duloxetine 20 mg CAPSULE, DR/EC</i> <b>MO</b>	1	QL(120 per 30 days)
<i>duloxetine 30 mg CAPSULE, DR/EC</i> <b>MO</b>	1	QL(90 per 30 days)
<i>duloxetine 60 mg CAPSULE, DR/EC</i> <b>MO</b>	1	QL(60 per 30 days)
KESIMPTA PEN 20 MG/0.4 ML PEN INJECTOR <b>DL</b>	4	PA,QL(1.2 per 28 days)
<i>pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE</i> <b>MO</b>	1	QL(90 per 30 days)
RADICAVA ORS STARTER KIT SUSP 105 MG/5 ML SUSPENSION <b>DL</b>	4	PA,QL(70 per 28 days)
VUMERITY 231 MG CAPSULE, DR/EC <b>DL</b>	4	PA,QL(120 per 30 days)
<b>DENTAL &amp; ORAL AGENTS</b>		
<i>chlorhexidine gluconate 0.12 % MOUTHWASH</i> <b>MO</b>	1	
<b>DERMATOLOGICAL AGENTS</b>		
ENSTILAR 0.005-0.064 % FOAM <b>MO</b>	3	QL(120 per 30 days)
<i>mupirocin 2 % OINTMENT</i> <b>MO</b>	1	
<b>ELECTROLYTES/MINERALS/METALS/VITAMINS</b>		
LOKELMA 10 GRAM, 5 GRAM POWDER IN PACKET <b>MO</b>	2	QL(30 per 30 days)
<i>potassium chloride 10 meq CAPSULE, ER</i> <b>MO</b>	1	
<i>potassium chloride 10 meq, 20 meq TABLET ER</i> <b>MO</b>	1	
<i>potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS</i> <b>MO</b>	1	
<b>GASTROINTESTINAL AGENTS</b>		
<i>dicyclomine 10 mg CAPSULE</i> <b>MO</b>	1	
<i>esomeprazole magnesium 40 mg CAPSULE, DR/EC</i> <b>MO</b>	1	QL(60 per 30 days)
<i>famotidine 20 mg, 40 mg TABLET</i> <b>MO</b>	1	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE <b>MO</b>	2	QL(30 per 30 days)
MOVANTI 12.5 MG, 25 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
<i>omeprazole 20 mg, 40 mg CAPSULE, DR/EC</i> <b>MO</b>	1	QL(60 per 30 days)
<i>pantoprazole 20 mg, 40 mg TABLET, DR/EC</i> <b>MO</b>	1	QL(60 per 30 days)
<i>sucralfate 1 gram TABLET</i> <b>MO</b>	1	
SUFLAVE 178.7-7.3-0.5 GRAM RECON SOLUTION <b>MO</b>	3	
SUTAB 1.479-0.188- 0.225 GRAM TABLET <b>MO</b>	2	
TALICIA 10-250-12.5 MG CAPSULE, IR/DR, BIPHASIC <b>MO</b>	3	
XIFAXAN 200 MG TABLET <b>MO</b>	3	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET <b>DL</b>	4	PA,QL(84 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<b>GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT</b>		
AMVUTTRA 25 MG/0.5 ML SYRINGE <b>DL</b>	4	PA,QL(0.5 per 90 days)
CREON 12,000-38,000 -60,000 UNIT, 24,000-76,000 -120,000 UNIT, 3,000-9,500- 15,000 UNIT, 36,000-114,000- 180,000 UNIT, 6,000-19,000 -30,000 UNIT CAPSULE, DR/EC <b>MO</b>	2	
ELELYSO 200 UNIT RECON SOLUTION <b>DL</b>	4	PA
ONPATTRO 2 MG/ML SOLUTION <b>DL</b>	4	PA
STRENSIQ 40 MG/ML SOLUTION <b>DL</b>	4	PA
VYNDAMAX 61 MG CAPSULE <b>DL</b>	4	PA,QL(30 per 30 days)
ZEMAIRA 1,000 MG RECON SOLUTION <b>DL</b>	4	PA
ZENPEP 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 -14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT, 60,000-189,600- 252,600 UNIT CAPSULE, DR/EC <b>MO</b>	3	
<b>GENITOURINARY AGENTS</b>		
<i>finasteride 5 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET <b>MO</b>	3	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. <b>MO</b>	2	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON <b>MO</b>	2	QL(300 per 30 days)
<i>oxybutynin chloride 10 mg TABLET, ER 24 HR.</i> <b>MO</b>	1	QL(60 per 30 days)
<i>oxybutynin chloride 5 mg TABLET</i> <b>MO</b>	1	
<i>tamsulosin 0.4 mg CAPSULE</i> <b>MO</b>	1	
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)</b>		
ACTHAR 80 UNIT/ML GEL <b>DL</b>	4	PA,QL(30 per 30 days)
<i>methylprednisolone 4 mg TABLET, DOSE PACK</i> <b>MO</b>	1	
<i>prednisone 10 mg, 20 mg, 5 mg TABLET</i> <b>MO</b>	1	BvsD
<i>triamcinolone acetonide 0.1 % CREAM</i> <b>MO</b>	1	
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)</b>		
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) CARTRIDGE <b>DL</b>	4	PA
OMNITROPE 5.8 MG RECON SOLUTION <b>DL</b>	4	PA
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)</b>		
<i>estradiol 0.01 % (0.1 mg/gram) CREAM</i> <b>MO</b>	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
OSPHENA 60 MG TABLET <b>MO</b>	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET <b>MO</b>	3	
PREMARIN 0.625 MG/GRAM CREAM <b>MO</b>	2	
<b>HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)</b>		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg TABLET <b>MO</b>	1	
TIROSINT 100 MCG, 112 MCG, 125 MCG, 13 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 37.5 MCG, 44 MCG, 50 MCG, 62.5 MCG, 75 MCG, 88 MCG CAPSULE <b>MO</b>	3	
TIROSINT-SOL 100 MCG/ML, 112 MCG/ML, 125 MCG/ML, 13 MCG/ML, 137 MCG/ML, 150 MCG/ML, 175 MCG/ML, 200 MCG/ML, 25 MCG/ML, 37.5 MCG/ML, 44 MCG/ML, 50 MCG/ML, 62.5 MCG/ML, 75 MCG/ML, 88 MCG/ML SOLUTION <b>MO</b>	3	
<b>HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)</b>		
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE <b>DL</b>	4	PA,QL(0.3 per 28 days)
<b>IMMUNOLOGICAL AGENTS</b>		
ADALIMUMAB-ADBM 10 MG/0.2 ML, 20 MG/0.4 ML SYRINGE KIT <b>DL</b>	4	PA,QL(2 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM 40 MG/0.4 ML, 40 MG/0.8 ML SYRINGE KIT <b>DL</b>	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
AREXVY (PF) 120 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION <b>AV,DL</b>	1	
COSENTYX 75 MG/0.5 ML SYRINGE <b>DL</b>	4	PA,QL(2 per 28 days)
COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE <b>DL</b>	4	PA,QL(8 per 28 days)
COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR <b>DL</b>	4	PA,QL(8 per 28 days)
COSENTYX UNOREADY PEN 300 MG/2 ML (150 MG/ML) PEN INJECTOR <b>DL</b>	4	PA,QL(8 per 28 days)
DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR <b>DL</b>	4	PA,QL(3.42 per 28 days)
DUPIXENT PEN 300 MG/2 ML PEN INJECTOR <b>DL</b>	4	PA,QL(8 per 28 days)
DUPIXENT SYRINGE 100 MG/0.67 ML SYRINGE <b>DL</b>	4	PA,QL(1.34 per 28 days)
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE <b>DL</b>	4	PA,QL(3.42 per 28 days)
DUPIXENT SYRINGE 300 MG/2 ML SYRINGE <b>DL</b>	4	PA,QL(8 per 28 days)
ENVARUSUS XR 0.75 MG, 1 MG TABLET, ER 24 HR. <b>MO</b>	3	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ENVARUSUS XR 4 MG TABLET, ER 24 HR. <b>DL</b>	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION <b>DL</b>	4	PA
HAEGARDA 2,000 UNIT, 3,000 UNIT RECON SOLUTION <b>DL</b>	4	PA,QL(24 per 28 days)
HUMIRA 40 MG/0.8 ML SYRINGE KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS 40 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML SYRINGE KIT <b>DL</b>	4	PA,QL(2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SYRINGE KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML SYRINGE KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS 80 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC 80 MG/0.8 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS 80 MG/0.8 ML-40 MG/0.4 ML PEN INJECTOR KIT <b>DL</b>	4	PA,QL(6 per 28 days)
<i>methotrexate sodium</i> 2.5 mg TABLET <b>MO</b>	1	BvsD
RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. <b>DL</b>	4	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET, ER 24 HR. <b>DL</b>	4	PA,QL(168 per 365 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION <b>AV,DL</b>	1	
SKYRIZI 150 MG/ML PEN INJECTOR	4	PA,QL(2 per 84 days)
SKYRIZI 150 MG/ML SYRINGE	4	PA,QL(2 per 84 days)
SKYRIZI 180 MG/1.2 ML (150 MG/ML) WEARABLE INJECTOR <b>DL</b>	4	PA,QL(8.4 per 365 days)
SKYRIZI 360 MG/2.4 ML (150 MG/ML) WEARABLE INJECTOR <b>DL</b>	4	PA,QL(16.8 per 365 days)
STELARA 45 MG/0.5 ML SOLUTION <b>DL</b>	4	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SYRINGE <b>DL</b>	4	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SYRINGE <b>DL</b>	4	PA,QL(3 per 84 days)
TREMFYA 100 MG/ML AUTO-INJECTOR	4	PA,QL(3 per 84 days)
TREMFYA 100 MG/ML SYRINGE	4	PA,QL(3 per 84 days)
<b>METABOLIC BONE DISEASE AGENTS</b>		
<i>alendronate</i> 70 mg TABLET <b>MO</b>	1	QL(4 per 28 days)
FORTEO 20 MCG/DOSE (600MCG/2.4ML) PEN INJECTOR <b>DL</b>	4	PA,QL(2.4 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PROLIA 60 MG/ML SYRINGE <b>MO</b>	3	QL(1 per 180 days)
TYMLOS 80 MCG (3,120 MCG/1.56 ML) PEN INJECTOR <b>DL</b>	4	PA,QL(1.56 per 30 days)
<b>MISCELLANEOUS THERAPEUTIC AGENTS</b>		
BD ALCOHOL SWABS PADS, MEDICATED <b>MO</b>	1	
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" NEEDLE <b>PDS,MO</b>	1	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE <b>PDS,MO</b>	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE <b>PDS,MO</b>	1	
BD INSULIN SYRINGE ULTRA-FINE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16 SYRINGE <b>PDS,MO</b>	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE <b>PDS,MO</b>	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE <b>PDS,MO</b>	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE <b>PDS,MO</b>	1	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE <b>PDS,MO</b>	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE <b>PDS,MO</b>	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE <b>PDS,MO</b>	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE <b>PDS,MO</b>	1	
BD VEO INSULIN SYRINGE UF 0.3 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 15/64", 1/2 ML 31 GAUGE X 15/64" SYRINGE <b>PDS,MO</b>	1	
CEQUR SIMPLICITY INSERTER MISCELLANEOUS <b>MO</b>	2	
DROPLET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16 SYRINGE <b>PDS,MO</b>	1	
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32" NEEDLE <b>PDS,MO</b>	1	
DROPSAFE ALCOHOL PREP PADS PADS, MEDICATED <b>MO</b>	1	
GIVLAARI 189 MG/ML SOLUTION <b>DL</b>	4	PA
OMNIPOD 5 G6 PODS (GEN 5) CARTRIDGE <b>MO</b>	2	
OXLUMO 94.5 MG/0.5 ML SOLUTION	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<b>OPHTHALMIC AGENTS</b>		
<i>brimonidine 0.2 % DROPS</i> <b>MO</b>	1	
COMBIGAN 0.2-0.5 % DROPS <b>MO</b>	2	QL(5 per 25 days)
<i>dorzolamide-timolol 22.3-6.8 mg/ml DROPS</i> <b>MO</b>	1	
EYSUVIS 0.25 % DROPS, SUSPENSION <b>MO</b>	2	QL(16.6 per 30 days)
ILEVRO 0.3 % DROPS, SUSPENSION <b>MO</b>	2	QL(3 per 30 days)
<i>latanoprost 0.005 % DROPS</i> <b>MO</b>	1	QL(5 per 25 days)
LOTEMAX 0.5 % DROPS, GEL <b>MO</b>	3	ST
LOTEMAX 0.5 % DROPS, SUSPENSION <b>MO</b>	3	ST
LOTEMAX 0.5 % OINTMENT <b>MO</b>	3	ST
LOTEMAX SM 0.38 % DROPS, GEL <b>MO</b>	3	
LUMIGAN 0.01 % DROPS <b>MO</b>	2	QL(2.5 per 25 days)
<i>prednisolone acetate 1 % DROPS, SUSPENSION</i> <b>MO</b>	1	
RHOPRESSA 0.02 % DROPS <b>MO</b>	2	ST,QL(2.5 per 25 days)
ROCKLATAN 0.02-0.005 % DROPS <b>MO</b>	2	ST,QL(2.5 per 25 days)
SIMBRINZA 1-0.2 % DROPS, SUSPENSION <b>MO</b>	3	QL(16 per 30 days)
<i>timolol maleate 0.5 % DROPS</i> <b>MO</b>	1	
VYZULTA 0.024 % DROPS <b>MO</b>	3	QL(2.5 per 25 days)
<b>RESPIRATORY TRACT/PULMONARY AGENTS</b>		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET <b>DL,LA</b>	4	PA,QL(90 per 30 days)
ADVAIR DISKUS 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE BLISTER WITH DEVICE <b>MO</b>	3	PA,QL(60 per 30 days)
ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER <b>MO</b>	2	QL(12 per 30 days)
<i>albuterol sulfate 2.5 mg /3 ml (0.083 %) SOLUTION FOR NEBULIZATION</i> <b>MO</b>	1	BvsD
<i>albuterol sulfate 90 mcg/actuation HFA AEROSOL INHALER</i> <b>MO</b>	1	QL(36 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE <b>MO</b>	2	QL(30 per 30 days)
AUVI-Q 0.1 MG/0.1 ML, 0.15 MG/0.15 ML, 0.3 MG/0.3 ML AUTO-INJECTOR <b>MO</b>	2	QL(4 per 30 days)
<i>azelastine 137 mcg (0.1 %) SPRAY, NON-AEROSOL</i> <b>MO</b>	1	QL(30 per 25 days)
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 MCG/DOSE BLISTER WITH DEVICE <b>MO</b>	2	QL(60 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACTUATION HFA AEROSOL INHALER <b>MO</b>	2	QL(10.7 per 30 days)
COMBIVENT RESPIMAT 20-100 MCG/ACTUATION MIST <b>MO</b>	3	QL(4 per 20 days)
FASENRA 30 MG/ML SYRINGE <b>DL</b>	4	PA,QL(1 per 28 days)
FASENRA PEN 30 MG/ML AUTO-INJECTOR <b>DL</b>	4	PA,QL(1 per 28 days)
<i>fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION</i> <b>MO</b>	1	QL(16 per 30 days)
<i>ipratropium-albuterol 0.5 mg-3 mg(2.5 mg base)/3 ml SOLUTION FOR NEBULIZATION</i> <b>MO</b>	1	BvsD
<i>levocetirizine 5 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
<i>montelukast 10 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)
NUCALA 100 MG RECON SOLUTION <b>DL</b>	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML AUTO-INJECTOR <b>DL</b>	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML SYRINGE <b>DL</b>	4	PA,QL(3 per 28 days)
NUCALA 40 MG/0.4 ML SYRINGE <b>DL</b>	4	PA,QL(0.4 per 28 days)
OFEV 100 MG, 150 MG CAPSULE <b>DL,LA</b>	4	PA,QL(60 per 30 days)
OPSUMIT 10 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
OPSYNVI 10-20 MG, 10-40 MG TABLET <b>DL</b>	4	PA,QL(30 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION MIST <b>MO</b>	2	QL(4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG CAPSULE, W/INHALATION DEVICE <b>MO</b>	2	QL(30 per 30 days)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACTUATION MIST <b>MO</b>	2	QL(4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION MIST <b>MO</b>	2	QL(4 per 30 days)
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER <b>MO</b>	2	QL(10.2 per 30 days)
TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE <b>MO</b>	2	QL(60 per 30 days)
TYVASO DPI 16 MCG, 32 MCG, 48 MCG, 64 MCG CARTRIDGE WITH INHALER <b>DL</b>	4	PA,QL(112 per 28 days)
TYVASO DPI 16(112)-32(112) -48(28) MCG CARTRIDGE WITH INHALER <b>DL</b>	4	PA,QL(252 per 28 days)
TYVASO DPI 32-48 MCG CARTRIDGE WITH INHALER <b>DL</b>	4	PA,QL(224 per 28 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER <b>MO</b>	2	QL(36 per 30 days)
<b>SKELETAL MUSCLE RELAXANTS</b>		
<i>cyclobenzaprine 10 mg, 5 mg TABLET</i> <b>MO</b>	1	
<i>methocarbamol 500 mg, 750 mg TABLET</i> <b>MO</b>	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<b>SLEEP DISORDER AGENTS</b>		
BELSOMRA 10 MG TABLET <b>MO</b>	2	QL(60 per 30 days)
BELSOMRA 15 MG, 20 MG TABLET <b>MO</b>	2	QL(30 per 30 days)
BELSOMRA 5 MG TABLET <b>MO</b>	2	QL(120 per 30 days)
<i>temazepam 15 mg, 30 mg CAPSULE</i> <b>DL</b>	1	QL(30 per 30 days)
<i>zolpidem 10 mg, 5 mg TABLET</i> <b>MO</b>	1	QL(30 per 30 days)

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## Humana Medicare Employer Plan Coverage of Additional Prescription Drugs

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<b>Cough/Cold - Mail Order Available</b>		
<i>benzonatate 100 mg, 150 mg, 200 mg CAPSULE</i>	1	
<i>bromfed dm 2-30-10 mg/5 ml SYRUP</i>	1	
<i>brompheniramine-pseudoeph-dm 2-30-10 mg/5 ml SYRUP</i>	1	
<i>HYCODAN 5-1.5 MG/5 ML (5 ML) SYRUP</i>	1	
<i>HYCODAN (WITH HOMATROPINE) 5-1.5 MG TABLET</i>	1	
<i>HYCODAN (WITH HOMATROPINE) 5-1.5 MG/5 ML SYRUP</i>	1	
<i>hydrocodone-chlorpheniramine 10-8 mg/5 ml SUSPENSION, ER 12 HR.</i>	1	
<i>hydrocodone-homatropine 5-1.5 mg TABLET</i>	1	
<i>hydrocodone-homatropine 5-1.5 mg/5 ml, 5-1.5 mg/5 ml (5 ml) SYRUP</i>	1	
<i>hydromet 5-1.5 mg/5 ml SYRUP</i>	1	
<i>OBREDON 2.5-200 MG/5 ML SOLUTION</i>	3	
<i>promethazine vc-codeine 6.25-5-10 mg/5 ml SYRUP</i>	1	
<i>promethazine-codeine 6.25-10 mg/5 ml SYRUP</i>	1	
<i>promethazine-dm 6.25-15 mg/5 ml SYRUP</i>	1	
<i>promethazine-phenyleph-codeine 6.25-5-10 mg/5 ml SYRUP</i>	1	
<i>RESPA-AR 8-90-0.24 MG TABLET, ER 12 HR.</i>	3	
<i>TUXARIN ER 8-54.3 MG TABLET, ER 12 HR.</i>	3	
<i>TUZISTRA XR 14.7-2.8 MG/5 ML SUSPENSION, ER 12 HR.</i>	3	
<b>Erectile Dysfunction - Mail Order Available</b>		
<i>ADDYI 100 MG TABLET</i>	3	
<i>CIALIS 10 MG, 20 MG TABLET</i>	3	QL(6 per 30 days)
<i>sildenafil 100 mg, 25 mg, 50 mg TABLET</i>	1	QL(6 per 30 days)
<i>STENDRA 100 MG, 200 MG, 50 MG TABLET</i>	3	QL(6 per 30 days)
<i>tadalafil 10 mg, 20 mg TABLET</i>	1	QL(6 per 30 days)

Your Humana Group Medicare Plan has additional coverage for some drugs that are not normally covered under Medicare Part D. Guidelines that apply to these drugs include: they are not subject to the Medicare appeals process and your member cost share does not apply to your annual maximum out-of-pocket (MOOP) spend.

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<b>Erectile Dysfunction - Mail Order Available</b>		
vardenafil 10 mg TABLET, DISINTEGRATING	1	QL(6 per 30 days)
vardenafil 10 mg, 2.5 mg, 20 mg, 5 mg TABLET	1	QL(6 per 30 days)
VIAGRA 100 MG, 25 MG, 50 MG TABLET	3	QL(6 per 30 days)
VYLEESI 1.75 MG/0.3 ML AUTO-INJECTOR	3	

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## 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 1-877-320-1235 (TTY: 711). Someone who speaks English 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (听障专线：711)。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 1-877-320-1235 (聽障專線：711)。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 panggagamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بخططنا الصحية أو خطة الأدوية الموصوفة لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711) 1-877-320-1235. 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 1-877-320-1235 (TTY: 711) 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 1-877-320-1235 (TTY: 711). Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). 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 1-877-320-1235 (TTY: 711). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康保険と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をご用意しています。通訳をご用命になるには、1-877-320-1235 (TTY:711) にお電話ください。日本語を話す者が支援いたします。これは無料のサービスです。











This abridged formulary was updated on 09/28/2024 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact the Humana Medicare Employer Plan with any questions at the number on the back of your membership card or, for TTY users, 711, Monday through Friday, from 8 a.m. - 9 p.m., Eastern time. Our automated phone system is available after hours, weekends, and holidays. Our website is also available 24 hours a day, 7 days a week, by visiting **Humana.com**.



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