

2026

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.

24

Formulary 26800

This abridged formulary was updated on 05/05/2026 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 Customer Care Team 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**.

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 May 2026. 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 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 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 May 2026. 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 34. 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**.

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 34.

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 29.

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
ANALGESICS		
celecoxib 100 mg, 200 mg CAPSULE MO	1	
diclofenac sodium 75 mg TABLET, DR/EC MO	1	
hydrocodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET DL	1	QL(360 per 30 days)
ibuprofen 600 mg, 800 mg TABLET MO	1	
meloxicam 15 mg TABLET MO	1	QL(30 per 30 days)
meloxicam 7.5 mg TABLET MO	1	QL(60 per 30 days)
naproxen 500 mg TABLET MO	1	
oxycodone 10 mg, 5 mg TABLET DL	1	QL(360 per 30 days)
oxycodone-acetaminophen 10-325 mg, 5-325 mg, 7.5-325 mg TABLET DL	1	QL(360 per 30 days)
tramadol 50 mg TABLET DL	1	QL(240 per 30 days)
ANESTHETICS		
lidocaine 5 % ADHESIVE PATCH, MEDICATED MO	1	QL(90 per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
KLOXXADO 8 MG/ACTUATION SPRAY, NON-AEROSOL MO	2	
OPVEE 2.7 MG/ACTUATION SPRAY, NON-AEROSOL MO	2	
ZUBSOLV 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG SUBLINGUAL TABLET MO	1	
ANTIBACTERIALS		
amoxicillin 500 mg CAPSULE MO	1	
amoxicillin 500 mg TABLET MO	1	
amoxicillin-pot clavulanate 875-125 mg TABLET MO	1	
azithromycin 250 mg TABLET MO	1	
cefdinir 300 mg CAPSULE MO	1	
cephalexin 500 mg CAPSULE MO	1	
ciprofloxacin hcl 500 mg TABLET MO	1	
DIFICID 200 MG TABLET DL	4	
DIFICID 40 MG/ML SUSPENSION FOR RECONSTITUTION DL	4	
doxycycline hyclate 100 mg CAPSULE MO	1	
doxycycline hyclate 100 mg TABLET MO	1	
levofloxacin 500 mg TABLET MO	1	
nitrofurantoin monohyd/m-cryst 100 mg CAPSULE MO	1	
sulfamethoxazole-trimethoprim 800-160 mg TABLET MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ANTICONVULSANTS		
EPIDIOLEX 100 MG/ML SOLUTION DL	4	PA
<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)
ANTIDEMENTIA AGENTS		
<i>donepezil 10 mg, 5 mg TABLET MO</i>	1	
<i>memantine 10 mg, 5 mg TABLET MO</i>	1	PA
NAMZARIC 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG CAPSULE ER SPRINKLE 24 HR. MO	3	PA,QL(30 per 30 days)
NAMZARIC 7/14/21/28 MG-10 MG CAPSULE ER SPRINKLE 24 HR. MO	3	PA,QL(28 per 28 days)
ANTIDEPRESSANTS		
<i>amitriptyline 25 mg TABLET MO</i>	1	
AUVELITY 45-105 MG TABLET, IR/ER, BIPHASIC MO	3	ST,QL(60 per 30 days)
<i>bupropion hcl 150 mg TABLET, ER 24 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, 20 mg, 40 mg TABLET MO</i>	1	
<i>escitalopram oxalate 10 mg, 20 mg, 5 mg TABLET MO</i>	1	
<i>fluoxetine 20 mg CAPSULE MO</i>	1	QL(120 per 30 days)
<i>fluoxetine 40 mg CAPSULE MO</i>	1	QL(90 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)
ANTIEMETICS		
<i>meclizine 25 mg TABLET MO</i>	1	
<i>ondansetron 4 mg, 8 mg TABLET, DISINTEGRATING MO</i>	1	BvsD
<i>ondansetron hcl 4 mg TABLET MO</i>	1	BvsD
ANTIFUNGALS		
<i>clotrimazole-betamethasone 1-0.05 % CREAM MO</i>	1	QL(180 per 30 days)
<i>fluconazole 150 mg TABLET MO</i>	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
<i>ketoconazole 2 % CREAM</i> MO	1	QL(60 per 30 days)
<i>ketoconazole 2 % SHAMPOO</i> MO	1	QL(120 per 30 days)
ANTIGOUT AGENTS		
<i>allopurinol 100 mg, 300 mg TABLET</i> MO	1	
<i>colchicine 0.6 mg TABLET</i> MO	1	QL(120 per 30 days)
ANTIMIGRAINE AGENTS		
EMGALITY PEN 120 MG/ML PEN INJECTOR MO	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 120 MG/ML SYRINGE MO	3	PA,QL(2 per 30 days)
EMGALITY SYRINGE 300 MG/3 ML (100 MG/ML X 3) SYRINGE MO	3	PA,QL(3 per 30 days)
QULIPTA 10 MG, 30 MG, 60 MG TABLET MO	3	PA,QL(30 per 30 days)
UBRELVY 100 MG, 50 MG TABLET MO	2	PA,QL(16 per 30 days)
ANTIMYASTHENIC AGENTS		
VYVGART 20 MG/ML SOLUTION DL	4	PA
VYVGART HYTRULO 1,000 MG-10,000 UNIT/5 ML SYRINGE DL	4	PA,QL(20 per 28 days)
VYVGART HYTRULO 1,008 MG-11,200 UNIT/5.6 ML SOLUTION DL	4	PA,QL(22.4 per 28 days)
ANTINEOPLASTICS		
ALECENSA 150 MG CAPSULE DL	4	PA,QL(240 per 30 days)
ALUNBRIG 180 MG, 90 MG TABLET DL	4	PA,QL(30 per 30 days)
ALUNBRIG 30 MG TABLET DL	4	PA,QL(180 per 30 days)
ALUNBRIG 90 MG (7)- 180 MG (23) TABLET, DOSE PACK DL	4	PA,QL(30 per 30 days)
<i>anastrozole 1 mg TABLET</i> MO	1	QL(30 per 30 days)
BRUKINSA 80 MG CAPSULE DL	4	PA,QL(120 per 30 days)
CABOMETYX 20 MG, 40 MG, 60 MG TABLET DL	4	PA,QL(30 per 30 days)
CALQUENCE (ACALABRUTINIB MAL) 100 MG TABLET DL	4	PA,QL(60 per 30 days)
ERIVEDGE 150 MG CAPSULE DL	4	PA,QL(28 per 28 days)
ERLEADA 240 MG TABLET DL	4	PA,QL(30 per 30 days)
ERLEADA 60 MG TABLET DL	4	PA,QL(120 per 30 days)
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE DL	4	PA,QL(21 per 28 days)
IBRANCE 100 MG, 125 MG, 75 MG TABLET DL	4	PA,QL(21 per 28 days)
IMBRUVICA 140 MG CAPSULE DL	4	PA,QL(120 per 30 days)
IMBRUVICA 140 MG, 280 MG TABLET DL	4	PA
IMBRUVICA 420 MG TABLET DL	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG CAPSULE DL	4	PA,QL(28 per 28 days)
IMBRUVICA 70 MG/ML SUSPENSION DL	4	PA
KISQALI 200 MG/DAY (200 MG X 1) TABLET DL	4	PA,QL(21 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
KISQALI 400 MG/DAY (200 MG X 2) TABLET DL	4	PA,QL(42 per 28 days)
KISQALI 600 MG/DAY (200 MG X 3) TABLET DL	4	PA,QL(63 per 28 days)
KISQALI FEMARA CO-PACK 200 MG/DAY(200 MG X 1)-2.5 MG TABLET DL	4	PA,QL(49 per 28 days)
KISQALI FEMARA CO-PACK 400 MG/DAY(200 MG X 2)-2.5 MG TABLET DL	4	PA,QL(70 per 28 days)
KISQALI FEMARA CO-PACK 600 MG/DAY(200 MG X 3)-2.5 MG TABLET DL	4	PA,QL(91 per 28 days)
LUMAKRAS 120 MG TABLET DL	4	PA,QL(240 per 30 days)
LUMAKRAS 240 MG TABLET DL	4	PA,QL(120 per 30 days)
LUMAKRAS 320 MG TABLET DL	4	PA,QL(90 per 30 days)
LYNPARZA 100 MG, 150 MG TABLET DL	4	PA,QL(120 per 30 days)
NUBEQA 300 MG TABLET DL	4	PA,QL(120 per 30 days)
ORGOVYX 120 MG TABLET DL	4	PA,QL(32 per 30 days)
RUXIENCE 10 MG/ML SOLUTION DL	4	PA
TRAZIMERA 150 MG, 420 MG RECON SOLUTION DL	4	PA
VERZENIO 100 MG, 150 MG, 200 MG, 50 MG TABLET DL	4	PA,QL(60 per 30 days)
XTANDI 40 MG CAPSULE DL	4	PA,QL(120 per 30 days)
XTANDI 40 MG TABLET DL	4	PA,QL(120 per 30 days)
XTANDI 80 MG TABLET DL	4	PA,QL(60 per 30 days)
ZEJULA 100 MG, 200 MG, 300 MG TABLET DL	4	PA,QL(30 per 30 days)
ZIRABEV 25 MG/ML SOLUTION DL	4	PA
ANTIPARASITICS		
hydroxychloroquine 200 mg TABLET MO	1	
ANTIPARKINSON AGENTS		
carbidopa-levodopa 25-100 mg TABLET MO	1	
CREXONT 35-140 MG, 52.5-210 MG, 70-280 MG, 87.5-350 MG CAPSULE, IR/ER, BIPHASIC MO	3	ST,QL(180 per 30 days)
RYTARY 23.75-95 MG, 48.75-195 MG CAPSULE, ER MO	3	ST,QL(360 per 30 days)
RYTARY 36.25-145 MG CAPSULE, ER MO	3	ST,QL(270 per 30 days)
RYTARY 61.25-245 MG CAPSULE, ER MO	3	ST,QL(300 per 30 days)
ANTIPSYCHOTICS		
ABILIFY 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG TABLET MO	3	PA
ABILIFY ASIMTUFI 720 MG/2.4 ML SUSPENSION, ER, SYRINGE	4	QL(2.4 per 56 days)
ABILIFY ASIMTUFI 960 MG/3.2 ML SUSPENSION, ER, SYRINGE	4	QL(3.2 per 56 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, RECON DL	4	QL(1 per 28 days)
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION, ER, SYRINGE DL	4	QL(1 per 28 days)
ARISTADA 1,064 MG/3.9 ML SUSPENSION, ER, SYRINGE	4	QL(3.9 per 56 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ARISTADA 441 MG/1.6 ML SUSPENSION, ER, SYRINGE DL	4	QL(1.6 per 28 days)
ARISTADA 662 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 28 days)
ARISTADA 882 MG/3.2 ML SUSPENSION, ER, SYRINGE DL	4	QL(3.2 per 28 days)
ARISTADA INITIO 675 MG/2.4 ML SUSPENSION, ER, SYRINGE DL	4	QL(2.4 per 42 days)
INVEGA 3 MG, 9 MG TABLET, ER 24 HR. MO	3	PA,QL(30 per 30 days)
INVEGA 6 MG TABLET, ER 24 HR. MO	3	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 DL	4	QL(1.5 per 28 days)
INVEGA SUSTENNA 156 MG/ML SYRINGE DL	4	QL(1 per 28 days)
INVEGA SUSTENNA 39 MG/0.25 ML SYRINGE MO	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 DL	4	PA,QL(30 per 30 days)
quetiapine 100 mg TABLET MO	1	QL(90 per 30 days)
quetiapine 25 mg, 50 mg TABLET MO	1	QL(120 per 30 days)
REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG TABLET DL	4	PA,QL(30 per 30 days)
RISPERDAL 0.5 MG TABLET MO	3	QL(120 per 30 days)
RISPERDAL 1 MG, 2 MG, 3 MG, 4 MG TABLET MO	3	QL(60 per 30 days)
RISPERDAL 1 MG/ML SOLUTION MO	3	
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML SUSPENSION, ER, RECON MO	3	QL(2 per 28 days)
RISPERDAL CONSTA 37.5 MG/2 ML, 50 MG/2 ML SUSPENSION, ER, RECON DL	4	QL(2 per 28 days)
ANTISPASTICITY AGENTS		
baclofen 10 mg TABLET MO	1	
tizanidine 4 mg TABLET MO	1	
ANTIVIRALS		
BIKTARVY 30-120-15 MG, 50-200-25 MG TABLET DL	4	QL(30 per 30 days)
DESCOVY 120-15 MG, 200-25 MG TABLET DL	4	QL(30 per 30 days)
EPCLUSA 150-37.5 MG PELLETS IN PACKET DL	4	PA,QL(28 per 28 days)
EPCLUSA 200-50 MG PELLETS IN PACKET DL	4	PA,QL(56 per 28 days)
EPCLUSA 200-50 MG, 400-100 MG TABLET DL	4	PA,QL(28 per 28 days)
GENVOYA 150-150-200-10 MG TABLET DL	4	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ODEFSEY 200-25-25 MG TABLET DL	4	QL(30 per 30 days)
oseltamivir 75 mg CAPSULE MO	1	QL(112 per 365 days)
PAXLOVID 150 MG (10)- 100 MG (10) TABLET, DOSE PACK MO	2	QL(40 per 10 days)
PAXLOVID 150 MG (6)- 100 MG (5) TABLET, DOSE PACK MO	2	QL(22 per 10 days)
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLET, DOSE PACK MO	2	QL(60 per 10 days)
valacyclovir 1 gram, 500 mg TABLET MO	1	
VEMLIDY 25 MG TABLET DL	4	QL(30 per 30 days)
VOSEVI 400-100-100 MG TABLET DL	4	PA,QL(28 per 28 days)
ANXIOLYTICS		
alprazolam 0.25 mg, 0.5 mg, 1 mg TABLET DL	1	QL(120 per 30 days)
bupirone 10 mg, 5 mg TABLET MO	1	
clonazepam 0.5 mg, 1 mg TABLET DL	1	
diazepam 5 mg TABLET DL	1	QL(90 per 30 days)
hydroxyzine hcl 25 mg TABLET MO	1	
lorazepam 0.5 mg, 1 mg TABLET DL	1	QL(90 per 30 days)
BLOOD GLUCOSE REGULATORS		
BAQSIMI 3 MG/ACTUATION SPRAY, NON-AEROSOL MO	2	
FARXIGA 10 MG, 5 MG TABLET MO	2	QL(30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML) CARTRIDGE CI,MO	2	
FIASP U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	2	
glimepiride 2 mg, 4 mg TABLET MO	1	
glipizide 10 mg, 5 mg TABLET MO	1	
GLYXAMBI 10-5 MG, 25-5 MG TABLET MO	2	QL(30 per 30 days)
HUMALOG JUNIOR KWIKPEN U-100 100 UNIT/ML INSULIN PEN, HALF-UNIT CI,MO	3	ST
HUMALOG KWIKPEN INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	ST
HUMALOG MIX 50-50 KWIKPEN 100 UNIT/ML (50-50) INSULIN PEN CI,MO	3	ST
HUMALOG MIX 75-25 KWIKPEN 100 UNIT/ML (75-25) INSULIN PEN CI,MO	3	ST
HUMALOG MIX 75-25(U-100)INSULN 100 UNIT/ML (75-25) SUSPENSION CI,MO	3	ST
HUMALOG TEMPO PEN(U-100)INSULN 100 UNIT/ML INSULIN PEN, SENSOR CI,MO	3	ST
HUMALOG U-100 INSULIN 100 UNIT/ML CARTRIDGE CI,MO	3	ST

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMALOG U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	ST
HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION CI,MO	3	ST
HUMULIN 70/30 U-100 KWIKPEN 100 UNIT/ML (70-30) INSULIN PEN CI,MO	3	ST
HUMULIN N NPH INSULIN KWIKPEN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	ST
HUMULIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION CI,MO	3	ST
HUMULIN R REGULAR U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	ST
HUMULIN R U-500 (CONC) KWIKPEN 500 UNIT/ML (3 ML) INSULIN PEN CI,DL	4	
INVOKAMET 150-1,000 MG, 150-500 MG, 50-1,000 MG, 50-500 MG TABLET MO	3	PA,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 MO	3	PA,QL(60 per 30 days)
INVOKANA 100 MG, 300 MG TABLET MO	3	PA,QL(30 per 30 days)
JANUMET 50-1,000 MG, 50-500 MG TABLET MO	2	QL(60 per 30 days)
JANUMET XR 100-1,000 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(30 per 30 days)
JANUMET XR 50-1,000 MG, 50-500 MG TABLET, ER 24 HR., MULTIPHASE MO	2	QL(60 per 30 days)
JANUVIA 100 MG, 25 MG, 50 MG TABLET MO	2	QL(30 per 30 days)
JARDIANCE 10 MG, 25 MG TABLET MO	2	QL(30 per 30 days)
JENTADUETO 2.5-1,000 MG, 2.5-500 MG TABLET MO	2	QL(60 per 30 days)
JENTADUETO XR 2.5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
JENTADUETO XR 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
LANTUS U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	2	
LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML INSULIN PEN CI,MO	3	ST
LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML) INSULIN PEN CI,MO	3	ST
LYUMJEV TEMPO PEN(U-100)INSULIN 100 UNIT/ML INSULIN PEN, SENSOR CI,MO	3	ST
LYUMJEV U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	3	ST
<i>metformin 1,000 mg, 500 mg TABLET MO</i>	1	
<i>metformin 500 mg TABLET, ER 24 HR. MO</i>	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 MO	2	PA,QL(2 per 28 days)
NOVOLIN 70-30 FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN CI,MO	2	
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML (70-30) SUSPENSION CI,MO	2	
NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
NOVOLIN N NPH U-100 INSULIN 100 UNIT/ML SUSPENSION CI,MO	2	
NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLIN R REGULAR U100 INSULIN 100 UNIT/ML SOLUTION CI,MO	2	
NOVOLOG FLEXPEN U-100 INSULIN 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML (70-30) SOLUTION CI,MO	2	
NOVOLOG MIX 70-30FLEXPEN U-100 100 UNIT/ML (70-30) INSULIN PEN CI,MO	2	
NOVOLOG PENFILL U-100 INSULIN 100 UNIT/ML CARTRIDGE CI,MO	2	
NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML SOLUTION CI,MO	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 MO	2	PA,QL(3 per 28 days)
<i>pioglitazone</i> 30 mg TABLET MO	1	QL(30 per 30 days)
RYBELSUS 14 MG, 3 MG, 7 MG TABLET MO	2	PA,QL(30 per 30 days)
SOLIQUA 100/33 100 UNIT-33 MCG/ML INSULIN PEN CI,MO	2	QL(15 per 24 days)
SYNJARDY 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG, 5-500 MG TABLET MO	2	QL(60 per 30 days)
SYNJARDY XR 10-1,000 MG, 25-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(30 per 30 days)
SYNJARDY XR 12.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML) INSULIN PEN CI,MO	2	
TRADJENTA 5 MG TABLET MO	2	QL(30 per 30 days)
TRESIBA FLEXTOUCH U-100 100 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
TRESIBA FLEXTOUCH U-200 200 UNIT/ML (3 ML) INSULIN PEN CI,MO	2	
TRESIBA U-100 INSULIN 100 UNIT/ML SOLUTION CI,MO	2	
TRIJARDY XR 10-5-1,000 MG, 25-5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	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 MO	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 MO	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 MO	2	QL(30 per 30 days)
XIGDUO XR 2.5-1,000 MG, 5-1,000 MG TABLET, IR/ER 24 HR., BIPHASIC MO	2	QL(60 per 30 days)
ZEGALOGUE AUTOINJECTOR 0.6 MG/0.6 ML AUTO-INJECTOR MO	2	
ZEGALOGUE SYRINGE 0.6 MG/0.6 ML SYRINGE MO	2	
BLOOD PRODUCTS AND MODIFIERS		
<i>clopidogrel</i> 75 mg TABLET MO	1	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ELIQUIS 2.5 MG TABLET MO	2	QL(60 per 30 days)
ELIQUIS 5 MG TABLET MO	2	QL(74 per 30 days)
ELIQUIS DVT-PE TREAT 30D START 5 MG (74 TABS) TABLET, DOSE PACK MO	2	QL(74 per 30 days)
NIVESTYM 300 MCG/0.5 ML, 480 MCG/0.8 ML SYRINGE DL	4	PA
NIVESTYM 300 MCG/ML, 480 MCG/1.6 ML SOLUTION DL	4	PA
PROMACTA 12.5 MG POWDER IN PACKET DL	4	PA,QL(360 per 30 days)
PROMACTA 12.5 MG, 25 MG TABLET DL	4	PA,QL(30 per 30 days)
PROMACTA 25 MG POWDER IN PACKET DL	4	PA,QL(180 per 30 days)
PROMACTA 50 MG TABLET DL	4	PA,QL(90 per 30 days)
PROMACTA 75 MG TABLET DL	4	PA,QL(60 per 30 days)
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 MO	3	PA,QL(14 per 30 days)
RETACRIT 40,000 UNIT/ML SOLUTION DL	4	PA,QL(14 per 30 days)
UDENYCA 6 MG/0.6 ML SYRINGE DL	4	PA,QL(1.2 per 28 days)
UDENYCA AUTOINJECTOR 6 MG/0.6 ML AUTO-INJECTOR DL	4	PA,QL(1.2 per 28 days)
<i>warfarin 5 mg TABLET MO</i>	1	
XARELTO 1 MG/ML SUSPENSION FOR RECONSTITUTION MO	2	ST,QL(600 per 30 days)
XARELTO 10 MG, 20 MG TABLET MO	2	QL(30 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET MO	2	QL(60 per 30 days)
XARELTO DVT-PE TREAT 30D START 15 MG (42)- 20 MG (9) TABLET, DOSE PACK MO	2	QL(51 per 30 days)
ZARXIO 300 MCG/0.5 ML, 480 MCG/0.8 ML SYRINGE DL	4	PA
CARDIOVASCULAR AGENTS		
<i>amiodarone 200 mg TABLET MO</i>	1	
<i>amlodipine 10 mg, 2.5 mg, 5 mg TABLET MO</i>	1	
<i>atenolol 25 mg, 50 mg TABLET MO</i>	1	
<i>atorvastatin 10 mg, 20 mg, 40 mg, 80 mg TABLET MO</i>	1	
<i>bumetanide 1 mg TABLET MO</i>	1	
<i>carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg TABLET MO</i>	1	
<i>chlorthalidone 25 mg TABLET MO</i>	1	
<i>clonidine hcl 0.1 mg TABLET MO</i>	1	
<i>diltiazem hcl 120 mg CAPSULE, ER 24 HR. MO</i>	1	
ENTRESTO 24-26 MG, 49-51 MG, 97-103 MG TABLET MO	3	PA,QL(60 per 30 days)
ENTRESTO SPRINKLE 15-16 MG, 6-6 MG PELLETT MO	2	QL(240 per 30 days)
<i>ezetimibe 10 mg TABLET MO</i>	1	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
fenofibrate 160 mg TABLET MO	1	QL(30 per 30 days)
fenofibrate nanocrystallized 145 mg TABLET MO	1	QL(30 per 30 days)
furosemide 20 mg, 40 mg TABLET MO	1	
hydralazine 25 mg, 50 mg TABLET MO	1	
hydrochlorothiazide 12.5 mg CAPSULE MO	1	
hydrochlorothiazide 12.5 mg, 25 mg TABLET MO	1	
isosorbide mononitrate 30 mg, 60 mg TABLET, ER 24 HR. MO	1	
KERENDIA 10 MG, 20 MG TABLET MO	2	PA,QL(30 per 30 days)
lisinopril 10 mg, 2.5 mg, 20 mg, 40 mg, 5 mg TABLET MO	1	
lisinopril-hydrochlorothiazide 20-12.5 mg, 20-25 mg TABLET MO	1	
losartan 100 mg, 25 mg, 50 mg TABLET MO	1	QL(60 per 30 days)
losartan-hydrochlorothiazide 100-12.5 mg, 100-25 mg, 50-12.5 mg TABLET MO	1	QL(60 per 30 days)
metoprolol succinate 100 mg, 25 mg, 50 mg TABLET, ER 24 HR. MO	1	
metoprolol tartrate 100 mg, 25 mg, 50 mg TABLET MO	1	
MULTAQ 400 MG TABLET MO	2	QL(60 per 30 days)
nitroglycerin 0.4 mg SUBLINGUAL TABLET MO	1	
olmesartan 20 mg, 40 mg TABLET MO	1	QL(30 per 30 days)
pravastatin 20 mg, 40 mg TABLET MO	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML WEARABLE INJECTOR MO	2	PA,QL(3.5 per 28 days)
REPATHA SURECLICK 140 MG/ML PEN INJECTOR MO	2	PA,QL(3 per 28 days)
REPATHA SYRINGE 140 MG/ML SYRINGE MO	2	PA,QL(3 per 28 days)
rosuvastatin 10 mg, 20 mg, 40 mg, 5 mg TABLET MO	1	
simvastatin 10 mg, 20 mg, 40 mg TABLET MO	1	
spironolactone 25 mg, 50 mg TABLET MO	1	
torseamide 20 mg TABLET MO	1	
triamterene-hydrochlorothiazid 37.5-25 mg TABLET MO	1	
valsartan 160 mg, 320 mg TABLET MO	1	QL(60 per 30 days)
VASCEPA 0.5 GRAM CAPSULE MO	2	QL(240 per 30 days)
VASCEPA 1 GRAM CAPSULE MO	2	QL(120 per 30 days)
VERQUVO 10 MG, 2.5 MG, 5 MG TABLET MO	2	PA,QL(30 per 30 days)
ZYPITAMAG 2 MG, 4 MG TABLET MO	2	ST,QL(30 per 30 days)
CENTRAL NERVOUS SYSTEM AGENTS		
AUSTEDO 12 MG, 9 MG TABLET DL	4	PA,QL(120 per 30 days)
AUSTEDO 6 MG TABLET DL	4	PA,QL(60 per 30 days)
AUSTEDO XR 12 MG, 6 MG TABLET, ER 24 HR. DL	4	PA,QL(90 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
AUSTEDO XR 18 MG, 30 MG, 36 MG, 42 MG, 48 MG TABLET, ER 24 HR. DL	4	PA,QL(30 per 30 days)
AUSTEDO XR 24 MG TABLET, ER 24 HR. DL	4	PA,QL(60 per 30 days)
AUSTEDO XR TITRATION KT(WK1-4) 12-18-24-30 MG TABLET, ER 24 HR., DOSE PACK DL	4	PA,QL(28 per 28 days)
AUSTEDO XR TITRATION KT(WK1-4) 6 MG (14)-12 MG (14)-24 MG (14) TABLET, ER 24 HR., DOSE PACK DL	4	PA,QL(42 per 28 days)
BETASERON 0.3 MG KIT DL	4	PA,QL(15 per 30 days)
COPAXONE 20 MG/ML SYRINGE DL	4	PA,QL(30 per 30 days)
COPAXONE 40 MG/ML SYRINGE DL	4	PA,QL(12 per 28 days)
duloxetine 20 mg CAPSULE, DR/EC MO	1	QL(120 per 30 days)
duloxetine 30 mg CAPSULE, DR/EC MO	1	QL(90 per 30 days)
duloxetine 60 mg CAPSULE, DR/EC MO	1	QL(60 per 30 days)
KESIMPTA PEN 20 MG/0.4 ML PEN INJECTOR DL	4	PA,QL(1.2 per 28 days)
pregabalin 100 mg, 150 mg, 50 mg, 75 mg CAPSULE MO	1	QL(90 per 30 days)
RADICAVA ORS STARTER KIT SUSP 105 MG/5 ML SUSPENSION DL	4	PA,QL(70 per 28 days)
VUMERITY 231 MG CAPSULE, DR/EC DL	4	PA,QL(120 per 30 days)
DENTAL & ORAL AGENTS		
chlorhexidine gluconate 0.12 % MOUTHWASH MO	1	
DERMATOLOGICAL AGENTS		
mupirocin 2 % OINTMENT MO	1	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
CARBAGLU 200 MG TABLET, DISPERSIBLE DL	4	PA
LOKELMA 10 GRAM, 5 GRAM POWDER IN PACKET MO	2	QL(30 per 30 days)
potassium chloride 10 meq CAPSULE, ER MO	1	
potassium chloride 10 meq, 20 meq TABLET ER MO	1	
potassium chloride 10 meq, 20 meq TABLET, ER PARTICLES/CRYSTALS MO	1	
GASTROINTESTINAL AGENTS		
dicyclomine 10 mg CAPSULE MO	1	
esomeprazole magnesium 40 mg CAPSULE, DR/EC MO	1	QL(60 per 30 days)
famotidine 20 mg, 40 mg TABLET MO	1	
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE MO	2	QL(30 per 30 days)
MOVANTI 12.5 MG, 25 MG TABLET MO	2	QL(30 per 30 days)
omeprazole 20 mg, 40 mg CAPSULE, DR/EC MO	1	
pantoprazole 20 mg, 40 mg TABLET, DR/EC MO	1	QL(60 per 30 days)
sucralfate 1 gram TABLET MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SUFLAVE 178.7-7.3-0.5 GRAM RECON SOLUTION MO	3	
SUTAB 1.479-0.188- 0.225 GRAM TABLET MO	2	
TALICIA 10-250-12.5 MG CAPSULE, IR/DR, BIPHASIC MO	3	
VOWST 1 X 10EXP6 TO 3 X 10EXP7 CELL CAPSULE DL	4	PA
XIFAXAN 200 MG TABLET MO	3	PA,QL(9 per 30 days)
XIFAXAN 550 MG TABLET DL	4	PA,QL(84 per 28 days)
GENETIC/ENZYME/PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
AMVUTTRA 25 MG/0.5 ML SYRINGE DL	4	PA,QL(0.5 per 90 days)
ATTRUBY 356 MG TABLET DL	4	PA,QL(120 per 30 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 MO	2	
ELELYSO 200 UNIT RECON SOLUTION DL	4	PA
ONPATTRO 2 MG/ML SOLUTION DL	4	PA
STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML SOLUTION DL	4	PA
VYNDAMAX 61 MG CAPSULE DL	4	PA,QL(30 per 30 days)
ZEMAIRA 1,000 MG RECON SOLUTION DL	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 MO	3	
GENITOURINARY AGENTS		
<i>finasteride</i> 5 mg TABLET MO	1	QL(30 per 30 days)
GEMTESA 75 MG TABLET MO	3	QL(30 per 30 days)
MYRBETRIQ 25 MG, 50 MG TABLET, ER 24 HR. MO	2	QL(30 per 30 days)
MYRBETRIQ 8 MG/ML SUSPENSION, ER, RECON MO	2	QL(300 per 30 days)
<i>oxybutynin chloride</i> 10 mg TABLET, ER 24 HR. MO	1	QL(60 per 30 days)
<i>oxybutynin chloride</i> 5 mg TABLET MO	1	
<i>tamsulosin</i> 0.4 mg CAPSULE MO	1	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (ADRENAL)		
ACTHAR 80 UNIT/ML GEL DL	4	PA,QL(30 per 30 days)
ACTHAR SELFJECT 40 UNIT/0.5 ML, 80 UNIT/ML PEN INJECTOR DL	4	PA,QL(45 per 30 days)
<i>methylprednisolone</i> 4 mg TABLET, DOSE PACK MO	1	
<i>prednisone</i> 10 mg, 20 mg, 5 mg TABLET MO	1	BvsD
<i>triamcinolone acetonide</i> 0.1 % CREAM MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (PITUITARY)		
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) CARTRIDGE DL	4	PA
OMNITROPE 5.8 MG RECON SOLUTION DL	4	PA
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (SEX HORMONES/MODIFIERS)		
estradiol 0.01 % (0.1 mg/gram) CREAM MO	1	
OSPHENA 60 MG TABLET MO	2	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET MO	3	
PREMARIN 0.625 MG/GRAM CREAM MO	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/MODIFYING (THYROID)		
levothyroxine 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg TABLET MO	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 MO	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 MO	3	PA
HORMONAL AGENTS, SUPPRESSANT (ADRENAL OR PITUITARY)		
SOMATULINE DEPOT 90 MG/0.3 ML SYRINGE DL	4	PA,QL(0.3 per 28 days)
IMMUNOLOGICAL AGENTS		
ACTHIB (PF) 10 MCG/0.5 ML RECON SOLUTION DL	1	
ADALIMUMAB-ADAZ 10 MG/0.1 ML SYRINGE DL	4	PA,QL(0.2 per 28 days)
ADALIMUMAB-ADAZ 20 MG/0.2 ML SYRINGE DL	4	PA,QL(1.2 per 28 days)
ADALIMUMAB-ADAZ 40 MG/0.4 ML PEN INJECTOR DL	4	PA,QL(2.4 per 28 days)
ADALIMUMAB-ADAZ 40 MG/0.4 ML SYRINGE DL	4	PA,QL(2.4 per 28 days)
ADALIMUMAB-ADAZ 80 MG/0.8 ML PEN INJECTOR DL	4	PA,QL(4.8 per 28 days)
ADALIMUMAB-ADB 10 MG/0.2 ML, 20 MG/0.4 ML SYRINGE KIT DL	4	PA,QL(2 per 28 days)
ADALIMUMAB-ADB 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADB 40 MG/0.4 ML, 40 MG/0.8 ML SYRINGE KIT DL	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADB(CF) PEN CROHNS 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
ADALIMUMAB-ADB(CF) PEN PS-UV 40 MG/0.4 ML, 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
COSENTYX 75 MG/0.5 ML SYRINGE DL	4	PA,QL(2 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
COSENTYX (2 SYRINGES) 150 MG/ML SYRINGE DL	4	PA,QL(8 per 28 days)
COSENTYX PEN (2 PENS) 150 MG/ML PEN INJECTOR DL	4	PA,QL(8 per 28 days)
COSENTYX UNOREADY PEN 300 MG/2 ML PEN INJECTOR DL	4	PA,QL(8 per 28 days)
DUPIXENT PEN 200 MG/1.14 ML PEN INJECTOR DL	4	PA,QL(3.42 per 28 days)
DUPIXENT PEN 300 MG/2 ML PEN INJECTOR DL	4	PA,QL(8 per 28 days)
DUPIXENT SYRINGE 200 MG/1.14 ML SYRINGE DL	4	PA,QL(3.42 per 28 days)
DUPIXENT SYRINGE 300 MG/2 ML SYRINGE DL	4	PA,QL(8 per 28 days)
ENTYVIO PEN 108 MG/0.68 ML PEN INJECTOR DL	4	PA,QL(1.36 per 28 days)
ENVARUSUS XR 0.75 MG, 1 MG, 4 MG TABLET, ER 24 HR. MO	3	PA
GAMUNEX-C 1 GRAM/10 ML (10 %) SOLUTION DL	4	PA
HAEGARDA 2,000 UNIT, 3,000 UNIT RECON SOLUTION DL	4	PA,QL(24 per 28 days)
HUMIRA 40 MG/0.8 ML SYRINGE KIT DL	4	PA,QL(6 per 28 days)
HUMIRA PEN 40 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) 10 MG/0.1 ML SYRINGE KIT DL	4	PA,QL(2 per 28 days)
HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML SYRINGE KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML PEN INJECTOR KIT DL	4	PA,QL(6 per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS 80 MG/0.8 ML PEN INJECTOR KIT DL	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 DL	4	PA,QL(6 per 28 days)
<i>methotrexate sodium</i> 2.5 mg TABLET MO	1	BvsD
OTULFI 45 MG/0.5 ML SYRINGE MO	2	PA,QL(1.5 per 84 days)
OTULFI 90 MG/ML SYRINGE DL	4	PA,QL(3 per 84 days)
RINVOQ 15 MG, 30 MG TABLET, ER 24 HR. DL	4	PA,QL(30 per 30 days)
RINVOQ 45 MG TABLET, ER 24 HR. DL	4	PA,QL(168 per 365 days)
RINVOQ LQ 1 MG/ML SOLUTION DL	4	PA,QL(360 per 30 days)
SHINGRIX (PF) 50 MCG/0.5 ML SUSPENSION FOR RECONSTITUTION AV,DL	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 DL	4	PA,QL(8.4 per 365 days)
SKYRIZI 360 MG/2.4 ML (150 MG/ML) WEARABLE INJECTOR DL	4	PA,QL(16.8 per 365 days)
STELARA 45 MG/0.5 ML SOLUTION DL	4	PA,QL(1.5 per 84 days)
STELARA 45 MG/0.5 ML SYRINGE DL	4	PA,QL(1.5 per 84 days)
STELARA 90 MG/ML SYRINGE DL	4	PA,QL(3 per 84 days)
TREMFYA 100 MG/ML SYRINGE	4	PA,QL(3 per 84 days)
TREMFYA 200 MG/2 ML SYRINGE DL	4	PA,QL(4 per 28 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TREMFYA PEN 200 MG/2 ML PEN INJECTOR DL	4	PA,QL(4 per 28 days)
YESINTEK 45 MG/0.5 ML SOLUTION MO	2	PA,QL(1.5 per 84 days)
YESINTEK 45 MG/0.5 ML SYRINGE MO	2	PA,QL(1.5 per 84 days)
YESINTEK 90 MG/ML SYRINGE DL	4	PA,QL(3 per 84 days)
METABOLIC BONE DISEASE AGENTS		
<i>alendronate 70 mg TABLET</i> MO	1	QL(4 per 28 days)
FORTEO 20 MCG/DOSE (560MCG/2.24ML) PEN INJECTOR DL	4	PA,QL(2.24 per 28 days)
PROLIA 60 MG/ML SYRINGE MO	3	QL(1 per 180 days)
TYMLOS 80 MCG (3.120 MCG/1.56 ML) PEN INJECTOR DL	4	PA,QL(1.56 per 30 days)
MISCELLANEOUS THERAPEUTIC AGENTS		
BD ALCOHOL SWABS PADS, MEDICATED MO	1	
BD AUTOSHIELD DUO PEN NEEDLE 30 GAUGE X 3/16" NEEDLE PDS,MO	1	
BD INSULIN SYRINGE (HALF UNIT) 0.3 ML 31 GAUGE X 5/16" SYRINGE PDS,MO	1	
BD INSULIN SYRINGE U-500 1/2 ML 31 GAUGE X 15/64" SYRINGE PDS,MO	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 PDS,MO	1	
BD NANO 2ND GEN PEN NEEDLE 32 GAUGE X 5/32" NEEDLE PDS,MO	1	
BD ULTRA-FINE MICRO PEN NEEDLE 32 GAUGE X 1/4" NEEDLE PDS,MO	1	
BD ULTRA-FINE MINI PEN NEEDLE 31 GAUGE X 3/16" NEEDLE PDS,MO	1	
BD ULTRA-FINE NANO PEN NEEDLE 32 GAUGE X 5/32" NEEDLE PDS,MO	1	
BD ULTRA-FINE ORIG PEN NEEDLE 29 GAUGE X 1/2" NEEDLE PDS,MO	1	
BD ULTRA-FINE SHORT PEN NEEDLE 31 GAUGE X 5/16" NEEDLE PDS,MO	1	
BD VEO INSULIN SYR (HALF UNIT) 0.3 ML 31 GAUGE X 15/64" SYRINGE PDS,MO	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 PDS,MO	1	
CEQUR SIMPLICITY INSERTER MISCELLANEOUS MO	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 PDS,MO	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 PDS,MO	1	

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
DROPSAFE ALCOHOL PREP PADS PADS, MEDICATED MO	1	
GIVLAARI 189 MG/ML SOLUTION DL	4	PA
OXLUMO 94.5 MG/0.5 ML SOLUTION	4	PA
XDEMVI 0.25 % DROPS MO	3	PA,QL(10 per 42 days)
OPHTHALMIC AGENTS		
<i>brimonidine 0.2 % DROPS</i> MO	1	
CEQUA 0.09 % DROPPERETTE MO	3	PA,QL(60 per 30 days)
COMBIGAN 0.2-0.5 % DROPS MO	2	
<i>dorzolamide-timolol 22.3-6.8 mg/ml DROPS</i> MO	1	
EYSUVIS 0.25 % DROPS, SUSPENSION MO	2	QL(16.6 per 30 days)
ILEVRO 0.3 % DROPS, SUSPENSION MO	2	QL(3 per 30 days)
<i>latanoprost 0.005 % DROPS</i> MO	1	QL(5 per 25 days)
LOTEMAX 0.5 % DROPS, GEL MO	3	ST
LOTEMAX 0.5 % DROPS, SUSPENSION MO	3	ST
LOTEMAX 0.5 % OINTMENT MO	3	ST
LOTEMAX SM 0.38 % DROPS, GEL MO	3	
LUMIGAN 0.01 % DROPS MO	2	QL(2.5 per 25 days)
<i>prednisolone acetate 1 % DROPS, SUSPENSION</i> MO	1	
RHOPRESSA 0.02 % DROPS MO	2	ST,QL(2.5 per 25 days)
ROCKLATAN 0.02-0.005 % DROPS MO	2	ST
SIMBRINZA 1-0.2 % DROPS, SUSPENSION MO	3	
<i>timolol maleate 0.5 % DROPS</i> MO	1	
VYZULTA 0.024 % DROPS MO	3	QL(2.5 per 25 days)
ZERVIATE 0.24 % DROPPERETTE MO	3	ST,QL(60 per 30 days)
RESPIRATORY TRACT/PULMONARY AGENTS		
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL	4	PA,QL(90 per 30 days)
ADVAIR HFA 115-21 MCG/ACTUATION, 230-21 MCG/ACTUATION, 45-21 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(12 per 30 days)
AIRSUPRA 90-80 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(32.1 per 30 days)
<i>albuterol sulfate 2.5 mg /3 ml (0.083 %) SOLUTION FOR NEBULIZATION</i> MO	1	BvsD
<i>albuterol sulfate 90 mcg/actuation HFA AEROSOL INHALER</i> MO	1	QL(36 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION BLISTER WITH DEVICE MO	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 MO	2	QL(4 per 30 days)
<i>azelastine 137 mcg (0.1 %) SPRAY, NON-AEROSOL</i> MO	1	QL(30 per 25 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
BREO ELLIPTA 100-25 MCG/DOSE, 200-25 MCG/DOSE, 50-25 MCG/DOSE BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
BREZTRI AEROSPHERE 160-9-4.8 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(10.7 per 30 days)
COMBIVENT RESPIMAT 20-100 MCG/ACTUATION MIST MO	3	QL(4 per 20 days)
FASENRA 10 MG/0.5 ML SYRINGE DL	4	PA,QL(0.5 per 28 days)
FASENRA 30 MG/ML SYRINGE DL	4	PA,QL(1 per 28 days)
FASENRA PEN 30 MG/ML AUTO-INJECTOR DL	4	PA,QL(1 per 28 days)
<i>fluticasone propionate 50 mcg/actuation SPRAY, SUSPENSION</i> MO	1	QL(16 per 30 days)
<i>ipratropium bromide 42 mcg (0.06 %) SPRAY, NON-AEROSOL</i> MO	1	QL(45 per 30 days)
<i>ipratropium-albuterol 0.5 mg-3 mg(2.5 mg base)/3 ml SOLUTION FOR NEBULIZATION</i> MO	1	BvsD
<i>levocetirizine 5 mg TABLET</i> MO	1	QL(30 per 30 days)
<i>montelukast 10 mg TABLET</i> MO	1	QL(30 per 30 days)
NUCALA 100 MG RECON SOLUTION DL	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML AUTO-INJECTOR DL	4	PA,QL(3 per 28 days)
NUCALA 100 MG/ML SYRINGE DL	4	PA,QL(3 per 28 days)
NUCALA 40 MG/0.4 ML SYRINGE DL	4	PA,QL(0.4 per 28 days)
OFEV 100 MG, 150 MG CAPSULE DL,LA	4	PA,QL(60 per 30 days)
OPSUMIT 10 MG TABLET DL	4	PA,QL(30 per 30 days)
OPSYNVI 10-20 MG, 10-40 MG TABLET DL	4	PA,QL(30 per 30 days)
SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION MIST MO	2	QL(4 per 28 days)
SPIRIVA WITH HANDIHALER 18 MCG CAPSULE, W/INHALATION DEVICE MO	2	QL(30 per 30 days)
STIOLTO RESPIMAT 2.5-2.5 MCG/ACTUATION MIST MO	2	QL(4 per 28 days)
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION MIST MO	2	QL(4 per 30 days)
SYMBICORT 160-4.5 MCG/ACTUATION, 80-4.5 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(30.6 per 30 days)
TRELEGY ELLIPTA 100-62.5-25 MCG, 200-62.5-25 MCG BLISTER WITH DEVICE MO	2	QL(60 per 30 days)
TYVASO DPI 16 MCG, 32 MCG, 48 MCG, 64 MCG CARTRIDGE WITH INHALER DL	4	PA,QL(112 per 28 days)
TYVASO DPI 16(112)-32(112) -48(28) MCG CARTRIDGE WITH INHALER DL	4	PA,QL(252 per 28 days)
UPTRAVI 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG TABLET DL	4	PA,QL(60 per 30 days)
UPTRAVI 200 MCG (140)- 800 MCG (60) TABLET, DOSE PACK DL	4	PA,QL(200 per 30 days)
VENTOLIN HFA 90 MCG/ACTUATION HFA AEROSOL INHALER MO	2	QL(36 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SKELETAL MUSCLE RELAXANTS		
<i>cyclobenzaprine 10 mg, 5 mg TABLET</i> MO	1	
<i>methocarbamol 500 mg, 750 mg TABLET</i> MO	1	
SLEEP DISORDER AGENTS		
BELSOMRA 10 MG TABLET MO	2	QL(60 per 30 days)
BELSOMRA 15 MG, 20 MG TABLET MO	2	QL(30 per 30 days)
BELSOMRA 5 MG TABLET MO	2	QL(120 per 30 days)
<i>sodium oxybate 500 mg/ml SOLUTION</i> DL	4	PA,QL(540 per 30 days)
<i>temazepam 30 mg CAPSULE</i> DL	1	QL(30 per 30 days)
<i>zolpidem 10 mg, 5 mg TABLET</i> MO	1	QL(30 per 30 days)

Need more information about the indicators displayed by the drug names? Please go to page 10. Need more information about the utilization management requirements? Please go to page 6.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL – Dispensing Limit • LA – Limited Access • MO – Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

Humana Medicare Employer Plan Coverage of Additional Prescription Drugs

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cosmetics - Mail Order Available		
<i>bimatoprost 0.03 % DROPS WITH APPLICATOR</i>	1	
<i>blanche 4 % CREAM</i>	1	
<i>finasteride 1 mg TABLET</i>	1	
<i>hydrocortisone-pramoxine 2.5-1 %, 2.5-1 % (4g) CREAM</i>	1	
<i>hydroquinone 4 % CREAM</i>	1	
LATISSE 0.03 % DROPS WITH APPLICATOR	3	
<i>obagi elastiderm 4 % CREAM</i>	1	
<i>obagi nu-derm blender 4 % CREAM</i>	1	
<i>obagi nu-derm clear 4 % CREAM</i>	1	
PROPECIA 1 MG TABLET	3	
<i>refissa 0.05 % CREAM</i>	1	
RENOVA 0.02 % CREAM	3	
<i>sulfacetamide sodium 10 % CLEANSER</i>	1	
<i>sulfacetamide sodium-sulfur 10-5 % (w/w) CREAM</i>	1	
<i>tretinoin (emollient) 0.05 % CREAM</i>	1	
TRI-LUMA 0.01-4-0.05 % CREAM	3	
Cough/Cold - Mail Order Available		
<i>benzonatate 100 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	
HYCODAN 5-1.5 MG/5 ML (5 ML) SOLUTION	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG TABLET	1	
HYCODAN (WITH HOMATROPINE) 5-1.5 MG/5 ML SOLUTION	1	

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.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Cough/Cold - Mail Order Available		
hydrocodone-chlorpheniramine 10-8 mg/5 ml SUSPENSION, ER 12 HR.	1	
hydrocodone-homatropine 5-1.5 mg TABLET	1	
hydrocodone-homatropine 5-1.5 mg/5 ml SOLUTION	1	
hydromet 5-1.5 mg/5 ml SOLUTION	1	
promethazine-codeine 6.25-10 mg/5 ml SYRUP	1	
promethazine-dm 6.25-15 mg/5 ml SOLUTION	1	
RESPA-AR 8-90-0.24 MG TABLET, ER 12 HR.	3	
TUXARIN ER 8-54.3 MG TABLET, ER 12 HR.	3	
Erectile Dysfunction - Mail Order Available		
ADDYI 100 MG TABLET	3	
avanafil 100 mg, 200 mg, 50 mg TABLET	1	QL(6 per 30 days)
CIALIS 10 MG, 20 MG TABLET	3	QL(6 per 30 days)
sildenafil 100 mg, 25 mg, 50 mg TABLET	1	QL(6 per 30 days)
STENDRA 100 MG, 200 MG, 50 MG TABLET	3	QL(6 per 30 days)
tadalafil 10 mg, 20 mg TABLET	1	QL(6 per 30 days)
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	
Fertility - Mail Order Available		
cetrorelix 0.25 mg KIT	1	
CETROTIDE 0.25 MG KIT	3	
clomid 50 mg TABLET	1	
clomiphene citrate 50 mg TABLET	1	

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.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Fertility - Mail Order Available		
FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML CARTRIDGE	3	
<i>fyremadel 250 mcg/0.5 ml SYRINGE</i>	1	
<i>ganirelix 250 mcg/0.5 ml SYRINGE</i>	3	
GONAL-F 1,050 UNIT, 450 UNIT RECON SOLUTION	3	
GONAL-F RFF 75 UNIT RECON SOLUTION	3	
GONAL-F RFF REDI-JECT 300 UNIT/0.48 ML, 450 UNIT/0.72 ML, 900 UNIT/1.44 ML PEN INJECTOR	3	
MENOPUR 75 UNIT RECON SOLUTION	3	
<i>milophene 50 mg TABLET</i>	1	
OVIDREL 250 MCG/0.5 ML SYRINGE	3	
Vitamins/Minerals - Mail Order Available		
<i>ascorbic acid (vitamin c) 500 mg/ml SOLUTION</i>	1	
<i>b complex 100 100-2-100-2-2 mg/ml SOLUTION</i>	1	
<i>b-complex injection 100-2-100-2-2 mg/ml SOLUTION</i>	1	
<i>cyanocobalamin (vitamin b-12) 1,000 mcg/ml SOLUTION</i>	1	
<i>cyanocobalamin (vitamin b-12) 500 mcg/spray SPRAY, NON-AEROSOL</i>	1	
<i>dodex 1,000 mcg/ml SOLUTION</i>	1	
<i>ergocalciferol (vitamin d2) 1,250 mcg (50,000 unit) CAPSULE</i>	1	
<i>folic acid 1 mg TABLET</i>	1	
<i>folic acid 5 mg/ml SOLUTION</i>	1	
<i>hydroxocobalamin 1,000 mcg/ml SOLUTION</i>	1	
INFUVITE ADULT 3,300 UNIT- 150 MCG/10 ML SOLUTION	3	
INFUVITE PEDIATRIC 80 MG-400 UNIT- 200 MCG/5 ML SOLUTION	3	
NASCOBAL 500 MCG/SPRAY SPRAY, NON-AEROSOL	3	
<i>phytonadione (vitamin k1) 1 mg/0.5 ml SYRINGE</i>	1	

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.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Vitamins/Minerals - Mail Order Available		
phytonadione (vitamin k1) 1 mg/0.5 ml, 10 mg/ml SOLUTION	1	
phytonadione (vitamin k1) 5 mg TABLET	1	
pyridoxine (vitamin b6) 100 mg/ml SOLUTION	1	
thiamine hcl (vitamin b1) 100 mg/ml SOLUTION	1	
vitamin d2 1,250 mcg (50,000 unit) CAPSULE	1	
vitamin k 1 mg/0.5 ml SOLUTION	1	
vitamin k1 10 mg/ml SOLUTION	1	
Weight Loss - Mail Order Available		
ADIPEX-P 37.5 MG TABLET	1	
benzphetamine 50 mg TABLET	1	
CONTRACE 8-90 MG TABLET ER	3	QL(120 per 30 days)
diethylpropion 25 mg TABLET	1	
diethylpropion 75 mg TABLET ER	1	
liraglutide (weight loss) 3 mg/0.5 ml (18 mg/3 ml) PEN INJECTOR	3	
lomaira 8 mg TABLET	1	
phendimetrazine tartrate 105 mg CAPSULE, ER	3	
phendimetrazine tartrate 35 mg TABLET	1	
phentermine 15 mg, 30 mg, 37.5 mg CAPSULE	1	
phentermine 37.5 mg, 8 mg TABLET	1	
phentermine-topiramate 11.25-69 mg, 15-92 mg, 3.75-23 mg, 7.5-46 mg CAPSULE ER MULTIPHASE 24 HR.	1	QL(30 per 30 days)
PLENITY 0.75 GRAM CAPSULE	3	
PLENITY (WELCOME KIT) 0.75 GRAM CAPSULE	3	
QSYMIA 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG CAPSULE ER MULTIPHASE 24 HR.	3	QL(30 per 30 days)
SAXENDA 3 MG/0.5 ML (18 MG/3 ML) PEN INJECTOR	3	

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.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Weight Loss - Mail Order Available		
ZEPBOUND 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	4	PA
ZEPBOUND 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 SOLUTION	4	PA
ZEPBOUND KWIKPEN 10 MG/0.6 ML (40 MG/2.4 ML), 12.5 MG/0.6 ML (50 MG/2.4 ML), 15 MG/0.6 ML (60 MG/2.4 ML), 2.5 MG/0.6 ML (10 MG/2.4 ML), 5 MG/0.6 ML (20 MG/2.4 ML), 7.5 MG/0.6 ML (30 MG/2.4 ML) PEN INJECTOR	3	PA,QL(2.4 per 28 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.

AV - ACIP Covered Part D vaccines • BvsD - Part B vs Part D • CI - Covered Insulin Products • DL - Dispensing Limit • LA - Limited Access • MO - Mail Order • PA - Prior Authorization • PDS - BD/HTL-Droplet are the Preferred Diabetic Supplies • QL - Quantity Limit • ST - Step Therapy

Index

A

ABILIFY ASIMTUFI... 14
ABILIFY MAINTENA... 14
ABILIFY... 14
ACTHAR SELFJECT... 22
ACTHAR... 22
ACTHIB (PF)... 23
ADALIMUMAB-ADAZ... 23
ADALIMUMAB-ADB(M)CF PEN
CROHNS... 23
ADALIMUMAB-ADB(M)CF PEN
PS-UV... 23
ADALIMUMAB-ADB(M)... 23
ADDYI... 30
ADEMPAS... 26
ADIPEX-P... 32
ADVAIR HFA... 26
AIRSUPRA... 26
albuterol sulfate... 26
ALECENSA... 13
alendronate... 25
allopurinol... 13
alprazolam... 16
ALUNBRIG... 13
amiodarone... 19
amitriptyline... 12
amlodipine... 19
amoxicillin-pot clavulanate... 11
amoxicillin... 11
AMVUTTRA... 22
anastrozole... 13
ARISTADA INITIO... 15
ARISTADA... 14, 15

ARNUITY ELLIPTA... 26
ascorbic acid (vitamin c)... 31
atenolol... 19
atorvastatin... 19
ATTRUBY... 22
AUSTEDO XR TITRATION
KT(WK1-4)... 21
AUSTEDO XR... 20, 21
AUSTEDO... 20
AUVELITY... 12
AUVI-Q... 26
avanafil... 30
azelastine... 26
azithromycin... 11

B

b complex 100... 31
b-complex injection... 31
baclofen... 15
BAQSIMI... 16
BD ALCOHOL SWABS... 25
BD AUTOSHIELD DUO PEN NEEDLE...
25
BD INSULIN SYRINGE (HALF UNIT)...
25
BD INSULIN SYRINGE U-500... 25
BD INSULIN SYRINGE ULTRA-FINE...
25
BD NANO 2ND GEN PEN NEEDLE...
25
BD ULTRA-FINE MICRO PEN
NEEDLE... 25
BD ULTRA-FINE MINI PEN NEEDLE...
25

BD ULTRA-FINE NANO PEN
NEEDLE... 25
BD ULTRA-FINE ORIG PEN NEEDLE...
25
BD ULTRA-FINE SHORT PEN
NEEDLE... 25
BD VEO INSULIN SYR (HALF UNIT)...
25
BD VEO INSULIN SYRINGE UF... 25
BELSOMRA... 28
benzonatate... 29
benzphetamine... 32
BETASERON... 21
BIKTARVY... 15
bimatoprost... 29
blanche... 29
BREO ELLIPTA... 27
BREZTRI AEROSPHERE... 27
brimonidine... 26
bromfed dm... 29
brompheniramine-pseudoeph-dm...
29
BRUKINSA... 13
bumetanide... 19
bupropion hcl... 12
buspirone... 16

C

CABOMETYX... 13
CALQUENCE (ACALABRUTINIB
MAL)... 13
CARBAGLU... 21
carbidopa-levodopa... 14
carvedilol... 19
cefdinir... 11

celecoxib... 11
 cephalexin... 11
 CEQUA... 26
 CEQUR SIMPLICITY INSERTER... 25
 cetorelix... 30
 CETROTIDE... 30
 chlorhexidine gluconate... 21
 chlorthalidone... 19
 CIALIS... 30
 ciprofloxacin hcl... 11
 citalopram... 12
 clomid... 30
 clomiphene citrate... 30
 clonazepam... 16
 clonidine hcl... 19
 clopidogrel... 18
 clotrimazole-betamethasone... 12
 colchicine... 13
 COMBIGAN... 26
 COMBIVENT RESPIMAT... 27
 CONTRAVE... 32
 COPAXONE... 21
 COSENTYX (2 SYRINGES)... 24
 COSENTYX PEN (2 PENS)... 24
 COSENTYX UNOREADY PEN... 24
 COSENTYX... 23
 CREON... 22
 CREXONT... 14
 cyanocobalamin (vitamin b-12)... 31
 cyclobenzaprine... 28
D
 DESCOVY... 15
 diazepam... 16
 diclofenac sodium... 11
 dicyclomine... 21
 diethylpropion... 32
 DIFICID... 11
 diltiazem hcl... 19
 dodex... 31
 donepezil... 12
 dorzolamide-timolol... 26
 doxycycline hyclate... 11
 DROPLET INSULIN SYRINGE... 25
 DROPLET PEN NEEDLE... 25
 DROPSAFE ALCOHOL PREP PADS... 26
 duloxetine... 21
 DUPIXENT PEN... 24
 DUPIXENT SYRINGE... 24
E
 ELELYSO... 22
 ELIQUIS DVT-PE TREAT 30D START... 19
 ELIQUIS... 19
 EMGALITY PEN... 13
 EMGALITY SYRINGE... 13
 ENTRESTO SPRINKLE... 19
 ENTRESTO... 19
 ENTYVIO PEN... 24
 ENVARUS XR... 24
 EPCLUSA... 15
 EPIDIOLEX... 12
 ergocalciferol (vitamin d2)... 31
 ERIVEDGE... 13
 ERLEADA... 13
 escitalopram oxalate... 12
 esomeprazole magnesium... 21
 estradiol... 23
 EYSUVIS... 26
 ezetimibe... 19
F
 famotidine... 21
 FARXIGA... 16
 FASENRA PEN... 27
 FASENRA... 27
 fenofibrate nanocrystallized... 20
 fenofibrate... 20
 FIASP FLEXTOUCH U-100 INSULIN... 16
 FIASP PENFILL U-100 INSULIN... 16
 FIASP U-100 INSULIN... 16
 finasteride... 22, 29
 fluconazole... 12
 fluoxetine... 12
 fluticasone propionate... 27
 folic acid... 31
 FOLLISTIM AQ... 31
 FORTEO... 25
 furosemide... 20
 fyremadel... 31
G
 gabapentin... 12
 GAMUNEX-C... 24
 ganirelix... 31
 GEMTESA... 22
 GENVOYA... 15
 GIVLAARI... 26
 glimepiride... 16
 glipizide... 16
 GLYXAMBI... 16
 GONAL-F RFF REDI-JECT... 31
 GONAL-F RFF... 31
 GONAL-F... 31
H

HAEGARDA... 24	hydrocodone-acetaminophen... 11	KERENDIA... 20
HUMALOG JUNIOR KWIKPEN	hydrocodone-chlorpheniramine... 30	KESIMPTA PEN... 21
U-100... 16	hydrocodone-homatropine... 30	ketoconazole... 13
HUMALOG KWIKPEN INSULIN... 16	hydrocortisone-pramoxine... 29	KISQALI FEMARA CO-PACK... 14
HUMALOG MIX 50-50 KWIKPEN... 16	hydromet... 30	KISQALI... 13, 14
HUMALOG MIX 75-25 KWIKPEN... 16	hydroquinone... 29	KLOXXADO... 11
HUMALOG MIX	hydroxocobalamin... 31	L
75-25(U-100)INSULN... 16	hydroxychloroquine... 14	LANTUS SOLOSTAR U-100
HUMALOG TEMPO	hydroxyzine hcl... 16	INSULIN... 17
PEN(U-100)INSULN... 16	I	LANTUS U-100 INSULIN... 17
HUMALOG U-100 INSULIN... 16, 17	IBRANCE... 13	latanoprost... 26
HUMIRA PEN... 24	ibuprofen... 11	LATISSE... 29
HUMIRA(CF) PEN CROHNS-UC-HS... 24	ILEVRO... 26	levetiracetam... 12
HUMIRA(CF) PEN PSOR-UV-ADOL HS... 24	IMBRUVICA... 13	levocetirizine... 27
HUMIRA(CF) PEN... 24	INFUVITE ADULT... 31	levofloxacin... 11
HUMIRA(CF)... 24	INFUVITE PEDIATRIC... 31	levothyroxine... 23
HUMIRA... 24	INVEGA HAFYERA... 15	lidocaine... 11
HUMULIN 70/30 U-100 INSULIN... 17	INVEGA SUSTENNA... 15	LINZESS... 21
HUMULIN 70/30 U-100 KWIKPEN... 17	INVEGA TRINZA... 15	liraglutide (weight loss)... 32
HUMULIN N NPH INSULIN KWIKPEN... 17	INVEGA... 15	lisinopril-hydrochlorothiazide... 20
HUMULIN N NPH U-100 INSULIN... 17	INVOKAMET XR... 17	lisinopril... 20
HUMULIN R REGULAR U-100 INSULN... 17	INVOKAMET... 17	LOKELMA... 21
HUMULIN R U-500 (CONC) KWIKPEN... 17	INVOKANA... 17	lomaira... 32
HYCODAN (WITH HOMATROPINE)... 29	ipratropium bromide... 27	lorazepam... 16
HYCODAN... 29	ipratropium-albuterol... 27	losartan-hydrochlorothiazide... 20
hydralazine... 20	isosorbide mononitrate... 20	losartan... 20
hydrochlorothiazide... 20	J	LOTEMAX SM... 26
	JANUMET XR... 17	LOTEMAX... 26
	JANUMET... 17	LUMAKRAS... 14
	JANUVIA... 17	LUMIGAN... 26
	JARDIANCE... 17	LYBALVI... 15
	JENTADUETO XR... 17	LYNPARZA... 14
	JENTADUETO... 17	LYUMJEV KWIKPEN U-100
	K	INSULIN... 17

LYUMJEV KWIKPEN U-200
INSULIN... 17
LYUMJEV TEMPO
PEN(U-100)INSULN... 17
LYUMJEV U-100 INSULIN... 17

M

meclizine... 12
meloxicam... 11
memantine... 12
MENOPUR... 31
metformin... 17
methocarbamol... 28
methotrexate sodium... 24
methylprednisolone... 22
metoprolol succinate... 20
metoprolol tartrate... 20
milophene... 31
mirtazapine... 12
montelukast... 27
MOUNJARO... 17
MOVANTIK... 21
MULTAQ... 20
mupirocin... 21
MYRBETRIQ... 22

N

NAMZARIC... 12
naproxen... 11
NASCOBAL... 31
NAYZILAM... 12
nitrofurantoin monohyd/m-cryst...
11
nitroglycerin... 20
NIVESTYM... 19
NOVOLIN 70-30 FLEXPEN U-100...
17

NOVOLIN 70/30 U-100 INSULIN...
17
NOVOLIN N FLEXPEN... 17
NOVOLIN N NPH U-100 INSULIN...
17
NOVOLIN R FLEXPEN... 17
NOVOLIN R REGULAR U100
INSULIN... 18
NOVOLOG FLEXPEN U-100
INSULIN... 18
NOVOLOG MIX 70-30 U-100
INSULN... 18
NOVOLOG MIX 70-30FLEXPEN
U-100... 18
NOVOLOG PENFILL U-100
INSULIN... 18
NOVOLOG U-100 INSULIN ASPART...
18
NUBEQA... 14
NUCALA... 27

O

obagi elastiderm... 29
obagi nu-derm blender... 29
obagi nu-derm clear... 29
ODEFSEY... 16
OFEV... 27
olmesartan... 20
omeprazole... 21
OMNITROPE... 23
ondansetron hcl... 12
ondansetron... 12
ONPATTRO... 22
OPSUMIT... 27
OPSYNVI... 27
OPVEE... 11
ORGOVYX... 14

oseltamivir... 16
OSPHENA... 23
OTULFI... 24
OVIDREL... 31
OXLUMO... 26
oxybutynin chloride... 22
oxycodone-acetaminophen... 11
oxycodone... 11
OZEMPIC... 18

P

pantoprazole... 21
PAXLOVID... 16
phendimetrazine tartrate... 32
phentermine-topiramate... 32
phentermine... 32
phytonadione (vitamin k1)... 31, 32
pioglitazone... 18
PLENITY (WELCOME KIT)... 32
PLENITY... 32
potassium chloride... 21
pravastatin... 20
prednisolone acetate... 26
prednisone... 22
pregabalin... 21
PREMARIN... 23
PROLIA... 25
PROMACTA... 19
promethazine-codeine... 30
promethazine-dm... 30
PROPECIA... 29
pyridoxine (vitamin b6)... 32

Q

QSYMIA... 32
quetiapine... 15
QULIPTA... 13

R

RADICAVA ORS STARTER KIT SUSP... 21
 refissa... 29
 RENOVA... 29
 REPATHA PUSHTRONEX... 20
 REPATHA SURECLICK... 20
 REPATHA SYRINGE... 20
 RESPA-AR... 30
 RETACRIT... 19
 REXULTI... 15
 RHOPRESSA... 26
 RINVOQ LQ... 24
 RINVOQ... 24
 RISPERDAL CONSTA... 15
 RISPERDAL... 15
 ROCKLATAN... 26
 rosuvastatin... 20
 RUXIENCE... 14
 RYBELSUS... 18
 RYTARY... 14

S

SAXENDA... 32
 sertraline... 12
 SHINGRIX (PF)... 24
 sildenafil... 30
 SIMBRINZA... 26
 simvastatin... 20
 SKYRIZI... 24
 sodium oxybate... 28
 SOLIQUA 100/33... 18
 SOMATULINE DEPOT... 23
 SPIRIVA RESPIMAT... 27
 SPIRIVA WITH HANDIHALER... 27
 spironolactone... 20

STELARA... 24
 STENDRA... 30
 STIOLTO RESPIMAT... 27
 STRENSIQ... 22
 STRIVERDI RESPIMAT... 27
 sucralfate... 21
 SUFLAVE... 22
 sulfacetamide sodium-sulfur... 29
 sulfacetamide sodium... 29
 sulfamethoxazole-trimethoprim... 11
 SUTAB... 22
 SYMBICORT... 27
 SYNJARDY XR... 18
 SYNJARDY... 18

T

tadalafil... 30
 TALICIA... 22
 tamsulosin... 22
 temazepam... 28
 thiamine hcl (vitamin b1)... 32
 timolol maleate... 26
 TIROSINT-SOL... 23
 TIROSINT... 23
 tizanidine... 15
 torsemide... 20
 TOUJEO MAX U-300 SOLOSTAR... 18
 TOUJEO SOLOSTAR U-300
 INSULIN... 18
 TRADJENTA... 18
 tramadol... 11
 TRAZIMERA... 14
 trazodone... 12
 TRELEGY ELLIPTA... 27
 TREMFYA PEN... 25

TREMFYA... 24
 TRESIBA FLEXTOUCH U-100... 18
 TRESIBA FLEXTOUCH U-200... 18
 TRESIBA U-100 INSULIN... 18
 tretinoin (emollient)... 29
 TRI-LUMA... 29
 triamcinolone acetonide... 22
 triamterene-hydrochlorothiazid... 20
 TRIJARDY XR... 18
 TRINTELLIX... 12
 TRULICITY... 18
 TUXARIN ER... 30
 TYMLOS... 25
 TYVASO DPI... 27

U

UBRELVY... 13
 UDENYCA AUTOINJECTOR... 19
 UDENYCA... 19
 UPTRAVI... 27

V

valacyclovir... 16
 valsartan... 20
 vardenafil... 30
 VASCEPA... 20
 VEMLIDY... 16
 venlafaxine... 12
 VENTOLIN HFA... 27
 VERQUOVO... 20
 VERZENIO... 14
 VIAGRA... 30
 vitamin d2... 32
 vitamin k... 32
 vitamin k1... 32
 VOSEVI... 16

VOWST... 22
VUMERITY... 21
VYLEESI... 30
VYNDAMAX... 22
VYVGART HYTRULO... 13
VYVGART... 13
VYZULTA... 26

W

warfarin... 19

X

XARELTO DVT-PE TREAT 30D
START... 19
XARELTO... 19
XDEMZY... 26
XIFAXAN... 22
XIGDUO XR... 18
XTANDI... 14

Y

YESINTEK... 25

Z

ZARXIO... 19
ZEGALOGUE AUTOINJECTOR... 18
ZEGALOGUE SYRINGE... 18
ZEJULA... 14
ZEMAIRA... 22
ZENPEP... 22
ZEPBOUND KWIKPEN... 33
ZEPBOUND... 33
ZERVIA... 26
ZIRABEV... 14
zolpidem... 28
ZUBSOLV... 11
ZYPITAMAG... 20

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available.
Call **877-320-1235 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **877-320-1235 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Չանգահարե՛ք՝ **877-320-1235 (TTY: 711)**:

বাংলা [Bengali]: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ।
ফোন করুন **877-320-1235 (TTY: 711)** নম্বরে।

简体中文 [Simplified Chinese]: 我们可提供免费的语言、辅助设备以及其他格式版本服务。
请致电 **877-320-1235 (听障专线: 711)**。

繁體中文 [Traditional Chinese]: 我們可提供免費的語言、輔助設備以及其他格式版本服務。
請致電 **877-320-1235 (聽障專線: 711)**。

Kreyòl Ayisyen [Haitian Creole]: Lang gratis, èd oksilyè, ak lòt fòm sèvis disponib. Rele **877-320-1235 (TTY: 711)**.

Hrvatski [Croatian]: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **877-320-1235 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **877-320-1235 (TTY: 711)** تماس بگیرید.

Français [French]: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **877-320-1235 (TTY: 711)**.

Deutsch [German]: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **877-320-1235 (TTY: 711)**.

Ελληνικά [Greek]: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **877-320-1235 (TTY: 711)**.

ગુજરાતી [Gujarati]: નિ:શુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે.
877-320-1235 (TTY: 711) પર કોલ કરો.

עברית [Hebrew]: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים.
נא התקשר למספר **877-320-1235 (TTY: 711)**

हिन्दी [Hindi]: नि:शुल्क भाषा, सहायक मदद और वैकल्पिक प्रारूप सेवाएं उपलब्ध हैं।
877-320-1235 (TTY: 711) पर कॉल करें।

Hmoob [Hmong]: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **877-320-1235 (TTY: 711)**.

Italiano [Italian]: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **877-320-1235 (TTY: 711)**.

日本語 [Japanese]: 言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**877-320-1235 (TTY: 711)** までお電話ください。

This notice is available at <https://www.humana.com/legal/multi-language-support>.

GHHNOA2025HUM_0425

**ភាសាខ្មែរ [Khmer]: សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាន់ប្រដាប់ផ្សេងៗជំនួសអាច
រកបាន។ ទូរសព្ទទៅលេខ 877-320-1235 (TTY: 711)។**

**한국어 [Korean]: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다.
877-320-1235 (TTY: 711)번으로 문의하십시오.**

**ພາສາລາວ [Lao] ມີການບໍລິການດ້ານພາສາ, ຊ່ວຍເຫຼືອຜູ້ເສຍສຽງ ແລະ ຮູບແບບທາງເລືອກອື່ນ
ໃຫ້ໃຊ້ພໍ. ໂທ 877-320-1235 (TTY: 711).**

**Diné [Navajo]: Saad t'áa' jiik'eh, t'áadoole'é binahjí' bee adahodoonííígíí diné bich'í'
anidahazt'í'í, dóo' łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohjí'
hodúlnih 877-320-1235 (TTY: 711).**

**Polski [Polish]: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty.
Zadzwoń pod numer 877-320-1235 (TTY: 711).**

**Português [Portuguese]: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e
outros formatos alternativos. Ligue 877-320-1235 (TTY: 711).**

**ਪੰਜਾਬੀ [Punjabi]: ਮੁਫਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ।
877-320-1235 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।**

**Русский [Russian]: Предоставляются бесплатные услуги языковой поддержки,
вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру
877-320-1235 (TTY: 711).**

**Español [Spanish]: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y
servicios en otro formato están disponibles. Llame al 877-320-1235 (TTY: 711).**

**Tagalog [Tagalog]: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na
pantulong, at kapalit na format. Tumawag sa 877-320-1235 (TTY: 711).**

**தமிழ் [Tamil]: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன.
877-320-1235 (TTY: 711) ஐ அழைக்கவும்.**

**తెలుగు [Telugu]: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు
అందుబాటులో గలవు. 877-320-1235 (TTY: 711) కి కాల్ చేయండి.**

اردو [Urdu]: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ 877-320-1235 (TTY: 711)

**Tiếng Việt [Vietnamese]: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định
dạng thay thế. Hãy gọi 877-320-1235 (TTY: 711).**

**አማርኛ [Amharic]: ቋንቋ፣ አገዥ ማዳመጫ እና አማራጭ ቅርፀት ያላቸው አገልግሎቶችን ይገኛሉ። በ
877-320-1235 (TTY: 711) ላይ ይደውሉ።**

**Bàsà [Bassa]: Wuḍu-xwíníín-mú-zà-zà kùà, Hwòdò-fóno-nyo, kè nyo-boŭn-po-kà bɛ́ bɛ́
nyuɛɛ se wídí péè-péè dò ko. 877-320-1235 (TTY: 711) dá.**

**Bekee [Igbo]: Asụsụ n'efu, enyemaka nkwarụ, na ọrụ usoro ndị ọzọ dị. Kpọọ 877-320-1235
(TTY: 711).**

**Òyìnbó [Yoruba]: Àwọn isẹ̀ àtilẹ̀hìn ìrànlọ́wọ́ èdè, àtì ọ̀nà kíkà mírán wà lárọ̀wọ́tọ́. Pe
877-320-1235 (TTY: 711).**

**नेपाली [Nepali]: भाषासम्बन्धी निःशुल्क, सहायक साधन र वैकल्पिक फार्मेट (ढाँचा/व्यवस्था)
सेवाहरू उपलब्ध छन् । 877-320-1235 (TTY: 711) मा कल गर्नुहोस् ।**



This abridged formulary was updated on 05/05/2026 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 Customer Care Team 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**.

GRP024PDG2680026_v1

