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PEEHIP HUMANA GROUP MEDICARE ADVANTAGE PPO PLAN

2022 MAPD PPO

# Group Medicare PPO MAPD Plan

## Public Education Employees' Health Insurance Plan

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PEEHIP

# Beyond healthcare

At Humana, we give you everything you expect from a healthcare plan, but that's just our starting point. We then find more ways to help, and more ways to support your health and your goals. That's human care, and it's just the way things ought to be.

# What's inside

- Information on your enrollment
- Summary of Benefits
- Introduction to Medicare
- Details about your plan
- Tools and programs to help manage your health
- Frequently asked questions

# What to expect after you enroll

### Enrollment confirmation

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

### Humana member ID card

Your Humana member ID card will arrive in the mail approximately 2 weeks after you are enrolled.

### Evidence of Coverage (EOC)

This detailed booklet about your healthcare coverage with your plan will arrive in the mail. This will also include your privacy notice.

### Take your Medicare Health Assessment

CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment.

It's nine simple questions about your health. Your answers will help us guide you to tools and resources available to help you reach your health goals. The information you provide will not affect your plan benefits.

**Once you have received your Humana member ID card or after your plan is effective,** you can call our automated voice service anytime to take this survey at **1-888-445-3389 (TTY: 711)**. When you call, you'll be asked to provide your eight-digit member ID number located on the front of your Humana member ID card, so have your ID card handy.

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# Humana Group Medicare Advantage PPO plan

Dear PEEHIP Group Medicare Retiree,

We're excited to let you know that **Public Education Employees' Health Insurance Plan (PEEHIP)** has asked Humana to offer you a Medicare Advantage and Prescription Drug Plan that gives you more benefits than Original Medicare.

At Humana, helping you achieve lifelong well-being is our mission. During our 30 years of experience with Medicare, we've learned how to be a better partner in health.

**Learn more about the PEEHIP Humana Group Medicare Advantage PPO plan**
Review the materials enclosed within this packet. Here you will find information about your PEEHIP Humana Group Medicare Advantage PPO healthcare coverage. You will also find information on the extra services Humana offers at no additional cost such as Silver Sneakers, Go365 and our Well Dine program.

- If you have questions about your premium, please call PEEHIP at 1-334-517-7000 (TTY: 711) or toll free at 1-877-517-0020 (TTY: 711), Monday through Friday 8:00 a.m. to 5:00 p.m. Central Time.

**How do I enroll**

- Enrolling is easy. There is nothing you have to do. If you have Medicare Parts A & B, PEEHIP will automatically enroll you in this plan. On your plan's effective date, this plan will replace your current coverage.

**What if I don't want to join this plan**

- You have the option not to enroll into this plan. If you do not want to be enrolled into this plan, you must return the enclosed opt out form to PEEHIP's office.
- You can also find additional information about your enrollment in the document titled "Important Enrollment Information," located in this packet.

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

Sincerely,
Group Medicare Operations

## We're here for you

**Humana Group Medicare Customer Care**
**1-800-747-0008 (TTY: 711)**
Monday – Friday, 7 a.m. – 8 p.m., Central Time
**our.Humana.com/peehip**

Please call our Group Medicare Customer Care representatives if you have any questions about the plan or enrollment in the plan.

# Important Enrollment Information

Public Education Employees' Health Insurance Plan (PEEHIP) is enrolling you in the Humana Group Medicare Advantage preferred provider organization (PPO) plan. You do not need to do anything to be automatically enrolled in this Medicare Advantage health plan. If you do not want to join this plan, you can follow the instructions included below. **Enrollment in this plan will end your enrollment in any Medicare Advantage plan that you are currently enrolled in.**

**What do I need to know as a member of the PEEHIP Humana Group Medicare Advantage PPO plan?**
This mailing includes important information about this plan and what it covers, including a Summary of Benefits document. Please review this information carefully.

Once enrolled, you will receive an Evidence of Coverage document (also known as a member contract or subscriber agreement) from the PEEHIP Humana Group Medicare Advantage PPO plan. Please read the document to learn about the plan's coverage and services. As a member of the PEEHIP Humana Group Medicare Advantage PPO plan, you can appeal plan decisions about payment or services if you disagree. Enrollment in this plan is generally for the entire year.

When your PEEHIP Humana Group Medicare Advantage PPO plan begins, Humana will cover all medically necessary items and services, even if you get the services out of network.

You must use network pharmacies to access Humana benefits, except under limited, non-routine circumstances when you can't reasonably use network pharmacies.

You **must** keep Medicare Parts A and B as the PEEHIP Humana Group Medicare PPO plan is a Medicare Advantage plan. **You must also continue to pay your Part B premium**. You can enroll in only one Medicare Advantage plan at a time. You must let us know if you think you might be enrolled in a different Medicare Advantage plan or a Medicare prescription drug plan and inform us of any prescription drug coverage that you may get in the future.

**What happens if I don't join the PEEHIP Humana Group Medicare Advantage PPO plan?**
You aren't required to be enrolled in this plan.

If you don't want to enroll please complete the enclosed opt out form and return it to PEEHIP prior to your plan's effective date to the following address:

**PEEHIP**
**P.O. Box 302150**
**Montgomery, AL 36130-2150**

**If you choose to opt out of this plan, please note, Humana is the only coverage offered for PEEHIP Medicare eligible retirees. If you opt out, you may not be eligible to enroll again until the next PEEHIP open enrollment period. For additional questions regarding your eligibility, or to see if there are any additional consequences for opting out, please contact PEEHIP at 1-334-517-7000 (TTY: 711) or toll free at 1-877-517-0020 (TTY: 711), Monday through Friday 8:00 a.m. to 5:00 p.m. Central Time.**

If you choose to join a different Medicare plan, you can contact **1-800-MEDICARE** anytime, 24 hours a day, 7 days a week, for help in learning how. TTY users can call **1-877-486-2048**. Your state may have counseling services through the State Health Insurance Assistance Program (SHIP). They can provide you with personalized counseling and assistance when selecting a plan, including Medicare Supplement plans, Medicare Advantage plans and prescription drug plans. They can also help you find medical assistance through your state Medicaid program and the Medicare Savings Program.

**What if I want to leave the PEEHIP Humana Group Medicare Advantage PPO plan?**
You can change or cancel your Humana coverage at any time and return to Original Medicare or another Medicare Advantage plan by using a special election**. If you choose to leave this plan, please contact PEEHIP at 1-334-517-7000 (TTY: 711) or toll free at 1-877-517-0020 (TTY: 711), Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Time or call 1-800-MEDICARE**.

**What happens if I move?**
If you move, **please contact PEEHIP at 1-334-517-7000 (TTY: 711) or toll free at 1-877-517-0020 (TTY: 711), Monday through Friday, 8:00 a.m. to 5:00 p.m., Central Time.**

Remember that if you leave this plan and don't have creditable prescription drug coverage (as good as Medicare's prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

**Release of Information**
By joining this Medicare Advantage plan, you give us permission to share your information with Medicare and other plans when needed for treatment, payment and health care operations. We do this to make sure you get the best treatment and to make sure that it is covered by the plan. Medicare may also use this information for research and other reasons allowed by Federal law.

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# Summary of Benefits

## PEEHIP Humana Group Medicare Advantage PPO Plan

**PPO 079/445**
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Our service area covers all 50 states, American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

# Let's talk about the **PEEHIP Humana Group Medicare Advantage PPO Plan.**

Find out more about the PEEHIP Humana Group Medicare Advantage PPO Plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage" booklet you will receive within 30 days of your effective date.

## To be eligible:

To join the PEEHIP Humana Group Medicare Advantage PPO Plan, you must be entitled to Medicare Part A and be enrolled in Medicare Part B.

## Plan name:

PEEHIP Humana Group Medicare Advantage PPO Plan

## How to reach us:

Members should call toll-free **1-800-747-0008** for questions **(TTY/TDD 711)**

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

Or visit our website: **https://our.Humana.com/peehip/**

The PEEHIP Humana Group Medicare Advantage PPO Plan has a network of doctors, hospitals, and other providers. For more information, please call your Humana Group Medicare Customer Care team at 1-800-747-0008.

## A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

# Monthly Premium, Deductible and Limits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PLAN COSTS** | | |
| **Monthly premium** | For information concerning the actual premiums you will pay, please contact PEEHIP at 1-334-517-7000 or toll free at 1-877-517-0020. | |
| **Medicare Part B premium** | It is important to know that you must keep paying your Medicare Part B premium through the Social Security Administration. | |
| **Medical Part B deductible** | **$203** per year for some combined in- and out-of-network services | **$203** per year for some combined in- and out-of-network services |
| **Maximum out-of-pocket responsibility**<br>The most you pay for copays and other costs for medical services for the year. | **In-Network Maximum Out-of-Pocket**<br>**$6,700** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, COVID-19 Testing; COVID-19 Treatment; Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Well Dine; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium.<br><br>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. | **Combined In and Out-of-Network Maximum Out-of-Pocket**<br>**$6,700** out-of-pocket limit for Medicare-covered services.<br>In-Network Exclusions: Part D Pharmacy, COVID-19 Testing; COVID-19 Treatment; Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Well Dine; Podiatry Services (Routine); Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket.<br><br>Out-of-Network Exclusions: Part D Pharmacy, Chiropractic Services (Routine); Hearing Services (Routine); Podiatry Services (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.<br><br>Your limit for services received from in-network providers will count toward this limit.<br><br>If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services. |

***Note:*** *some services require prior authorization.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | | |
| Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | **$200** copay per day for day 1<br>**$25** copay per day for days 2-5<br>**$0** copay per day for days 6-365 | **$200** copay per day for day 1<br>**$25** copay per day for days 2-5<br>**$0** copay per day for days 6-365 |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Outpatient hospital visits** | **$0** copay | **$0** copay |
| **Ambulatory surgical center** | **$0** copay | **$0** copay |
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$13** copay | **$13** copay |
| **Specialists** | **$18** copay | **$18** copay |
| **PREVENTIVE CARE** | | |
| Including: One Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered. | **Covered at no cost** | **Covered at no cost** |
| **EMERGENCY CARE** | | |
| **Emergency room**<br>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | **$35** copay for Medicare-covered emergency room visit(s) | **$35** copay for Medicare-covered emergency room visit(s) |
| **Urgently needed services**<br>Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | **$18** copay | **$18** copay |

***Note:*** *some services require prior authorization.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Diagnostic radiology** | **$0** copay | **$0** copay |
| **Lab services** | **$0** copay | **$0** copay |
| **Diagnostic tests and procedures** | **$0** copay | **$0** copay |
| **Outpatient X-rays** | **$0** copay | **$0** copay |
| **Radiation Therapy** | **$0** copay | **$0** copay |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing evaluation** | **$18** copay | **$18** copay |
| **Routine hearing** | **$0** copayment for fitting/evaluation, routine hearing exams up to 1 per year. **$500** combined in and out of network maximum benefit coverage amount for hearing aid(s) (all types) every 3 years. | **$0** copayment for fitting/evaluation, routine hearing exams up to 1 per year. **$500** combined in and out of network maximum benefit coverage amount for hearing aid(s) (all types) every 3 years. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **$18** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease) | **$18** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease) |
| **VISION SERVICES** | | |
| **Medicare-covered vision services** | **$18** copay (services include diagnosis and treatment of diseases and injuries of the eye) | **$18** copay (services include diagnosis and treatment of diseases and injuries of the eye) |
| **Glaucoma Screening** | **$0** copay | **$0** copay |
| **Diabetic eye exam** | **$0** copay | **$0** copay |
| **Eyewear (post-cataract)** | **$0** copay | **$0** copay |
| **Routine vision** | **$18** copayment for routine exam up to 1 per year. | **$18** copayment for routine exam up to 1 per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |

***Note:*** *some services require prior authorization.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient**<br>The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | **$200** copay per day for day 1<br>**$25** copay per day for days 2-5<br>**$0** copay per day for days 6-365 | **$200** copay per day for day 1<br>**$25** copay per day for days 2-5<br>**$0** copay per day for days 6-365 |
| **Outpatient group and individual therapy visits** | **Outpatient therapy visit:**<br>**$18** copay<br>**Partial Hospitalization:**<br>**$0** copay | **Outpatient therapy visit:**<br>**$18** copay<br>**Partial Hospitalization:**<br>**$0** copay |
| **SKILLED NURSING FACILITY** | | |
| Our plan covers up to 100 days in a SNF.<br>No 3-day hospital stay is required.<br>Plan pays $0 after 100 days. | **$0** copay per day for days 1-20<br>**$161** copay per day for days 21-100 | **$0** copay per day for days 1-20<br>**$161** copay per day for days 21-100 |
| **PHYSICAL THERAPY** | | |
| | **$0** copay | **$0** copay |
| **AMBULANCE** | | |
| | **$0** copay | **$0** copay |
| **PART B PRESCRIPTION DRUGS** | | |
| | **$0** copay | **$0** copay |
| **ACUPUNCTURE SERVICES** | | |
| **Medicare-covered acupuncture visit(s) for chronic low back pain** | **$18** copay<br>Limit 20 combined in and out-of-network visit(s) per year | **$18** copay<br>Limit 20 combined in and out-of-network visit(s) per year |
| **ALLERGY** | | |
| **Allergy Shots & Serum** | **$0** copay | **$0** copay |
| **CHIROPRACTIC SERVICES** | | |
| **Medicare-covered chiropractic visit(s)** | **$0** copay | **$0** copay |
| **Routine chiropractic visit(s)** | **20%** of the cost<br>18 visit(s) per year for routine chiropractic services | **20%** of the cost<br>18 visit(s) per year for routine chiropractic services |

***Note:*** *some services require prior authorization.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **COVID-19** | | |
| **Testing and Treatment** | **$0** copay for testing and treatment services for COVID-19 | **$0** copay for testing and treatment services for COVID-19 |
| **DIABETES MANAGEMENT TRAINING** | | |
| | **$0** copay | **$0** copay |
| **FOOT CARE (PODIATRY)** | | |
| **Medicare-covered foot care** | **$18** copay | **$18** copay |
| **Routine foot care** | **$18** copay<br>6 visit(s) per year for routine podiatry services | **$18** copay<br>6 visit(s) per year for routine podiatry services |
| **HOME HEALTH CARE** | | |
| | **$0** copay | **$0** copay |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **$0** copay | **$0** copay |
| **Medical Supplies** | **$0** copay | **$0** copay |
| **Prosthetics (artificial limbs or braces)** | **$0** copay | **$0** copay |
| **Diabetes monitoring supplies** | **$0** copay | **$0** copay |
| **OUTPATIENT SUBSTANCE ABUSE** | | |
| **Outpatient group and individual substance abuse treatment visits** | **Outpatient substance abuse treatment visit:**<br>**$18** copay<br>**Partial Hospitalization:**<br>**$0** copay | **Outpatient substance abuse treatment visit:**<br>**$18** copay<br>**Partial Hospitalization:**<br>**$0** copay |

***Note:*** *some services require prior authorization.*

# Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **REHABILITATION SERVICES** | | |
| **Occupational and speech therapy** | **$0** copay | **$0** copay |
| **Cardiac rehabilitation** | **$0** copay | **$0** copay |
| **Pulmonary rehabilitation** | **$0** copay | **$0** copay |
| **RENAL DIALYSIS** | | |
| **Renal dialysis** | **$0** copay | **$0** copay |
| **Kidney disease education services** | **$0** copay | **$0** copay |
| **FITNESS AND WELLNESS** | | |
| | SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes. | |

**HOSPICE**
You must get care from a Medicare-certified hospice. You must consult with your plan at 1-800-747-0008 before you select hospice.

***Note:*** *some services require prior authorization.*

# Notes

# Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-800-747-0008** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services** , Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** , or at **U.S. Department of Health and Human Services** , 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 1-800-747-0008 (TTY: 711)

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

**Language assistance services, free of charge, are available to you.**
**1-800-747-0008 (TTY: 711)**

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

# Find out **more**

You can see our plan's provider directory at **https://our.Humana.com/peehip/** or call us at 1-800-747-0008 and we will send you one.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

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

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# Prescription Drug Summary of Benefits

## PEEHIP Humana Group Medicare Advantage PPO Plan

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**Rx 339**
PEEHIP

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# Let's talk about the **PEEHIP Humana Group Medicare Advantage Rx Plan.**

Find out more about the PEEHIP Humana Group Medicare Advantage Rx Plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage" booklet you will receive within 30 days of your effective date.

# Monthly Premium, Deductible and Limits

**Pharmacy (Part D) deductible** This plan does not have a deductible.

# Prescription Drug Benefits

Initial coverage
You pay the following until your total yearly drug costs reach **$4,430.** Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

| Tier | Standard Retail Pharmacy |
|---|---|
| **30-day supply (Maintenance and Non-maintenance Drugs)** | |
| **1 (Preferred Generic)** | **$6** copay |
| **2 (Preferred Brand)** | **$40** copay |
| **3 (Non-Preferred Drug)** | **$60** copay |
| **4 (Specialty Tier)** | **$60** copay |
| **60-day supply (Maintenance Drugs)** | |
| **1 (Preferred Generic)** | **$12** copay |
| **2 (Preferred Brand)** | **$80** copay |
| **3 (Non-Preferred Drug)** | **$120** copay |
| **4 (Specialty Tier)** | N/A |
| **90-day supply (Maintenance Drugs)** | |
| **1 (Preferred Generic)** | **$12** copay |
| **2 (Preferred Brand)** | **$120** copay |
| **3 (Non-Preferred Drug)** | **$180** copay |
| **4 (Specialty Tier)** | N/A |

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary, starting on page 49. The Prescription Drug Guide/Formulary can also be referenced at https://our.Humana.com/peehip/.

## Coverage Gap

After the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,430,** you will continue to pay the same amount as when you were in the initial coverage stage.

## Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy) reach **$7,050,** you pay the greater of:

- **5%** coinsurance with a minimum of **$3.95** (**$6** maximum out-of-pocket per prescription for tier 1 drugs for a one-month supply).
- **$3.95** for generic (including brand drugs treated as generic) and **$9.85** for all other drugs, or **5%** coinsurance (**$40** maximum out-of-pocket per prescription for tier 2 drugs, **$60** maximum out-of-pocket per prescription for tier 3 drugs and **$60** maximum out-of-pocket per prescription for tier 4 drugs for a one-month supply).

# Notes

# Notes

# Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-800-747-0008** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services** , Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** , or at **U.S. Department of Health and Human Services** , 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

## Auxiliary aids and services, free of charge, are available to you. 1-800-747-0008 (TTY: 711)

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

**Language assistance services, free of charge, are available to you.**
**1-800-747-0008 (TTY: 711)**

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。

**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.

**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

**فارسی (Farsi)**

برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nika'adoowoł.

**العربية (Arabic)**

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

# Find out **more**

You can see your plan's pharmacy directory at **https://our.Humana.com/peehip/** or call us at 1-800-747-0008 and we will send you one.

You can see your plan's drug formulary at **https://our.humana.com/peehip/plan-documents** or call us at 1-800-747-0008 and we will send you one.

Humana is a Medicare Advantage PPO organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.

Humana®

PEEHIP

# PEEHIP Humana Group Medicare Advantage

## PPO Plan MAPD Guidebook

Humana®

PEEHIP

# What's inside

# Everyone deserves a more human way to healthcare

Humana cares for people. We have for over 50 years. And for more than 30 of those years, we've helped seniors get their Medicare coverage. It starts with helping you understand your plan and then to get the most from it, with a more active and involved way to help you take care of your health. We call this human care.

Humana's Group Medicare Advantage PPO plan for the Public Education Employees Health Insurance Plan offers the value and responsiveness—even the anticipation of needs—you deserve. Human care is an attentive ear, a compassionate voice, essential information and a clear explanation.

At Humana, we know that treating you like a human being is more than just the right thing to do—it's actually better for your health, too.

After you are enrolled, Humana will mail you an Evidence of Coverage booklet that will have all your plan information and details, including a full list of benefits.

# Humana offers you a Medicare Advantage PPO

## A PPO offers

- All the benefits of Original Medicare, plus extra benefits
- Maximum out-of-pocket protections
- Worldwide emergency coverage
- Programs to help improve health and well-being
- Dedicated Customer Care specialists designated specifically for PEEHIP Medicare retirees
- The same benefit levels for in-network and out-of-network providers
- A large network of doctors, specialists and hospitals to choose from
- No need for a referral to see any healthcare provider
- Coverage for office visits, including routine physical exams

# Humana Medicare Advantage PPO with prescription drug plan also offers:

## A large network

There are more than 66,000 participating pharmacies in our network.

## Maximize Your Benefit® Rx

Humana keeps in touch by telephone and mail to let you know about ways to save on prescription drugs by switching to others that cost less.

## Pharmacy finder

An online tool that helps you find pharmacies. It also tells you how far they are from you, the hours they're open, if they have a drive-through available, if they offer emergency Rx and if they have bilingual employees. Visit **our.Humana.com/peehip** or **MyHumana.com** to locate a pharmacy near you.

# Extra benefits—offered at no additional cost to you

## SilverSneakers® fitness*

This program opens the doors to fitness locations nationwide where you can:

**Work out indoors.** You receive a basic fitness membership and SilverSneakers group exercise classes (where available).

**Go outside with SilverSneakers FLEX®.** Try tai chi, yoga, walking groups and more. Available at local parks and recreation centers (where available).

**Get SilverSneakers Steps®.** At home or on the go—receive your choice of a kit for general fitness, strength, walking or yoga (one per member per year). Visit **SilverSneakers.com/StartHere** to get your SilverSneakers ID number and find a convenient location near you, or call **1-888-423-4632 (TTY: 711)**, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

*Equipment and classes may vary by location.

## Humana Care Management

Humana care management programs support qualifying members to help them remain independent at home, by providing education about chronic conditions and medication adherence, help with discharge instructions, accessing community resources, finding social support and more, all included in your plan at no additional cost. For more information, call **1-800-432-4803 (TTY: 711)**, Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time.

## Humana Well Dine® meal program

After an overnight inpatient stay in a hospital or nursing facility, you're eligible to receive 2 meals per day for 14 days, up to 28 nutritious meals. You can choose from regular, diabetic, puree, vegetarian, kosher and renal-support meal plans delivered to your door at no additional cost to you. For more information, please contact Group Medicare Customer Care at **1-800-747-0008 (TTY:711)**.

## Go365 by Humana™

Go365 is a wellness and rewards program available through your PEEHIP Humana Group Medicare PPO plan. It rewards you for completing your preventive screenings, getting your steps in, and participating in other healthy activities. When you've completed qualified activities, you'll earn rewards in the Go365 Mall to redeem for gift cards to various retail stores and restaurants. The more steps you take to improve your health, the more rewards you accumulate.

Go to **our.Humana.com/peehip/extra-benefits** and select the "Here" link under Go365 to sign in. Here you will be able to track activities and rewards!

To earn your reward for your activities, you will need to submit an activity form showing what activity you've completed. You can find the form when you sign in at MyHumana, then select "Go365." Or you may request paper materials by calling Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)**.

You can redeem your rewards for gift cards online by signing into **Go365.com/shop** or by calling **1-866-677-0999 (TTY: 711)**.

# Medication therapy management

As part of your Medicare Part D coverage with Humana, you may be eligible to take part in a program called Medication Therapy Management (MTM) at no extra cost. MTM may help you to:

- Know more about getting the greatest benefit from your medications
- Reduce risk by learning how to avoid harmful side effects
- Possibly save money by finding lower-cost alternatives to prescribed medications

## Who's eligible?

Members are chosen for MTM using the following Centers for Medicare & Medicaid Services (CMS) and Humana criteria:

- Have three of the five multiple chronic conditions:
  - Mental health-Bipolar
  - Hypertension
  - Dyslipidemia (high or low LDL cholesterol)
  - Osteoporosis
  - Chronic obstructive pulmonary disease (COPD)
- Take at least eight chronic/maintenance Part D drugs
- Spend more than $4,696 on prescription drugs per calendar year

## How does the program work?

MTM offers additional information on your SmartSummary®, a statment that helps you track your healthcare, that can help you manage medications and drug costs. You also get a face-to-face or phone consultation with a healthcare professional to talk about your medications. To learn more about your SmartSummary, refer to page 41.

## Scheduling a consultation

If you qualify for MTM, you will receive an invitation letter and see a note in your SmartSummary to call the MTM call center. If you think you qualify but don't see the note, please call Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)**.

Although the MTM program is a special service offered at no cost to Medicare members, it is not considered a benefit. But it all adds up to human care.

# Building healthy provider relationships

Your relationship with your provider is important in helping you protect and manage your health. With the PEEHIP Humana Group Medicare Advantage PPO plan, you can use any provider who accepts Medicare and agrees to bill Humana. Your benefit plan coverage remains the same, even if you receive care from an out-of-network provider.

# Medical preauthorization

For certain services and procedures, your doctor or hospital may need to get advance approval from Humana before your plan will cover any costs. This is called a preauthorization. Doctors or hospitals will submit the preauthorization request to Humana. If you have questions regarding what medical services require a preauthorization, you can call Customer Care at **1-800-747-0008 (TTY: 711)**.

## Why choose a Humana network provider?

- Humana Medicare PPO network providers must take payment from Humana for treating plan members.
- Network providers coordinate with Humana, which makes it easier to share information. Patients may have a better experience when providers share information this way.
- Humana supplies in-network providers with information about services and programs available to patients with chronic conditions.

## Is your health care provider in Humana's provider network?

Humana respects your relationship with your provider. We want you to be able to select a provider who's close to home and who can focus on your specific needs. If you need help finding a provider, call our Group Medicare Customer Care team at **1-800-747-0008 (TTY: 711)** or use our online directory. Humana's online provider lookup is an easy way to find doctors, hospitals and other healthcare providers in Humana's network:

- Go to **our.Humana.com/peehip/tools-resources** and select "Find a Doctor"
- Get provider phone numbers, addresses and directions
- Customize your search by specialty, location and name

## Is your pharmacy in Humana's network?

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

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

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

- Printable Drug Lists
- Prior authorization information
- Maximize Your Benefit Rx

*Standard data rates may apply.

# Connect with a doctor or behavioral health professional virtually*

MDLIVE®
Virtual Care, Anywhere.

## Care when you need it

Your health care should always begin with your primary care doctor or behavioral health specialist. But sometimes you have a nonemergency illness in the middle of the night, need a prescription refill or need someone to help you through a difficult moment. You may call your trusted local provider to ask if they offer telehealth visits. Or, you may register with Humana's national in-network teletealth option, MDLIVE.

- A virtual visit on your phone, tablet or laptop is a convenient way to get help 24 hours a day, seven days a week
- No appointment needed for medical visits, you can connect to a doctor within minutes and may be less expensive than a trip to an urgent care facility**
- Private, secure and confidential visits
- Talk to a board-certified psychiatrist or a behavioral health clinician by appointment only

## Three ways to talk to a doctor

- **MDLIVE.com/yourbenefit**
- **1-888-673-1992 (TTY: 711)**
- **Download the MDLIVE® mobile app from the App Store® or Google Play™**
  - Behavioral health visits require a pre-scheduled appointment. Internet access required. Data fees may apply***

## What are virtual visits?

A virtual visit is a remote appointment with a U.S. board-certified doctor or behavioral health provider for nonemergency medical and behavioral health conditions. Virtual visits should not replace your primary care provider, but can be used in nonemergency situations when your PCP's office is not available or convenient.

## When should I use it?

- For a nonemergency issue, instead of going to the emergency room (ER) or an urgent care center.
- For nonemergency mental and behavioral health conditions (by appointment).
- On a holiday, weekend or if you are traveling. You may even share the records from your virtual visit with your primary care provider.

*Vendors are subject to change.

**For more information, call Group Medicare Customer Care at **1-800-747-0008 (TTY:711)**. Telephonic visits not available in Idaho and New York; visits in these states are video only.

***Based on MDLIVE'S connection times and speed of individual's internet connection.

## What kinds of conditions can be treated?

Doctors are available to treat many conditions, including:

- Allergies
- Cold and flu symptoms
- Constipation
- Diarrhea
- Depression, anxiety, stress and family and relationship counseling
- Fever
- Sore throat
- Sinus infection
- Insect bites

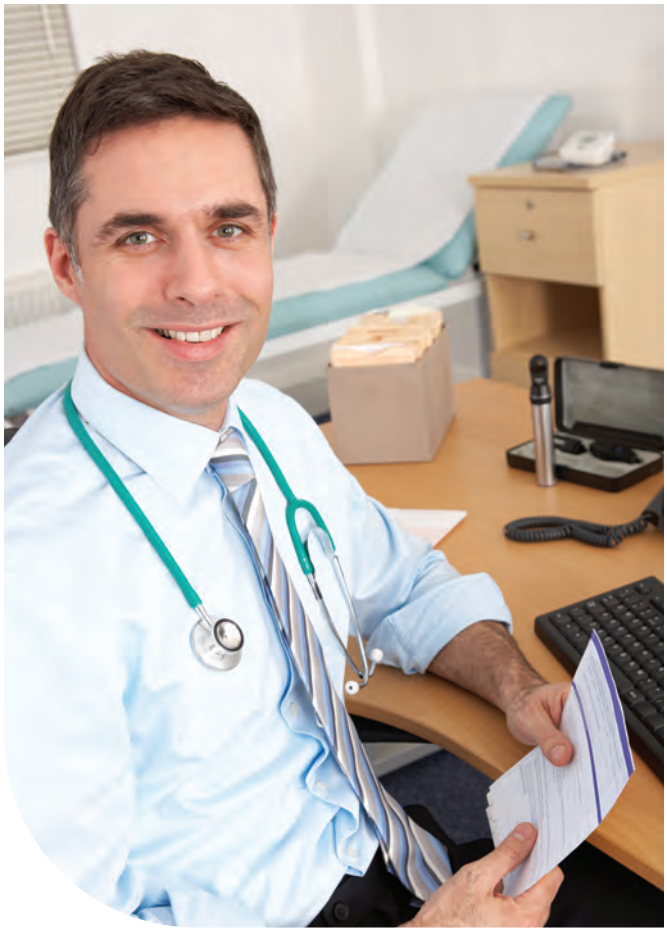
Your telemedicine virtual visit benefits have been extended to include, medication needs, lab orders, treatment for minor infections, and to assist your PCP in managing certain chronic conditions. Information about the care you receive during these virtual visits can be shared with your PCP.

## Who are the doctors?

Humana has teamed up with MDLIVE, a group of in-network doctors. On average, MDLIVE doctors have 15 years of experience practicing medicine and are all U.S. based and U.S. board-certified. MDLIVE doctors are committed to providing convenient, quality care and are always ready to visit with you. All MDLIVE psychiatrists and therapists are U.S. board certified and in-state licensed and/or credentialed in the states they practice.

**"Remember, when you have a life-threatening injury or major trauma, call 911.**

# Take this to your provider



## Having a provider you're happy with can play an important role in your health and meeting your needs.

**What if my doctor says they do not accept Humana insurance?**

**Give this flyer to your provider.**
Once you are a member of the PEEHIP Humana Group Medicare Advantage PPO Plan, sharing this information can help your provider understand how this plan works.

**Don't forget to take your Humana member ID card to your first appointment as well.**

## A message for your provider

> Humana will provide coverage for this retiree under the PEEHIP Group Medicare Advantage PPO plan. This retiree's in-network and out-of-network benefits are the same. This means you can provide services to this retiree or any member of this plan if you are a provider who is eligible to participate in Medicare.

**Contracted healthcare providers** – If you're a Humana Medicare Employer PPO-contracted healthcare provider, you'll receive your contracted rate.

**Out-of-network healthcare providers** – Humana is dedicated to an easy transition. If you're a provider who is eligible to participate in Medicare, you can treat and receive payment for your Humana-covered patients who have this plan. Humana pays providers according to the Original Medicare fee schedule less any member plan responsibility.

**If you need more information** about our claims processes or about becoming a Humana Medicare Employer PPO-contracted provider, call Provider Relations at **800-626-2741**, Monday – Friday, 8 a.m. – 5 p.m., Central time.

**NOTE:** This number is not for patient use. Patients, please call the Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)**.

**The in-network and out-of-network benefits are structured the same for any member of this plan.**

Humana. PEEHIP



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## Important!

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

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-800-747-0008** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
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**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
**Tagalog (Tagalog – Filipino):** Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
**Русский (Russian):** Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
**العربية (Arabic)**
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

# Vaccines: Where you get them determines how much you pay

The Medicare Part D portion of your plan covers all commercially available vaccines—except for those covered by Part B—as long as the vaccine is reasonable and necessary to prevent illness.

### Get vaccines like the ones listed below at your provider's office

The Medicare Part B portion of your plan pays for the following vaccines at your provider's office and at the pharmacy: influenza (flu) vaccine—once per season; pneumococcal vaccines; hepatitis B vaccines for persons at increased risk of hepatitis and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus.

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

If you get them at your provider's office, you'll pay the full cost of the vaccine out of pocket. Some common vaccines that you should get at your pharmacy, not from your provider, are shingles, Tdap and hepatitis A.

# Understanding your diabetes coverage

At Humana, we are here to help. We want you to have an easy experience when getting your diabetic supplies and prescriptions.

### Diabetes prescriptions and supplies, Part B vs. Part D

Medicare Part B helps cover diabetic testing supplies, insulin pumps, insulin administered (or used) in insulin pumps and continuous glucose monitors* (CGM). Medicare Part D helps cover diabetes medications, insulin administered (or used) with syringes or pens and syringes, pen needles or other insulin administration devices that are not durable medical equipment (e.g. Omnipod* or VGO).

### Important information for your pharmacist

Let your pharmacist know to use **BIN 610649** and **PCN 03200004** when filling your prescription for items covered under Part B.

# Diabetic testing supplies

Your PEEHIP Humana Group Medicare Advantage Plan covers a variety of diabetic glucose testing supplies such as Roche Accu-Chek Guide Me®, Roche Accu-Chek Guide and HP® True Metrix® AIR by Trividia.

You can receive a meter and test strips through a pharmacy or durable medical equipment provider. Your doctor can also send prescriptions for meters and other testing supplies by fax or e-prescribe.

You can request a no-cost meter from the manufacturer by calling Roche at **1-877-264-7263 (TTY: 711)**, or Trividia Health at **1-866-788-9618 (TTY: 711)**, Monday – Friday, 7 a.m. – 7 p.m., Central time.

*CGMs can be obtained through a durable medical equipment (DME) provider of your choice. Preferred Humana providers are CCS Medical **1-877-531-7959** or Edwards Healthcare **1-888-344-3434**.

# Important information about your prescription drug coverage

Some drugs covered by Humana may have requirements or limits on coverage. These requirements and limits may include prior authorization, step therapy or quantity limits. You can visit **our.Humana.com/peehip** to register or sign in and select Pharmacy or call Humana's Group Medicare Customer Care team at **1-800-747-0008 (TTY: 711)** to check coverage on the medications you take.

## Prior authorization

The PEEHIP Humana Group Medicare Advantage PPO plan requires your provider to get prior authorization for certain drugs. This means that your provider will need to get approval from the PEEHIP Humana Group Medicare Advantage PPO plan before you fill your prescriptions. The reason a prior authorization is required can vary depending on the medication. Humana will work with your provider when a prior authorization is required.

Your provider can go online to **Humana.com/Provider** and visit our provider prior authorization page. This website has a printable form that your provider can mail or fax to Humana to request the prior authorization for your drug. If your provider prescribes a drug that needs prior authorization, you can check the status of the prior authorization prior to filling your prescription by calling Humana's Clinical Pharmacy Review team at **1-800-555-2546 (TTY: 711)**. The Centers for Medicare & Medicaid Services (CMS) requires a turnaround time of 72 hours for a prior authorization. However, an expedited review can be requested by your provider if waiting 72 hours may be harmful to you.

If you would like to check the status of your authorization or have questions, you can speak with our Humana Clinical Pharmacy Review team by calling **1-800-555-2546 (TTY: 711)**, Monday – Friday, 8 a.m. – 6 p.m., Eastern time.

Remember—before making a change, you should always talk about treatment options with your doctor.

## Step therapy

In some cases, the PEEHIP Humana Group Medicare Advantage PPO plan requires that you first try certain drugs to treat your medical condition before coverage is available for a more expensive drug prescribed to treat your medical condition. For example, if Drug A and Drug B both treat your medical condition, the PEEHIP Humana Group Medicare Advantage PPO plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the PEEHIP Humana Group Medicare Advantage PPO plan can then cover Drug B. Your doctor will need to contact Humana's Clinical Pharmacy review department at **1-800-555-2546 (TTY: 711)** to provide the specific information to submit a request for a step therapy prior authorization. A step therapy prescription can be filled once the necessary requirements are met. If you have already tried other medications that did not provide the desired clinical results, or you had an adverse reaction, your provider may submit this information to Humana for consideration in meeting the step therapy requirements. If you have any questions regarding step therapy, please contact your provider.

## One-time transition fill

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

*Some drugs do not qualify for a transitional fill, such as drugs that require a Part B vs. Part D determination, CMS excluded drugs, or those that require a diagnosis review to determine coverage.

## Quantity limits

For some drugs, the PEEHIP Humana Group Medicare Advantage PPO plan limits the quantity of the drug that is covered. The PEEHIP Humana Group Medicare Advantage PPO plan might limit how many refills you can get or quantity of a drug you can get each time you fill your prescription. For example, if it's 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. Specialty drugs are limited to a 30-day supply regardless of tier placement on the formulary.

## Next steps for you

You can call Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)** if you have general questions about your prescription drug benefit, to see if your medications require prior authorization, if step therapy is needed or if your medications have quantity limits.

# Your formulary drug categories

## Tier 1 – Preferred generic

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

## Tier 2 – Preferred brand

**A medicine available to you for less than a nonpreferred**
Preferred-brand drugs are generic or brand-name drugs that Humana offers at a lower cost to you than nonpreferred drugs.

## Tier 3 – Nonpreferred drug

**A more expensive drug than a preferred**
Nonpreferred drugs are more expensive generic or brand-name prescription drugs that Humana offers at a higher cost to you than preferred drugs.

## Tier 4 – Specialty

**Drugs for specific uses**
These include some injectable and other high-cost drugs to treat chronic or complex illnesses like rheumatoid arthritis and cancer.

# Communication counts

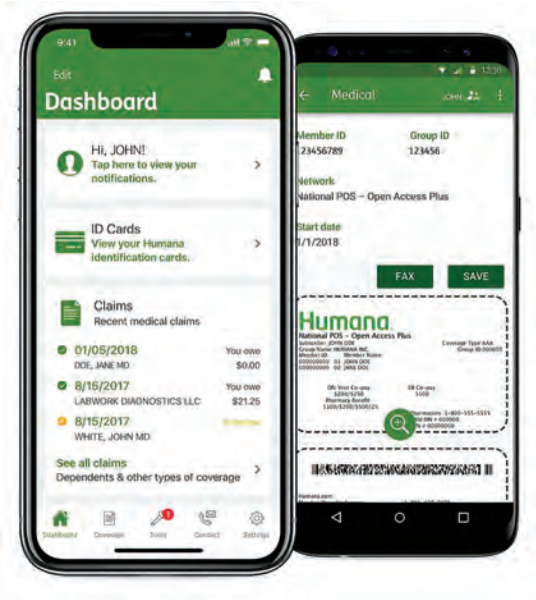
## MyHumana and MyHumana mobile app

### Get your personalized health information on MyHumana

As soon as you receive your Humana member ID card, **go to our.Humana.com/peehip** and register for MyHumana. This is your personal, secure online account. It allows you to access your plan details from your computer or smartphone.

Use MyHumana to check the status of your claims, find a provider in your plan's network and view plan documents such as important plan messages, letters and notifications.

If you need help along the way, select the green "Chat with Us" button or call Customer Care at **1-800-747-0008 (TTY: 711).**




### Getting started is easy—just have your Humana member ID card ready and follow these three steps.

1. **Create your account.**
   Visit **our.Humana.com/peehip**, under the green MyHumana box, select the link "Register or Log into MyHumana.com".

2. **Choose your preferences.**
   The first time you sign into your MyHumana account, be sure to choose how you want to receive information from us—online or mailed to your home. You can update your communication preferences at any time.

3. **View your plan benefits.**
   After you set up your account, be sure to view your plan documents so you understand your benefits and costs. You can also update your member profile if your contact information has changed.

### The MyHumana Mobile app

If you have an iPhone or Android, download the MyHumana Mobile app.* You'll have your plan details with you at all times.

Visit **Humana.com/mobile-apps** to learn about our many mobile apps, the app features and how to use them.

### With MyHumana and the MyHumana Mobile app, you can:

- Review your plan benefits and claims
- Find providers in your network
- Find pharmacies in your network
- Compare drug prices
- Access digital ID cards
- Establish communication preferences

### Have questions?

If you need help along the way, select the green "Chat with Us" button or call Customer Care at the number on the back of your Humana member ID card.

*Standard data rates may apply.

# Choose a caregiver to help you

## Consent forms

Everyone needs a little help now and then. We're happy to work with you and whomever you designate as a helper. Many people trust a family member or close friend to help them with their healthcare—someone who may help you talk with us about your insurance plan, keep track of your benefits and claims or answer healthcare questions.

We need your permission to share your personal information with someone else. To give your permission, you'll need to read and sign a consent form.

## Here are the ways you can do that:

- Fill out and submit the form online once you have registered on MyHumana
- Print the form from **our.Humana.com/peehip/addl-information** and return it by following the instructions on the form
- Call us and we'll mail the form to you to complete and return

A signed consent form allows insurers to share health plan information and protected health information with your designated helper. It's different from granting medical power of attorney, which allows someone to make decisions about your care.

## Choose a caregiver to help you

You may find it useful to choose a family member or friend you trust who can talk to Humana on your behalf—someone who can help you along your health and well-being journey.

Visit **Humana.com/caregiver** to learn more about naming a caregiver and how to submit the Consent for Release of Protected Health Information (PHI) form.

# SmartSummary is your personalized benefits statement

## We make it easy for you to understand, track, manage and possibly save money on your healthcare.

At Humana, we believe Medicare members deserve a better way to understand, track, manage and possibly save money on their healthcare. Your SmartSummary® helps you do just that. You can use your SmartSummary as a portable health record. You'll receive this statement after each month for which you've had a claim. You can also sign into MyHumana and see your past SmartSummary statements anytime.

## SmartSummary helps you:

- Understand your total healthcare picture
- Manage your monthly and yearly healthcare costs
- Engage with your providers by having a list of the healthcare services you receive
- Learn about preventive care, health conditions, treatment options and ways to help reduce health expenses

## SmartSummary also includes:

- Numbers to watch – SmartSummary shows your total drug costs for the month and year to date. It also shows how much of these costs your plan paid and how much you paid—so you can see the value of your prescription benefits.
- Personalized messages – SmartSummary gives you tips on saving money on the prescription drugs you take, information about any potential changes in prescription copayments and how to plan ahead.
- Your Rx record – A personalized prescription manager tells you more about your prescription medications, including information about dosage and the prescribing doctor. It also has a refill calendar that helps you know the date of your next refill. This page can be useful to take to your doctor appointments or to your pharmacist.
- Healthcare news relevant for you – SmartSummary personalizes a news section to let you know about things you can do for your health, including medicines and treatments for health problems.

> **Human care focuses on meeting your changing needs and smoothing your move to Medicare, so you can focus on work and play and living your life.**

# What is Medicare?

Medicare is a federal health insurance program for U.S. citizens and legal residents who are 65 and older or qualify due to a disability. You must be entitled to Medicare Part A and enrolled in Medicare Part B as the Humana Group Medicare PPO plan is a Medicare Advantage plan. You must also continue paying Medicare Part B premiums to remain enrolled in this plan.

A

## Medicare Part A

HOSPITAL INSURANCE

It helps cover medically necessary inpatient care in a hospital or skilled nursing facility. It also helps cover some home healthcare and hospice care.

B

## Medicare Part B

MEDICAL INSURANCE

It helps cover medically necessary providers' services, outpatient care and other medical services and supplies. Part B also helps cover some preventive services.

C

## Medicare Part C

MEDICARE ADVANTAGE PLANS

These are available through private insurance companies, such as Humana. Medicare Part C helps cover everything medically necessary that Part A and Part B cover, including hospital and medical services. You still have Medicare if you elect Medicare Part C coverage. You must be entitled to Medicare Part A and enrolled in Part B to be eligible for a Medicare Part C plan.

D

## Medicare Part D

PRESCRIPTION DRUG COVERAGE

Like Part C Medicare Advantage plans, Part D is only available through private companies, such as Humana. Many Part C Medicare Advantage plans include Medicare Part D prescription drug coverage. Part D helps pay for the medications your provider prescribes.

# Frequently asked questions

**Do I need to show my red, white and blue Medicare card when I visit the doctor?**
No. You'll get a Humana member ID card that will take its place. Keep your Medicare ID card in a safe place—or use it only when it's needed for discounts and other offers from retailers.

**What should I do if I move or have a temporary address change?**
If you move to another area or state, it may affect your plan. It's important to contact PEEHIP at **1-344-517-7000** or toll-free at **1-877-517-0020** for details and call to notify Humana of the move.

**What should I do if I have to file a claim?**
Call Humana Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)** for more information and assistance. To request reimbursement for a charge you paid for a service, send the provider's itemized receipt and the Health Benefits Claim Form (also available at **our.Humana.com/peehip/addl-information**) to the claims address on the back of your Humana member ID card. Make sure the receipt includes your name and Humana member ID number. Be sure to save a copy of your receipt for your own personal records.

**What if I have other health insurance coverage?**
If you have other health insurance, show your Humana member ID card and your other insurance cards when you see a healthcare provider. The PEEHIP Humana Group Medicare Advantage PPO plan may be eligible in combination with other types of health insurance coverage you may have. This is called coordination of benefits. Please notify PEEHIP if you have any other medical coverage, such as VA or TRICARE®.

**When does my coverage begin?**
Your former employer decides how and when you enroll. Check with PEEHIP at **1-344-517-7000** or toll-free at **1-877-517-0020** for the proposed effective date of your enrollment. Be sure to keep your current healthcare coverage until your PEEHIP Humana Group Medicare Advantage PPO plan enrollment is confirmed.

**What if my service needs a prior authorization?**
If your medical service or medication requires an authorization, your provider can contact Humana to request it. Your provider can also visit **Humana.com/Provider** to submit a request for a prior authorization. If you have questions regarding what medical services or medications require an authorization call Customer Care at **1-800-747-0008 (TTY: 711)**. To check the status of your authorization, you can call **1-800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team.

**What if my provider says they will not accept my plan?**
If your provider says they will not accept your PPO plan, you can give your provider the "Group Medicare Provider Information" flyer. It explains how your PPO plan works. You can also call Customer Care at **1-800-747-0008 (TTY: 711)** and have a Humana representative contact your provider and explain how your PPO plan works.

**How can I get help with my drug plan costs?**
People with limited incomes may qualify for assistance from the Extra Help program to pay for their prescription drug costs. To see if you qualify for Extra Help, call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. If you use a TTY, call **1-877-486-2048**. You can also call the Social Security Administration at **800-772-1213**. If you use a TTY, call **1-800-325-0778**. Your state's Medical Assistance (Medicaid) Office may also be able to help, or you can apply for Extra Help online at **www.socialsecurity.gov**.

# Glossary

## Medical common terms and definitions

All those insurance terms can be a little confusing. Here are a few of the most common terms and definitions.

### Coinsurance

**Your share of the cost after deductible**

A percentage of your medical and drug costs that you may pay out of your pocket for services after you pay any plan deductible.

### Copayment

**What you pay at the provider's office for medical services**

The set dollar amount you pay when you receive medical services or have a prescription filled.

| PEEHIP benefits | Copay |
|---|---|
| Office visit | $13 |
| Specialist visit | $18 |
| Emergency room | $35 |
| Hospital inpatient | $200 copay (day 1) then $25 copay per day (days 2–5) then $0 copay (days 6–365) per admission |

### Deductible

**What you pay up front**

The amount you pay for healthcare before your plan begins to pay for your benefits.
The Part B deductible for your PEEHIP Humana Group Medicare Advantage PPO plan is $203.

### Exclusions and limitations

**Anything not covered or covered under limited situations or conditions**

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

### Maximum out-of-pocket

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

The most you would have to pay for medical services covered by a health plan, including medical deductibles, copays and coinsurance. If and when you reach your annual out-of-pocket limit, the PEEHIP Humana Group Medicare Advantage PPO plan pays 100% of the Medicare-approved amount for most covered medical charges.

### Network

**Your plan's contracted medical providers**

A group of healthcare providers contracted to provide medical services at discounted rates.
The providers include doctors, hospitals and other healthcare professionals and facilities.

# Pharmacy common terms and definitions

## Catastrophic coverage

**What you pay for covered drugs after reaching $7,050**
Once your pharmacy out-of-pocket costs reach the $7,050 maximum, you pay a copayment for covered drug costs until the end of the plan year.

## Copayment

**What you pay at the pharmacy for your prescription**
The set dollar amount you pay when you fill a prescription.

## Deductible

**Your cost for Part D prescription drugs before the plan pays**
The amount you pay for Part D prescription drugs before the plan begins to pay its share. PEEHIP covers the Part D deductible for your plan so you do not pay a Part D deductible.

## Exclusions and limitations

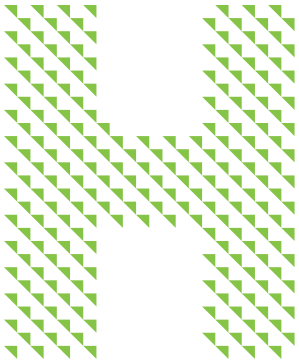
**Anything not covered**
Specific conditions or circumstances that aren't covered under a plan.

## Formulary

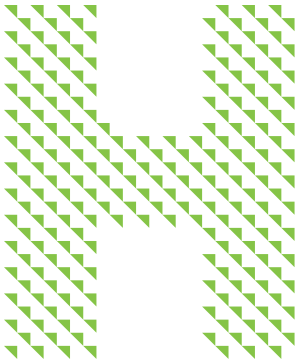
**Drugs covered under your plan**
A list of drugs approved for coverage under the plan. Also called a Drug List.

## Notes

## Notes



## Notes




Humana®

2022

# Prescription Drug Guide

## PEEHIP Humana Group Medicare Advantage Plan (PPO) Abbreviated Formulary

Partial list of covered drugs

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

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This abridged formulary was updated on 09/02/2021 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact PEEHIP Humana Group Medicare Advantage Plan with any questions at 1-800-747-0008 or for TTY users, 711, Monday through Friday, from 7 a.m. - 8 p.m. Central 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 **https://our.Humana.com/peehip/**.

Instructions for getting information about all covered drugs are inside.

Humana®

PEEHIP

# Welcome to PEEHIP Humana Group Medicare Advantage Plan!

**Note to existing members:** 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 PEEHIP Humana Group Medicare Advantage Plan. This document includes a partial list of the drugs (formulary) for our plan which is current as of January 1, 2022. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages of the formulary. 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 PEEHIP Humana Group Medicare Advantage formulary?**
A formulary is the entire list of covered drugs or medicines selected by the PEEHIP Humana Group Medicare Advantage Plan. The terms formulary and Drug List may be used interchangeably throughout communications regarding changes to your pharmacy benefits. The Plan worked with a team of doctors and pharmacists to build a formulary that represents the prescription drugs we think you need for a quality treatment program. The Plan will generally cover the drugs listed in the formulary as long as the drug is medically necessary, the prescription is filled at a Plan network pharmacy, and other plan rules are followed. For more information on how to fill your medicines, please review your plan benefit materials.

This document is a partial formulary, which means it includes only some of the drugs covered by the PEEHIP Humana Group Medicare Advantage Plan. To search the complete list of all prescription drugs Humana covers, you can visit **https://our.humana.com/peehip/tools-resources/**. The Drug List Search tool lets you search for your drug by name or drug type.

If you have questions about your enrollment into the PEEHIP Humana Group Medicare Advantage Plan, please call the Group Medicare Customer Care number at 1-800-747-0008. Our representatives are available Monday through Friday, from 7 a.m. - 8 p.m. Central Time. The automated phone system may answer your call on Saturdays, Sundays, and some public holidays.

**Can the formulary change?**
Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

**Changes that can affect you this year:** In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs**. We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that 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 the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section titled "**How do I request an exception to the Formulary?**"

- **Drugs removed from the market**. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and 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 add a generic drug that is not new to market to replace a brand name drug currently on the formulary or

add new restrictions to the brand name drug or move it to a different cost sharing tier or both. Or 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, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

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 brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section titled **"How do I request an exception to the Formulary?"**

**Changes that will not affect you if you are currently taking the drug.** Generally, if you are taking a drug on our 2022 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2022 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. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List 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 happens or we will provide a 30-day refill of the affected medicine with notice of the change.

The enclosed formulary is current as of January 1, 2022. We will update the printed formularies each month and they will be available on **https://our.humana.com/peehip/plan-documents**.

To get updated information about the drugs that Humana covers, please visit **https://our.humana.com/peehip/plan-documents**.

**How do I use the formulary?**
The formulary is listed in alphabetical order.

The chart later in this document titled **"PEEHIP Humana Group Medicare Advantage Plan Coverage of Additional Prescription Drugs"** is an alphabetical list of all of the drugs included in this document. Both brand-name and generic drugs are listed.

Prescription drugs are grouped into one of four tiers.
The PEEHIP Humana Group Medicare Advantage 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 - 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 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 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 plan benefit materials or call Group Medicare Customer Care at 1-800-747-0008 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 are called Utilization Management Requirements. These requirements and limits may include:
- **Prior Authorization (PA):** The Plan requires prior authorization for certain drugs to be covered under your plan. This means that your health care provider will need to get approval from the Plan before you fill your prescriptions. If your health care provider does not get approval, the Plan may not cover the drug.
- **Quantity Limits (QL):** For some drugs, the Plan limits the amount of the drug that is covered. The 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 Plan requires that you first try certain drugs to treat your medical condition before coverage is available for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the Plan will then cover Drug B once proper documentation has been received.
- **Part B versus Part D (B vs D):** Some drugs may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted to the 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 Plan at **1-877-486-2621**. Representatives are available Monday - Friday, 8 a.m. - 8 p.m.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins in the chart later in this document titled, **"PEEHIP Humana Group Medicare Advantage Plan Coverage of Additional Prescription Drugs"**.

You can also visit **https://our.humana.com/peehip/plan-documents** to get more information about the restrictions applied to specific covered drugs (such as prior authorizations, quantity limits, and step therapy).

You can ask the Plan to make an exception to these restrictions or limits. See the section "**How do I request an exception to the formulary?**" below 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 list of covered drugs, visit **https://our.humana.com/peehip/tools-resources/** to see if your plan covers your drug. You can also call Group Medicare Customer Care at 1-800-747-0008 and ask if your drug is covered.

If the Plan does not cover your drug, you have two options:
- You can ask Group Medicare Customer Care for a list of similar drugs that the PEEHIP Humana Group Medicare Advantage Plan covers. Show the list to your doctor and ask him or her to prescribe a similar drug that is covered by the Plan.
- You can ask the Plan to make an exception and cover your drug. See below for information about how to request an exception.

Talk to your health care provider to decide if you should switch to another drug that is covered or if you should request a formulary exception so that it can be considered for coverage.

**How do I request an exception to the formulary?**
You can ask the Plan to make an exception to the coverage rules. There are several types of exceptions that you can ask to be made.
- **Formulary exception:** You can request that your drug be covered if it is not on the formulary.
- **Utilization restriction exception:** You can request coverage restrictions or limits not be applied to your drug. For example, if your drug has a quantity limit, you can ask for the limit not to be applied and to cover more doses of the drug.
- **Tier exception:** You can request a higher level of coverage for your drug. For example, if your drug is usually considered a non-preferred drug, you can request it to be covered as a preferred drug instead. This would lower how much money you must pay for your drug. Please remember a higher level of coverage cannot be requested for the drug if approval was granted to cover a drug that was not on the formulary. *You can ask us to cover a formulary drug at a lower cost-sharing level, unless the drug is on the specialty tier.*

Generally, the 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 other restrictions would not be as effective in treating your health condition and/or would cause adverse medical effects.

You should contact Group Medicare Customer Care at 1-800-747-0008 to ask for an initial coverage decision for a formulary, tier, or utilization restriction exception. When you ask for an exception, you should submit a statement from your health care provider that supports your request. This is called a supporting statement.

Generally, we must make the decision within 72 hours of receiving your health care provider's supporting statement. You can request a quicker, or expedited, exception if you or your health care provider thinks your health would seriously suffer if you wait as long as 72 hours for a decision. Once an expedited request is received, we must give you a decision no later than 24 hours after we get your health care provider's supporting statement.

**Will my plan cover my drugs if they are not on the formulary?**
You may take drugs that your plan does not cover. Or, you may talk to your provider about taking a different drug that your plan covers, but that drug might have a Utilization Management Requirement, such as a Prior Authorization or Step Therapy, that keeps you from getting the drug right away. In certain cases, we may cover as much as a 30-day supply of your drug during the first 90 days you are a member of the plan.

Here is what we will do for each of your current Part D drugs that are not on the formulary, or if you have limited ability to get your drugs:
- We will cover a 30-day transition fill of your 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 30 days of a drug) when you go to a pharmacy.
- There will be no coverage for the drugs after your first 30-day supply, even if you have been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you are a resident of a long-term care facility and you take Part D drugs that are not on the formulary, we will cover a 31-day supply 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) during the first 90 days you are a member of our plan. We will cover a 31-day emergency supply of your drug unless you have a prescription for fewer days (in which we will allow multiple fills to provide up to a total of 31 days of a drug) while you request a formulary exception if:

- You need a drug that is not on the formulary *or*
- You have limited ability to get your drugs *and*
- You are past the first 90 days of membership in the plan

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 Plan will cover as much as a 31-day transition fill 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 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 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, **https://our.Humana.com/peehip/**, in the same area where the Prescription Drug Guides are displayed.

**Opioid Usage**

Opioids are often used to treat pain after surgery or an injury. However, they carry serious risks that increase with higher doses and length of use. In accordance with CMS direction, Humana conducts various reviews of opioid claims when submitted for processing.

An opioid drug used for the treatment of acute pain may be limited to a 7-day supply for members with no recent history of opioid use. For members who are new to the plan, and have a recent history of using opioids, the limit may be overridden by the pharmacy when submitting the claim with a specific code, if deemed appropriate.

Additional quantity limits may apply across all drugs in the opioid class used for the treatment of pain. This additional limit is called a cumulative morphine milligram equivalent (MME), and is designed to monitor safe dosing levels of opioids for individuals who may be taking more than one opioid drug for pain management. The pharmacy may consult with your doctor to ensure the higher dose is appropriate and submit the claim with a specific code for processing, if deemed appropriate. Alternatively, your doctor can ask the plan to cover the additional quantity through a coverage determination.

## For More Information

For more detailed information about your Plan prescription drug coverage, please refer to your plan benefit materials.

If you have questions about Humana, please visit our website at **https://our.Humana.com/peehip/**. The Drug List Search tool on our website lets you search for your drug by name or drug type.

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**.

# PEEHIP Humana Group Medicare Advantage Plan Formulary

The formulary that begins on the next page provides coverage information about the drugs covered by the Plan. The formulary is listed in alphabetical order for your convenience.

**Remember: This is only a partial list of drugs covered by Humana.** If your prescription drug is not listed in this partial formulary, please visit our website at **https://our.humana.com/peehip/plan-documents** for a comprehensive list of covered drugs. Our additional contact information is listed on the cover page.

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.

**How to read your abbreviated formulary**
The first column of the chart lists the drug name. Next to the drug name you may see an indicator to tell you about additional coverage information for that drug. You might see the following indicators:
**MD** - Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. Members can receive quantities up to but not more than a 90-day supply of maintenance drugs and supplies.
**DL** - Dispensing Limit; Drugs that may be limited to a 30 day supply, regardless of tier placement.
**LA** - Limited Access; Drugs that the health plan has authorized certain pharmacies to dispense, as it requires extra handling, doctor coordination or patient education. Please call your PEEHIP Humana Group Medicare Customer Care team at 1-800-747-0008 (TTY/TDD 711) for additional information.

The second column lists the tier of the drug. See "**How do I use the formulary?**" for more details on the drug tiers in your plan.

The third column shows the Utilization Management Requirements for the drug. The 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 the section titled, **"Are there any restrictions on my coverage?"** for more information about these requirements.

# PEEHIP Humana Group Medicare Advantage Plan Coverage of Additional Prescription Drugs

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| ABILIFY MAINTENA 300 MG, 400 MG, INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE[DL] | 4 | QL (1 per 28 days) |
| ABILIFY MAINTENA 300 MG, 400 MG, SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE[DL] | 4 | QL (1 per 28 days) |
| ACETAMINOPHEN-COD #3 TABLET[DL] | 1 | QL (360 per 30 days) |
| ACYCLOVIR 400 MG, 800 MG, TABLET[DL] | 1 | |
| ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG, TABLET[DL] | 4 | PA,QL (90 per 30 days) |
| ADVAIR DISKUS 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; ADVAIR DISKUS 500 MCG-50 MCG/DOSE POWDER FOR INHALATION[MD] | 2 | QL (60 per 30 days) |
| ADVAIR HFA 115 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 230 MCG-21 MCG/ACTUATION AEROSOL INHALER; ADVAIR HFA 45 MCG-21 MCG/ACTUATION AEROSOL INHALER[MD] | 2 | QL (12 per 30 days) |
| AFINITOR 10 MG, 2.5 MG, 5 MG, 7.5 MG, TABLET[DL] | 4 | PA,QL (30 per 30 days) |
| AFINITOR DISPERZ 2 MG, 3 MG, 5 MG, TABLET FOR ORAL SUSPENSION[DL] | 4 | PA |
| AIMOVIG AUTOINJECTOR 140 MG/ML, SUBCUTANEOUS AUTO-INJECTOR[DL] | 3 | PA,QL (1 per 30 days) |
| AIMOVIG AUTOINJECTOR 70 MG/ML, SUBCUTANEOUS AUTO-INJECTOR[DL] | 3 | PA,QL (2 per 30 days) |
| ALBUTEROL HFA 90 MCG INHALER[MD] | 1 | QL (36 per 30 days) |
| ALENDRONATE SODIUM 35 MG, 70 MG, TAB[MD] | 1 | QL (4 per 28 days) |
| ALLOPURINOL 100 MG, 300 MG, TABLET[MD] | 1 | |
| ALPHAGAN P 0.1 %, EYE DROPS[MD] | 2 | |
| ALPRAZOLAM 0.25 MG, 0.5 MG, 1 MG, TABLET[DL] | 1 | QL (120 per 30 days) |
| ALUNBRIG 180 MG, 90 MG, 90 MG (7)- 180 MG (23), TABLET; ALUNBRIG 90 MG (7)-180 MG (23) TABLETS IN A DOSE PACK[DL] | 4 | PA,QL (30 per 30 days) |
| ALUNBRIG 30 MG, TABLET[DL] | 4 | PA,QL (180 per 30 days) |
| AMIODARONE HCL 100 MG, 200 MG, TABLET[MD] | 1 | |
| AMITRIPTYLINE HCL 10 MG, 100 MG, 150 MG, 25 MG, 50 MG, 75 MG, TAB[MD] | 1 | |
| AMLODIPINE BESYLATE 10 MG, 2.5 MG, 5 MG, TAB[MD] | 1 | |
| AMLODIPINE-BENAZEPRIL 10-20 MG, 2.5-10 MG, 5-10 MG, 5-20 MG,; AMLODIPINE-BENAZEPRIL 2.5-10[MD] | 1 | QL (60 per 30 days) |
| AMOX-CLAV 250-125 MG, 500-125 MG, 875-125 MG, TABLET[DL] | 1 | |
| AMOXICILLIN 250 MG, 500 MG, CAPSULE[DL] | 1 | |
| ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION[MD] | 2 | QL (60 per 30 days) |
| ANUCORT-HC 25 MG, SUPPOSITORY[DL] | 1 | |
| ARIPIPRAZOLE 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG, TABLET[MD] | 1 | |
| ARISTADA 1,064 MG/3.9 ML, SUSPENSION, EXTEND.REL. IM SYRINGE[DL] | 4 | QL (3.9 per 56 days) |
| ARISTADA 441 MG/1.6 ML, SUSPENSION, EXTEND.REL. IM SYRINGE[DL] | 4 | QL (1.6 per 28 days) |
| ARISTADA 662 MG/2.4 ML, SUSPENSION, EXTEND.REL. IM SYRINGE[DL] | 4 | QL (2.4 per 28 days) |

Your plan has additional coverage of some drugs. These drugs are not normally covered under Medicare Part D. These drugs are not subject to the Medicare appeals process.

B vs D - Part B vs Part D • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
DL – Dispensing Limit • LA – Limited Access • MD – Maintenance Drug

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| ARISTADA 882 MG/3.2 ML, SUSPENSION, EXTEND.REL. IM SYRINGE[DL] | 4 | QL (3.2 per 28 days) |
| ARISTADA INITIO 675 MG/2.4 ML, SUSPENSION, EXTEND.REL. IM SYRINGE[DL] | 4 | QL (2.4 per 42 days) |
| ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION, POWDER FOR INHALATION[MD] | 2 | QL (30 per 30 days) |
| ATENOLOL 100 MG, 25 MG, 50 MG, TABLET[MD] | 1 | |
| ATORVASTATIN 10 MG, 20 MG, 40 MG, 80 MG, TABLET[MD] | 1 | |
| AURYXIA 210 MG IRON, TABLET[MD] | 3 | PA,QL (360 per 30 days) |
| 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) |
| AVAR 10 %-5 % (W/W) TOPICAL CLEANSER[DL] | 1 | |
| AZITHROMYCIN 250 MG, 500 MG, 600 MG, TABLET[DL] | 1 | |
| BACLOFEN 10 MG, 20 MG, TABLET[MD] | 1 | |
| BAQSIMI 3 MG/ACTUATION, NASAL SPRAY[DL] | 2 | |
| BD ALCOHOL SWABS[MD] | 1 | |
| BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG, 900 MCG, BUCCAL FILM[DL] | 3 | QL (60 per 30 days) |
| BELLADONNA-OPIUM 16.2-30 SUPP; BELLADONNA-OPIUM 16.2-60 SUPP[DL] | 1 | |
| BELLADONNA-PHENOBARBITAL TAB[DL] | 1 | |
| BELSOMRA 10 MG, TABLET[DL] | 2 | QL (60 per 30 days) |
| BELSOMRA 15 MG, 20 MG, TABLET[DL] | 2 | QL (30 per 30 days) |
| BELSOMRA 5 MG, TABLET[DL] | 2 | QL (120 per 30 days) |
| BENAZEPRIL HCL 10 MG, 20 MG, 40 MG, 5 MG, TABLET[MD] | 1 | |
| BENZONATATE 100 MG, 150 MG, 200 MG, CAPSULE[DL] | 1 | |
| BENZTROPINE MES 0.5 MG, 1 MG, 2 MG, TAB; BENZTROPINE MES 0.5 MG, 1 MG, 2 MG, TABLET[DL] | 1 | |
| BETASERON 0.3 MG, SUBCUTANEOUS KIT[DL] | 3 | QL (15 per 30 days) |
| BETHKIS 300 MG/4 ML, SOLUTION FOR NEBULIZATION[DL] | 4 | PA |
| BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER[MD] | 3 | QL (10.7 per 30 days) |
| BIKTARVY 50 MG-200 MG-25 MG TABLET[DL] | 4 | QL (30 per 30 days) |
| BREO ELLIPTA 100 MCG-25 MCG/DOSE POWDER FOR INHALATION; BREO ELLIPTA 200 MCG-25 MCG/DOSE POWDER FOR INHALATION[MD] | 2 | QL (60 per 30 days) |
| BREZTRI AEROSPHERE 160 MCG-9MCG-4.8MCG/ACTUATION HFA AEROSOL INHALER[DL] | 2 | QL (10.7 per 30 days) |
| BRILINTA 60 MG, 90 MG, TABLET[MD] | 2 | QL (60 per 30 days) |
| BRIMONIDINE 0.2% EYE DROP; BRIMONIDINE TARTRATE 0.15% DRP[MD] | 1 | |
| BUMETANIDE 0.5 MG, 1 MG, 2 MG, TABLET[MD] | 1 | |
| BUPROPION HCL SR 150 MG, TABLET[MD] | 1 | QL (90 per 30 days) |
| BUPROPION HCL XL 300 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| BUSPIRONE HCL 10 MG, 15 MG, 30 MG, 5 MG, 7.5 MG, TABLET[DL] | 1 | |
| BYDUREON 2 MG PEN INJECT[MD] | 3 | QL (4 per 28 days) |
| BYDUREON BCISE 2 MG/0.85 ML, SUBCUTANEOUS AUTO-INJECTOR[MD] | 3 | QL (3.4 per 28 days) |

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DL – Dispensing Limit • LA – Limited Access • MD – Maintenance Drug

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| BYSTOLIC 10 MG, TABLET[MD] | 2 | QL (120 per 30 days) |
| BYSTOLIC 2.5 MG, 5 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| BYSTOLIC 20 MG, TABLET[MD] | 2 | QL (60 per 30 days) |
| CABOMETYX 20 MG, 40 MG, 60 MG, TABLET[DL] | 4 | PA,QL (30 per 30 days) |
| CARBIDOPA-LEVO 10-100 MG, 25-100 MG, 25-250 MG, ODT; CARBIDOPA-LEVODOPA 10-100 TAB; CARBIDOPA-LEVODOPA 25-100 TAB; CARBIDOPA-LEVODOPA 25-250 TAB[MD] | 1 | |
| CARVEDILOL 12.5 MG, 25 MG, 3.125 MG, 6.25 MG, TABLET[MD] | 1 | |
| CEFDINIR 300 MG, CAPSULE[DL] | 1 | |
| CELECOXIB 100 MG, 200 MG, 400 MG, 50 MG, CAPSULE[MD] | 1 | QL (60 per 30 days) |
| CEPHALEXIN 250 MG, 500 MG, 750 MG, CAPSULE[DL] | 1 | |
| CERDELGA 84 MG, CAPSULE[DL] | 4 | PA |
| CEREZYME 400 UNIT, INTRAVENOUS SOLUTION[DL] | 4 | PA |
| CETROTIDE 0.25 MG, SUBCUTANEOUS KIT[DL] | 3 | |
| CHLORHEXIDINE 0.12% RINSE[DL] | 1 | |
| CHLORTHALIDONE 25 MG, 50 MG, TABLET[MD] | 1 | |
| CHOLINE MAG TRISAL LIQUID[DL] | 1 | |
| CIPROFLOX-DEXAMETH OTIC SUSP[DL] | 1 | |
| CIPROFLOXACIN HCL 100 MG, 250 MG, 500 MG, 750 MG, TAB[DL] | 1 | |
| CITALOPRAM HBR 10 MG, 40 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| CITALOPRAM HBR 20 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| CLEANSING WASH 10 %-4 %-10 % TOPICAL CLEANSER[DL] | 1 | |
| CLINDAMYCIN HCL 150 MG, 300 MG, 75 MG, CAPSULE[DL] | 1 | |
| CLOMIPHENE CITRATE 50 MG, TAB[DL] | 1 | |
| CLONAZEPAM 0.125 MG, 0.25 MG, 0.5 MG, 1 MG, 2 MG ODT; CLONAZEPAM 0.5 MG, 1 MG, 2 MG TABLET[MD] | 1 | |
| CLONIDINE HCL 0.1 MG, 0.2 MG, 0.3 MG, TABLET[MD] | 1 | |
| CLOPIDOGREL 75 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| CLOTRIMAZOLE-BETAMETHASONE CRM[DL] | 1 | QL (180 per 30 days) |
| COMBIGAN 0.2 %-0.5 % EYE DROPS[MD] | 2 | QL (5 per 25 days) |
| COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION[MD] | 2 | QL (4 per 20 days) |
| COPAXONE 20 MG/ML, SUBCUTANEOUS SYRINGE[DL] | 3 | PA,QL (30 per 30 days) |
| COPAXONE 40 MG/ML, SUBCUTANEOUS SYRINGE[DL] | 3 | PA,QL (12 per 28 days) |
| CORLANOR 5 MG, 7.5 MG, TABLET[MD] | 3 | PA,QL (60 per 30 days) |
| CORTANE-B 1 %-1 %-0.1 % LOTION[DL] | 3 | |
| CORTI-SAV 1 %-1 % TOPICAL CREAM[DL] | 1 | |
| COSENTYX 150 MG/ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (8 per 28 days) |
| COSENTYX 300 MG/2 SYRINGES (150 MG/ML,) SUBCUTANEOUS[DL] | 4 | PA,QL (8 per 28 days) |
| COSENTYX PEN 150 MG/ML, SUBCUTANEOUS[DL] | 4 | PA,QL (8 per 28 days) |
| COSENTYX PEN 300 MG/2 PENS (150 MG/ML,) SUBCUTANEOUS[DL] | 4 | PA,QL (8 per 28 days) |

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DL – Dispensing Limit • LA – Limited Access • MD – Maintenance Drug

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| COVARYX 1.25 MG-2.5 MG TABLET[DL] | 1 | |
| COVARYX H.S. 0.625 MG-1.25 MG TABLET[DL] | 1 | |
| CREON 12,000-38,000-60,000 UNIT CAPSULE,DELAYED RELEASE; CREON 24,000-76,000-120,000 UNIT CAPSULE,DELAYED RELEASE; CREON 3,000 UNIT-9,500 UNIT-15,000 UNIT CAPSULE,DELAYED RELEASE; CREON 36,000 UNIT-114,000 UNIT-180,000 UNIT CAPSULE,DELAYED RELEASE; CREON 6,000-19,000-30,000 UNIT CAPSULE,DELAYED RELEASE[MD] | 2 | |
| CYANOCOBALAMIN 1,000 MCG/ML,[DL] | 1 | |
| CYCLOBENZAPRINE 10 MG, 5 MG, TABLET[DL] | 1 | |
| CYTRA-K CRYSTALS PACKET[DL] | 1 | |
| DALIRESP 250 MCG, TABLET[MD] | 2 | QL (28 per 365 days) |
| DALIRESP 500 MCG, TABLET[MD] | 2 | QL (30 per 30 days) |
| DANTROLENE SODIUM 100 MG, 25 MG, 50 MG, CAP[DL] | 1 | |
| DAPTOMYCIN 350 MG, 500 MG, VIAL[DL] | 1 | |
| DERMAZENE CREAM[DL] | 1 | |
| DESCOVY 200 MG-25 MG TABLET[DL] | 4 | QL (30 per 30 days) |
| DESMOPRESSIN ACETATE 0.1 MG, TB[DL] | 1 | QL (180 per 30 days) |
| DESMOPRESSIN ACETATE 0.2 MG, TB[DL] | 1 | |
| DEXILANT 30 MG, 60 MG, CAPSULE, DELAYED RELEASE[MD] | 3 | QL (30 per 30 days) |
| DEXTROAMP-AMPHETAM 10 MG, 12.5 MG, 15 MG, 20 MG, 5 MG, 7.5 MG, TAB; DEXTROAMP-AMPHETAMIN 10 MG, 12.5 MG, 15 MG, 20 MG, 5 MG, 7.5 MG, TAB; DEXTROAMP-AMPHETAMINE 10 MG, 12.5 MG, 15 MG, 20 MG, 5 MG, 7.5 MG, TAB[DL] | 1 | QL (90 per 30 days) |
| DIAZEPAM 2 MG, 5 MG, TABLET[DL] | 1 | QL (90 per 30 days) |
| DICLOFENAC SOD EC 25 MG, 50 MG, 75 MG, TAB[MD] | 1 | |
| DICLOFENAC SODIUM 1% GEL[MD] | 1 | |
| DICYCLOMINE 10 MG, CAPSULE[DL] | 1 | |
| DIFICID 200 MG, TABLET[DL] | 4 | |
| DIFICID 40 MG/ML, ORAL SUSPENSION[DL] | 4 | |
| DIGOXIN 125 MCG TABLET; DIGOXIN 250 MCG TABLET[MD] | 1 | QL (30 per 30 days) |
| DILTIAZEM 24H ER(CD) 120 MG, 180 MG, 240 MG, CP; DILTIAZEM 24HR ER 120 MG, 180 MG, 240 MG, CAP[MD] | 1 | QL (60 per 30 days) |
| DIVALPROEX SOD DR 125 MG, 250 MG, 500 MG, TAB[MD] | 1 | |
| DIVALPROEX SOD ER 250 MG, 500 MG, TAB[MD] | 1 | |
| DONEPEZIL HCL 10 MG, 5 MG, TABLET; DONEPEZIL HCL ODT 10 MG, 5 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| DONEPEZIL HCL 10 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| DORZOLAMIDE-TIMOLOL EYE DROPS[MD] | 1 | |
| DOXAZOSIN MESYLATE 1 MG, 2 MG, 4 MG, 8 MG, TAB[MD] | 1 | |
| DOXYCYCLINE HYCLATE 100 MG, 50 MG, CAP[DL] | 1 | |
| DRITHOCREME HP 1 %, TOPICAL[DL] | 3 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| DULOXETINE HCL DR 20 MG, 30 MG, 40 MG, 60 MG, CAP[MD] | 1 | QL (60 per 30 days) |
| DUPIXENT 200 MG/1.14 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (3.42 per 28 days) |
| DUPIXENT 300 MG/2 ML, SUBCUTANEOUS PEN INJECTOR[DL] | 4 | PA,QL (6 per 28 days) |
| DUPIXENT 300 MG/2 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (6 per 28 days) |
| DUREZOL 0.05 %, EYE DROPS[DL] | 2 | |
| ED-SPAZ 0.125 MG, DISINTEGRATING TABLET[DL] | 1 | |
| EEMT 1.25 MG-2.5 MG TABLET[DL] | 1 | |
| EEMT HS 0.625 MG-1.25 MG TABLET[DL] | 1 | |
| EFFER-K 10 MEQ, 20 MEQ, EFFERVESCENT TABLET[DL] | 3 | |
| EFFER-K 25 MEQ, EFFERVESCENT TABLET[DL] | 3 | |
| ELELYSO 200 UNIT, INTRAVENOUS SOLUTION[DL] | 4 | PA |
| ELIQUIS 2.5 MG, TABLET[MD] | 2 | QL (60 per 30 days) |
| ELIQUIS 5 MG, TABLET[MD] | 2 | QL (74 per 30 days) |
| ELIQUIS DVT-PE TREATMENT 30-DAY STARTER 5 MG (74 TABLETS) IN DOSE PACK[MD] | 2 | QL (74 per 30 days) |
| EMGALITY 120 MG/ML, SUBCUTANEOUS SYRINGE[DL] | 3 | PA,QL (2 per 30 days) |
| EMGALITY PEN 120 MG/ML, SUBCUTANEOUS PEN INJECTOR[DL] | 3 | PA,QL (2 per 30 days) |
| ENALAPRIL MALEATE 10 MG, 2.5 MG, 20 MG, 5 MG, TAB; ENALAPRIL MALEATE 10 MG, 2.5 MG, 20 MG, 5 MG, TABLET[MD] | 1 | |
| ENBREL 25 MG (1 ML), 25 MG/0.5 ML, SUBCUTANEOUS POWDER FOR SOLUTION; ENBREL 25 MG (1 ML), 25 MG/0.5 ML, SUBCUTANEOUS SOLUTION[DL] | 4 | PA,QL (8 per 28 days) |
| ENBREL 25 MG/0.5 ML (0.5 ML) SUBCUTANEOUS SYRINGE; ENBREL 25 MG/0.5 ML (0.5), 50 MG/ML (1 ML), SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (8 per 28 days) |
| ENBREL MINI 50 MG/ML (1 ML), SUBCUTANEOUS CARTRIDGE[DL] | 4 | PA,QL (8 per 28 days) |
| ENBREL SURECLICK 50 MG/ML (1 ML), SUBCUTANEOUS PEN INJECTOR[DL] | 4 | PA,QL (8 per 28 days) |
| ENOXAPARIN 100 MG/ML, 150 MG/ML, SYRINGE[DL] | 1 | QL (28 per 28 days) |
| ENOXAPARIN 120 MG/0.8 ML, 80 MG/0.8 ML, SYR[DL] | 1 | QL (22.4 per 28 days) |
| ENOXAPARIN 30 MG/0.3 ML, 60 MG/0.6 ML, SYR[DL] | 1 | QL (16.8 per 28 days) |
| ENOXAPARIN 300 MG/3 ML, VIAL[DL] | 1 | QL (84 per 28 days) |
| ENOXAPARIN 40 MG/0.4 ML, SYR[DL] | 1 | QL (11.2 per 28 days) |
| ENSTILAR 0.005 %-0.064 % TOPICAL FOAM[DL] | 3 | QL (120 per 30 days) |
| ENTRESTO 24 MG-26 MG TABLET; ENTRESTO 49 MG-51 MG TABLET; ENTRESTO 97 MG-103 MG TABLET[MD] | 2 | QL (60 per 30 days) |
| ENVARSUS XR 0.75 MG, 1 MG, 4 MG, TABLET,EXTENDED RELEASE[MD] | 3 | PA |
| EPCLUSA 200 MG-50 MG TABLET; EPCLUSA 400 MG-100 MG TABLET[DL] | 4 | PA,QL (28 per 28 days) |
| EPIDIOLEX 100 MG/ML, ORAL SOLUTION[DL] | 4 | PA |
| ERIVEDGE 150 MG, CAPSULE[DL] | 4 | PA,QL (28 per 28 days) |
| ERLEADA 60 MG, TABLET[DL] | 4 | PA,QL (120 per 30 days) |
| ESBRIET 267 MG, CAPSULE[DL,LA] | 4 | PA,QL (270 per 30 days) |
| ESBRIET 267 MG, TABLET[DL,LA] | 4 | PA,QL (270 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| ESBRIET 801 MG, TABLET[DL,LA] | 4 | PA,QL (90 per 30 days) |
| ESCITALOPRAM 10 MG, TABLET[MD] | 1 | QL (45 per 30 days) |
| ESOMEPRAZOLE MAG DR 20 MG, 40 MG, CAP[MD] | 1 | QL (60 per 30 days) |
| ESTRADIOL 0.5 MG, 1 MG, 2 MG, TABLET[DL] | 1 | |
| ESTROGEN-METHYLTESTOS F.S. TAB; ESTROGEN-METHYLTESTOS H.S. TAB[DL] | 1 | |
| ETHYL CHLORIDE SPRAY[DL] | 1 | |
| EZETIMIBE 10 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| FAMOTIDINE 20 MG, 40 MG, TABLET[MD] | 1 | |
| FARXIGA 10 MG, 5 MG, TABLET[MD] | 3 | QL (30 per 30 days) |
| FASENRA PEN 30 MG/ML, SUBCUTANEOUS AUTO-INJECTOR[DL] | 4 | PA,QL (1 per 28 days) |
| FEM PH 0.9 %-0.025 % VAGINAL GEL[DL] | 3 | |
| FENOFIBRATE 160 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| FENTANYL 100 MCG/HR, 12 MCG/HR, 25 MCG/HR, 37.5 MCG/HOUR, 50 MCG/HR, 62.5 MCG/HOUR, 75 MCG/HR, 87.5 MCG/HOUR, PATCH; FENTANYL 37.5 MCG/HR PATCH; FENTANYL 62.5 MCG/HR PATCH; FENTANYL 87.5 MCG/HR PATCH[DL] | 1 | QL (20 per 30 days) |
| FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN[MD] | 2 | |
| FIASP PENFILL U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS CARTRIDGE[MD] | 2 | |
| FIASP U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| FINASTERIDE 5 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION, POWDER FOR INHALATION[MD] | 2 | QL (60 per 30 days) |
| FLOVENT HFA 110 MCG/ACTUATION, 220 MCG/ACTUATION, AEROSOL INHALER[MD] | 2 | QL (24 per 30 days) |
| FLOVENT HFA 44 MCG/ACTUATION, AEROSOL INHALER[MD] | 2 | QL (10.6 per 30 days) |
| FLUCONAZOLE 100 MG, 150 MG, 200 MG, 50 MG, TABLET[DL] | 1 | |
| FLUOXETINE HCL 10 MG, 40 MG, CAPSULE[MD] | 1 | QL (60 per 30 days) |
| FLUOXETINE HCL 20 MG, CAPSULE[MD] | 1 | QL (120 per 30 days) |
| FLUTICASONE PROP 50 MCG SPRAY[MD] | 1 | QL (16 per 30 days) |
| FOLIC ACID 1 MG, TABLET[MD] | 1 | |
| FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML, SUBCUTANEOUS CARTRIDGE[DL] | 3 | |
| FORTEO 20 MCG/DOSE (620 MCG/2.48 ML) SUBCUTANEOUS PEN INJECTOR[DL] | 4 | PA,QL (2.48 per 28 days) |
| FUROSEMIDE 20 MG, 40 MG, 80 MG, TABLET[MD] | 1 | |
| GABAPENTIN 100 MG, 300 MG, 400 MG, CAPSULE[MD] | 1 | QL (270 per 30 days) |
| GABAPENTIN 600 MG, 800 MG, TABLET[MD] | 1 | QL (180 per 30 days) |
| GALZIN 25 MG (ZINC), 50 MG (ZINC), CAPSULE[DL] | 3 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| GAMUNEX-C 1 GRAM/10 ML (10 %), 10 GRAM/100 ML (10 %), 2.5 GRAM/25 ML (10 %), 20 GRAM/200 ML (10 %), 40 GRAM/400 ML (10 %), 5 GRAM/50 ML (10 %), INJECTION SOLUTION[DL] | 4 | PA |
| GANIRELIX ACET 250 MCG/0.5 ML,[DL] | 3 | |
| GEMTESA 75 MG, TABLET[DL] | 3 | QL (30 per 30 days) |
| GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET[DL] | 4 | QL (30 per 30 days) |
| GILENYA 0.25 MG, 0.5 MG, CAPSULE[MD] | 3 | QL (30 per 30 days) |
| GLIMEPIRIDE 1 MG, 2 MG, 4 MG, TABLET[MD] | 1 | |
| GLIPIZIDE 10 MG, 5 MG, TABLET[MD] | 1 | |
| GLIPIZIDE ER 10 MG, 2.5 MG, 5 MG, TABLET[MD] | 1 | |
| GLUCAGEN HYPOKIT 1 MG, INJECTION[DL] | 2 | |
| GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET[MD] | 2 | QL (30 per 30 days) |
| GONAL-F 1,050 UNIT, 450 UNIT, SUBCUTANEOUS SOLUTION[DL] | 3 | |
| GONAL-F RFF 75 UNIT, SUBCUTANEOUS SOLUTION[DL] | 3 | |
| GONAL-F RFF REDI-JECT 300 UNIT/0.5 ML SUBCUTANEOUS PEN INJECTOR; GONAL-F RFF REDI-JECT 450 UNIT/0.75 ML SUBCUTANEOUS PEN INJECTOR; GONAL-F RFF REDI-JECT 900 UNIT/1.5 ML SUBCUTANEOUS PEN INJECTOR[DL] | 3 | |
| GVOKE HYPOPEN 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS AUTO-INJECTOR[DL] | 2 | |
| GVOKE PFS 1-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS SYRINGE[DL] | 2 | |
| GVOKE PFS 2-PACK 0.5 MG/0.1 ML, 1 MG/0.2 ML, SUBCUTANEOUS SYRINGE[DL] | 2 | |
| HARVONI 33.75 MG-150 MG ORAL PELLETS IN PACKET[DL] | 4 | PA,QL (28 per 28 days) |
| HARVONI 45 MG-200 MG ORAL PELLETS IN PACKET[DL] | 4 | PA,QL (56 per 28 days) |
| HARVONI 45 MG-200 MG TABLET; HARVONI 90 MG-400 MG TABLET[DL] | 4 | PA,QL (28 per 28 days) |
| HEMMOREX-HC 25 MG, RECTAL SUPPOSITORY[DL] | 1 | |
| HERCEPTIN HYLECTA 600 MG-10,000 UNIT/5 ML, SUBCUTANEOUS SOLUTION[DL] | 4 | PA,QL (5 per 21 days) |
| HOMATROPAIRE 5 %, EYE DROPS[DL] | 1 | |
| HOMATROPINE 5% EYE DROPS[DL] | 1 | |
| HUMALOG JUNIOR KWIKPEN (U-100) 100 UNIT/ML, SUBCUTANEOUS HALF-UNIT PEN[MD] | 2 | |
| HUMALOG KWIKPEN (U-100) INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML), SUBCUTANEOUS; HUMALOG KWIKPEN U-200 INSULIN 100 UNIT/ML, 200 UNIT/ML (3 ML), SUBCUTANEOUS[MD] | 2 | |
| HUMALOG MIX 50-50 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION[MD] | 2 | |
| HUMALOG MIX 50-50 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN[MD] | 2 | |
| HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION[MD] | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| HUMALOG MIX 75-25 KWIKPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN[MD] | 2 | |
| HUMALOG U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS CARTRIDGE[MD] | 2 | |
| HUMALOG U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| HUMIRA 10 MG/0.2 ML, SYRINGE[DL] | 4 | PA,QL (2 per 28 days) |
| HUMIRA 20 MG/0.4 ML, 40 MG/0.8 ML, SUBCUTANEOUS SYRINGE KIT; HUMIRA 20 MG/0.4 ML, 40 MG/0.8 ML, SYRINGE[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN 40 MG/0.8 ML, SUBCUTANEOUS KIT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML, SUBCUT KIT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML, SUBCUT KT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) 10 MG/0.1 ML, SUBCUTANEOUS SYRINGE KIT[DL] | 4 | PA,QL (2 per 28 days) |
| HUMIRA(CF) 20 MG/0.2 ML, 40 MG/0.4 ML, SUBCUTANEOUS SYRINGE KIT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML, SUBCUT SYR KIT; HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML, SUBCUT SYRINGE KIT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML, SUBCUTANEOUS KIT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML, SUBCUT KT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT[DL] | 4 | PA,QL (6 per 28 days) |
| HUMULIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION[MD] | 2 | |
| HUMULIN 70/30 U-100 INSULIN KWIKPEN 100 UNIT/ML SUBCUTANEOUS[MD] | 2 | |
| HUMULIN N NPH U-100 INSULIN (ISOPHANE SUSP) 100 UNIT/ML, SUBCUTANEOUS[MD] | 2 | |
| HUMULIN N NPH U-100 INSULIN KWIKPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS[MD] | 2 | |
| HUMULIN R REGULAR U-100 INSULIN 100 UNIT/ML, INJECTION SOLUTION[MD] | 2 | |
| HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML), SUBCUTANEOUS[MD] | 2 | |
| HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML, SUBCUTANEOUS SOLN[MD] | 2 | |
| HYCODAN (WITH HOMATROPINE) 5 MG-1.5 MG/5 ML ORAL SYRUP[DL] | 1 | |
| HYDRALAZINE 10 MG, 100 MG, 25 MG, 50 MG, TABLET[MD] | 1 | |
| HYDROCHLOROTHIAZIDE 12.5 MG, 25 MG, 50 MG, TAB; HYDROCHLOROTHIAZIDE 12.5 MG, 25 MG, 50 MG, TB[MD] | 1 | |
| HYDROCODONE-ACETAMIN 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG,; HYDROCODONE-ACETAMIN 2.5-325; HYDROCODONE-ACETAMIN 7.5-325[DL] | 1 | QL (360 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| HYDROCODONE-CHLORPHEN ER SUSP[DL] | 1 | |
| HYDROCODONE-HOMATROPINE 5-1.5[DL] | 1 | |
| HYDROCODONE-HOMATROPINE SOLN[DL] | 1 | |
| HYDROCORT-PRAMOXINE 2.5%-1% CM; HYDROCORT-PRAMOXINE 2.5-1% CRM[DL] | 1 | |
| HYDROCORT-PRAMOXINE 2.5-1% CRM[DL] | 1 | |
| HYDROCORTISONE 1% CREAM; HYDROCORTISONE 2.5% CREAM[DL] | 1 | QL (240 per 30 days) |
| HYDROCORTISONE AC 25 MG, 30 MG, SUPP[DL] | 1 | |
| HYDROCORTISONE-IODOQUINOL CRM[DL] | 1 | |
| HYDROMET 5 MG-1.5 MG/5 ML ORAL SYRUP[DL] | 1 | |
| HYDROXOCOBALAMIN 1,000 MCG/ML,[DL] | 3 | |
| HYDROXYCHLOROQUINE 200 MG, TAB[DL] | 1 | |
| HYDROXYZINE HCL 10 MG, 25 MG, 50 MG, TABLET[DL] | 1 | |
| HYDROXYZINE PAM 100 MG, 25 MG, 50 MG, CAP[DL] | 1 | |
| HYOSCYAMINE 0.125 MG, ODT; HYOSCYAMINE 0.125 MG, TAB SL; HYOSCYAMINE SULF 0.125 MG, TAB[DL] | 1 | |
| HYOSCYAMINE 0.125 MG/5 ML, ELIX[DL] | 1 | |
| HYOSCYAMINE 0.125 MG/ML, DROP[DL] | 1 | |
| HYOSCYAMINE ER 0.375 MG, TAB[DL] | 1 | |
| HYOSYNE 0.125 MG/5 ML, ORAL ELIXIR[DL] | 1 | |
| HYOSYNE 0.125 MG/ML, ORAL DROPS[DL] | 1 | |
| 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) |
| IBUPROFEN 400 MG, 600 MG, 800 MG, TABLET[MD] | 1 | |
| ILEVRO 0.3 %, EYE DROPS,SUSPENSION[DL] | 2 | QL (3 per 30 days) |
| IMBRUVICA 140 MG, 280 MG, TABLET[DL] | 4 | PA |
| IMBRUVICA 140 MG, CAPSULE[DL] | 4 | PA,QL (90 per 30 days) |
| IMBRUVICA 420 MG, 560 MG, TABLET[DL] | 4 | PA,QL (28 per 28 days) |
| IMBRUVICA 70 MG, CAPSULE[DL] | 4 | PA,QL (28 per 28 days) |
| IMIPENEM-CILASTATIN 250 MG, 500 MG, VL[DL] | 1 | |
| INCRUSE ELLIPTA 62.5 MCG/ACTUATION, POWDER FOR INHALATION[MD] | 2 | QL (30 per 30 days) |
| INFLECTRA 100 MG, INTRAVENOUS SOLUTION[DL] | 4 | PA |
| INSULIN ASPART 100 UNIT/ML PEN[MD] | 2 | |
| INSULIN ASPART 100 UNIT/ML, CRT[MD] | 2 | |
| INSULIN ASPART 100 UNIT/ML, VL[MD] | 2 | |
| INSULIN ASPART PRO MIX70-30 PN[MD] | 2 | |
| INSULIN ASPART PRO MIX70-30 VL[MD] | 2 | |
| INSULIN LISPRO 100 UNIT/ML, PEN; INSULIN LISPRO JR 100 UNIT/ML,[MD] | 2 | |
| INSULIN LISPRO 100 UNIT/ML, VL[MD] | 2 | |
| INSULIN LISPRO MIX 75-25 KWKPN[MD] | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| INVEGA SUSTENNA 117 MG/0.75 ML, 234 MG/1.5 ML, 78 MG/0.5 ML, INTRAMUSCULAR SYRINGE[DL] | 4 | QL (1.5 per 28 days) |
| INVEGA SUSTENNA 156 MG/ML, INTRAMUSCULAR SYRINGE[DL] | 4 | QL (1 per 28 days) |
| INVEGA SUSTENNA 39 MG/0.25 ML, INTRAMUSCULAR SYRINGE[DL] | 3 | QL (1.5 per 28 days) |
| INVEGA TRINZA 273 MG/0.875 ML, INTRAMUSCULAR SYRINGE[DL] | 4 | QL (0.875 per 90 days) |
| INVEGA TRINZA 410 MG/1.315 ML, INTRAMUSCULAR SYRINGE[DL] | 4 | QL (1.315 per 90 days) |
| INVEGA TRINZA 546 MG/1.75 ML, INTRAMUSCULAR SYRINGE[DL] | 4 | QL (1.75 per 90 days) |
| INVEGA TRINZA 819 MG/2.625 ML, INTRAMUSCULAR SYRINGE[DL] | 4 | QL (2.625 per 90 days) |
| INVOKAMET 150 MG-1,000 MG TABLET; INVOKAMET 150 MG-500 MG TABLET; INVOKAMET 50 MG-1,000 MG TABLET; INVOKAMET 50 MG-500 MG TABLET[MD] | 2 | QL (60 per 30 days) |
| INVOKAMET XR 150 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 150 MG-500 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-1,000 MG TABLET, EXTENDED RELEASE; INVOKAMET XR 50 MG-500 MG TABLET, EXTENDED RELEASE[MD] | 2 | QL (60 per 30 days) |
| INVOKANA 100 MG, 300 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| IRBESARTAN 150 MG, 300 MG, 75 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| ISOSORBIDE MONONIT ER 120 MG, 30 MG, 60 MG,; ISOSORBIDE MONONIT ER 120 MG, 30 MG, 60 MG, TB[MD] | 1 | |
| ISOXSUPRINE 10 MG, 20 MG, TABLET[DL] | 1 | |
| IVERMECTIN 3 MG, TABLET[DL] | 1 | |
| JANUMET 50 MG-1,000 MG TABLET; JANUMET 50 MG-500 MG TABLET[MD] | 2 | QL (60 per 30 days) |
| JANUMET XR 100 MG-1,000 MG TABLET,EXTENDED RELEASE[MD] | 2 | QL (30 per 30 days) |
| JANUMET XR 50 MG-1,000 MG TABLET,EXTENDED RELEASE; JANUMET XR 50 MG-500 MG TABLET,EXTENDED RELEASE[MD] | 2 | QL (60 per 30 days) |
| JANUVIA 100 MG, 25 MG, 50 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| JARDIANCE 10 MG, 25 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| JENTADUETO 2.5 MG-1,000 MG TABLET; JENTADUETO 2.5 MG-500 MG TABLET; JENTADUETO 2.5 MG-850 MG TABLET[MD] | 2 | QL (60 per 30 days) |
| JENTADUETO XR 2.5 MG-1,000 MG TABLET, EXTENDED RELEASE[MD] | 2 | QL (60 per 30 days) |
| JENTADUETO XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE[MD] | 2 | QL (30 per 30 days) |
| K-PHOS ORIGINAL 500 MG, SOLUBLE TABLET[DL] | 3 | |
| KETOCONAZOLE 2% SHAMPOO[DL] | 1 | QL (120 per 30 days) |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML, SUBCUTANEOUS PEN INJECTOR[DL] | 4 | PA,QL (2.28 per 28 days) |
| KEVZARA 150 MG/1.14 ML, 200 MG/1.14 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (2.28 per 28 days) |
| KOMBIGLYZE XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE[MD] | 3 | QL (60 per 30 days) |
| KOMBIGLYZE XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE; KOMBIGLYZE XR 5 MG-500 MG TABLET,EXTENDED RELEASE[MD] | 3 | QL (30 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| KYNMOBI 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG, SUBLINGUAL FILM; KYNMOBI 10 MG-15 MG-20 MG-25 MG-30 MG SUBLINGUAL FILM[DL] | 4 | PA,QL (150 per 30 days) |
| LAMOTRIGINE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, TABLET; LAMOTRIGINE ODT 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, TABLET[MD] | 1 | |
| LANTUS SOLOSTAR U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN[MD] | 2 | |
| LANTUS U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| LATANOPROST 0.005% EYE DROPS[MD] | 1 | QL (5 per 25 days) |
| LEDIPASVIR-SOFOSBUVIR 90-400MG[DL] | 4 | PA,QL (28 per 28 days) |
| LEVEMIR FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN[MD] | 2 | |
| LEVEMIR U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| LEVETIRACETAM 1,000 MG, 500 MG, 750 MG, TABLET[MD] | 1 | |
| LEVOCETIRIZINE 5 MG, TABLET[DL] | 1 | QL (30 per 30 days) |
| LEVOFLOXACIN 250 MG, 500 MG, 750 MG, TABLET[DL] | 1 | |
| LEVOTHYROXINE 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG, TABLET[MD] | 1 | |
| LIDOCAINE 5% PATCH[DL] | 1 | PA,QL (90 per 30 days) |
| LIDOCAINE-HC 2.8-0.55% GEL[DL] | 3 | |
| LIDOCAINE-PRILOCAINE CREAM[DL] | 1 | |
| LINZESS 145 MCG, 290 MCG, 72 MCG, CAPSULE[MD] | 2 | QL (30 per 30 days) |
| LIOTHYRONINE SOD 10 MCG/ML, VL[DL] | 1 | |
| LIOTHYRONINE SOD 25 MCG, 5 MCG, 50 MCG, TAB[MD] | 1 | |
| LISINOPRIL 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG, TABLET[MD] | 1 | |
| LISINOPRIL-HCTZ 10-12.5 MG, 20-12.5 MG, 20-25 MG, TAB[MD] | 1 | |
| LITHIUM 8 MEQ/5 ML, SOLUTION[MD] | 1 | |
| LITHIUM CARBONATE 150 MG, 300 MG, 600 MG, CAP[MD] | 1 | |
| LITHIUM CARBONATE 300 MG, TAB[MD] | 1 | |
| LITHIUM CARBONATE ER 300 MG, 450 MG, TB[MD] | 1 | |
| LOKELMA 10 GRAM, 5 GRAM, ORAL POWDER PACKET[DL] | 2 | QL (30 per 30 days) |
| LORAZEPAM 0.5 MG, 1 MG, TABLET[DL] | 1 | QL (90 per 30 days) |
| LOSARTAN POTASSIUM 100 MG, 25 MG, 50 MG, TAB[MD] | 1 | QL (60 per 30 days) |
| LOSARTAN-HCTZ 100-12.5 MG, 100-25 MG, 50-12.5 MG, TAB[MD] | 1 | QL (60 per 30 days) |
| LOTEMAX 0.5 %, EYE DROPS,SUSPENSION; LOTEMAX 0.5 %, EYE GEL DROPS[DL] | 3 | |
| LOTEMAX 0.5 %, EYE OINTMENT[DL] | 3 | |
| LOTEMAX SM 0.38 %, EYE GEL DROPS[DL] | 3 | |
| LOVASTATIN 10 MG, 20 MG, 40 MG, TABLET[MD] | 1 | |
| LUMIGAN 0.01 %, EYE DROPS[MD] | 2 | QL (2.5 per 25 days) |
| LYSODREN 500 MG, TABLET[DL] | 4 | |
| LYUMJEV KWIKPEN U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS[MD] | 2 | |

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|---|---|---|
| LYUMJEV KWIKPEN U-200 INSULIN 200 UNIT/ML (3 ML), SUBCUTANEOUS[MD] | 2 | |
| LYUMJEV U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| MECLIZINE 12.5 MG, 25 MG, TABLET[DL] | 1 | |
| MELOXICAM 15 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| MELOXICAM 7.5 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| MEMANTINE HCL 10 MG, 5 MG, TABLET[MD] | 1 | PA,QL (60 per 30 days) |
| MENOPUR 75 UNIT, SUBCUTANEOUS SOLUTION[DL] | 3 | |
| MEROPENEM IV 1 GM VIAL; MEROPENEM IV 1 GRAM, 500 MG, VIAL[DL] | 1 | |
| MEROPENEM-0.9% NACL 1 GRAM/50; MEROPENEM-0.9% NACL 500 MG/50[DL] | 1 | |
| MESALAMINE ER 0.375 GRAM, CAP[MD] | 1 | QL (120 per 30 days) |
| METFORMIN HCL 1,000 MG, 500 MG, 850 MG, TABLET[MD] | 1 | |
| METFORMIN HCL ER 500 MG, TABLET[MD] | 1 | QL (120 per 30 days) |
| METHIMAZOLE 10 MG, 5 MG, TABLET[MD] | 1 | |
| METHOCARBAMOL 500 MG, 750 MG, TABLET[DL] | 1 | |
| METHOTREXATE 2.5 MG, TABLET[MD] | 1 | B vs D |
| METHYLPREDNISOLONE 4 MG, DOSEPK[DL] | 1 | |
| METOPROLOL SUCC ER 100 MG, 200 MG, 25 MG, 50 MG, TAB[MD] | 1 | QL (60 per 30 days) |
| METOPROLOL TARTRATE 100 MG, 25 MG, 37.5 MG, 50 MG, 75 MG, TAB; METOPROLOL TARTRATE 100 MG, 25 MG, 37.5 MG, 50 MG, 75 MG, TB[MD] | 1 | |
| METRONIDAZOLE 250 MG, 500 MG, TABLET[DL] | 1 | |
| MIRTAZAPINE 15 MG, 30 MG, 45 MG, 7.5 MG, TABLET[MD] | 1 | |
| MITIGARE 0.6 MG, CAPSULE[MD] | 2 | |
| MONTELUKAST SOD 10 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| MORPHINE SULF ER 15 MG, 30 MG, 60 MG, TABLET[DL] | 1 | QL (120 per 30 days) |
| MOVANTIK 12.5 MG, 25 MG, TABLET[DL] | 2 | QL (30 per 30 days) |
| MULTAQ 400 MG, TABLET[MD] | 2 | QL (60 per 30 days) |
| MUPIROCIN 2% OINTMENT[DL] | 1 | |
| MYRBETRIQ 25 MG, 50 MG, TABLET,EXTENDED RELEASE[MD] | 2 | QL (30 per 30 days) |
| NAFCILLIN 1 GM ADD-VAN VIAL; NAFCILLIN 1 GM VIAL; NAFCILLIN 10 GM BULK VIAL; NAFCILLIN 2 GM ADD-VANT VIAL; NAFCILLIN 2 GM VIAL[DL] | 1 | |
| NAFCILLIN 1 GM/ 50 ML INJ; NAFCILLIN 2 GM/ 100 ML INJ[DL] | 1 | |
| NAMZARIC 14 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 21 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 28 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE; NAMZARIC 7 MG-10 MG CAPSULE SPRINKLE,EXTENDED RELEASE[MD] | 2 | QL (30 per 30 days) |
| NAMZARIC 7/14/21/28 MG-10 MG, CAPSULE,SPRINKLE,EXTEND RELEASE,DOSE PACK[DL] | 2 | QL (28 per 28 days) |
| NAPROXEN 250 MG, 375 MG, 500 MG, TABLET; NAPROXEN DR 250 MG, 375 MG, 500 MG, TABLET[MD] | 1 | |
| NARCAN 4 MG/ACTUATION, NASAL SPRAY[DL] | 2 | QL (2 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| NATURE-THROID 113.75 MG, 130 MG, 146.25 MG, 16.25 MG, 162.5 MG, 195 MG, 260 MG, 32.5 MG, 325 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG, TABLET[MD] | 3 | |
| NEBUSAL 3 %, SOLUTION FOR NEBULIZATION[DL] | 1 | B vs D |
| NEBUSAL 6 %, SOLUTION FOR NEBULIZATION[DL] | 3 | B vs D |
| NEOMYCIN-POLYMYXIN-HC EAR SOLN[DL] | 1 | |
| NEOMYCIN-POLYMYXIN-HC EAR SUSP[DL] | 1 | |
| NEULASTA 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (1.2 per 28 days) |
| NEULASTA ONPRO 6 MG/0.6 ML, WITH WEARABLE SUBCUTANEOUS INJECTOR[DL] | 4 | PA,QL (1.2 per 28 days) |
| NEUPOGEN 300 MCG/0.5 ML, INJECTION SYRINGE[DL] | 4 | QL (7 per 30 days) |
| NEUPOGEN 300 MCG/ML, INJECTION SOLUTION[DL] | 4 | QL (14 per 30 days) |
| NEUPOGEN 480 MCG/0.8 ML, INJECTION SYRINGE[DL] | 4 | QL (11.2 per 30 days) |
| NEUPOGEN 480 MCG/1.6 ML, INJECTION SOLUTION[DL] | 4 | QL (22.4 per 30 days) |
| NEUPRO 1 MG/24 HOUR, 2 MG/24 HOUR, 3 MG/24 HOUR, 4 MG/24 HOUR, 6 MG/24 HOUR, 8 MG/24 HOUR, TRANSDERMAL 24 HOUR PATCH[MD] | 3 | QL (30 per 30 days) |
| NEXLETOL 180 MG, TABLET[DL] | 2 | PA,QL (30 per 30 days) |
| NEXLIZET 180 MG-10 MG TABLET[DL] | 2 | PA,QL (30 per 30 days) |
| NIFEDIPINE ER 30 MG, 60 MG, 90 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| NITROFURANTOIN MONO-MCR 100 MG,[DL] | 1 | |
| NITROGLYCERIN 0.3 MG, 0.4 MG, 0.6 MG, TABLET SL[MD] | 1 | |
| NIVESTYM 300 MCG/0.5 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (7 per 30 days) |
| NIVESTYM 300 MCG/ML, INJECTION SOLUTION[DL] | 4 | PA,QL (14 per 30 days) |
| NIVESTYM 480 MCG/0.8 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (11.2 per 30 days) |
| NIVESTYM 480 MCG/1.6 ML, INJECTION SOLUTION[DL] | 4 | PA,QL (22.4 per 30 days) |
| NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30), SUBCUTANEOUS[MD] | 2 | |
| NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION[MD] | 2 | |
| NOVOLIN N FLEXPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN[MD] | 2 | |
| NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML, SUBCUTANEOUS SUSP[MD] | 2 | |
| NOVOLIN R FLEXPEN 100 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN[MD] | 2 | |
| NOVOLIN R REGULAR U-100 INSULIN 100 UNIT/ML, INJECTION SOLUTION[MD] | 2 | |
| NOVOLOG FLEXPEN U-100 INSULIN ASPART 100 UNIT/ML (3 ML), SUBCUTANEOUS[MD] | 2 | |
| NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN[MD] | 2 | |
| NOVOLOG MIX 70-30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION[MD] | 2 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| NOVOLOG PENFILL U-100 INSULIN ASPART 100 UNIT/ML, SUBCUTANEOUS CARTRIDG[MD] | 2 | |
| NOVOLOG U-100 INSULIN ASPART 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| NP THYROID 120 MG, 15 MG, 30 MG, TABLET[MD] | 1 | |
| NUBEQA 300 MG, TABLET[DL] | 4 | PA,QL (120 per 30 days) |
| NUCALA 100 MG, 100 MG/ML, SUBCUTANEOUS AUTO-INJECTOR; NUCALA 100 MG, 100 MG/ML, SUBCUTANEOUS SOLUTION[DL] | 4 | PA,QL (3 per 28 days) |
| NUCALA 100 MG/ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (3 per 28 days) |
| NUZYRA 150 MG, TABLET[DL] | 4 | QL (30 per 14 days) |
| NYSTATIN 100,000 UNIT/GM CREAM[DL] | 1 | |
| ODEFSEY 200 MG-25 MG-25 MG TABLET[DL] | 4 | QL (30 per 30 days) |
| OFEV 100 MG, 150 MG, CAPSULE[DL,LA] | 4 | PA,QL (60 per 30 days) |
| OFLOXACIN 0.3% EAR DROPS[DL] | 1 | |
| OLANZAPINE 10 MG, 15 MG, 2.5 MG, 20 MG, 5 MG, 7.5 MG, TABLET[MD] | 1 | |
| OLMESARTAN MEDOXOMIL 20 MG, 40 MG, 5 MG, TAB[MD] | 1 | QL (30 per 30 days) |
| OMEPRAZOLE DR 10 MG, 20 MG, 40 MG, CAPSULE[MD] | 1 | QL (60 per 30 days) |
| OMNIPOD DASH 5 PACK INSULIN POD SUBCUTANEOUS CARTRIDGE[MD] | 2 | |
| OMNIPOD INSULIN MANAGEMENT[MD] | 2 | |
| OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE[MD] | 2 | |
| OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML), SUBCUTANEOUS CARTRIDGE[DL] | 3 | PA |
| OMNITROPE 5.8 MG, SUBCUTANEOUS SOLUTION[DL] | 3 | PA |
| ONDANSETRON HCL 4 MG, 8 MG, TABLET[DL] | 1 | B vs D,QL (90 per 30 days) |
| ONDANSETRON ODT 4 MG, 8 MG, TABLET[DL] | 1 | B vs D,QL (90 per 30 days) |
| ONGLYZA 2.5 MG, 5 MG, TABLET[MD] | 3 | QL (30 per 30 days) |
| ORACIT 490 MG-640 MG/5 ML ORAL SOLUTION[DL] | 3 | |
| ORGOVYX 120 MG, TABLET[DL] | 4 | PA,QL (32 per 30 days) |
| OSCIMIN 0.125 MG, ODT; OSCIMIN 0.125 MG, TABLET[DL] | 1 | |
| OSCIMIN SL 0.125 MG, SUBLINGUAL TABLET[DL] | 1 | |
| OSCIMIN SR 0.375 MG, TABLET,EXTENDED RELEASE[DL] | 1 | |
| OSELTAMIVIR PHOS 45 MG, 75 MG, CAPSULE[DL] | 1 | QL (112 per 365 days) |
| OSPHENA 60 MG, TABLET[DL] | 2 | PA |
| OVIDREL 250 MCG/0.5 ML, SUBCUTANEOUS SYRINGE[DL] | 3 | |
| OXYBUTYNIN 5 MG, TABLET[MD] | 1 | |
| OXYBUTYNIN CL ER 10 MG, 15 MG, 5 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| OXYCODONE HCL 10 MG, 15 MG, 20 MG, 30 MG, 5 MG, TABLET[DL] | 1 | QL (360 per 30 days) |
| OXYCODONE-ACETAMINOPHEN 10-325; OXYCODONE-ACETAMINOPHEN 5-325; OXYCODONE-ACETAMINOPHN 2.5-325; OXYCODONE-ACETAMINOPHN 7.5-325[DL] | 1 | QL (360 per 30 days) |
| OZEMPIC 0.25 MG OR 0.5 MG (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR[MD] | 2 | QL (1.5 per 28 days) |

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|---|---|---|
| OZEMPIC 1 MG/DOSE (2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), SUBCUTANEOUS PEN INJECTOR[MD] | 2 | QL (3 per 28 days) |
| PANTOPRAZOLE SOD DR 20 MG, 40 MG, TAB[MD] | 1 | QL (60 per 30 days) |
| PAREGORIC LIQUID[DL] | 1 | |
| PAROXETINE HCL 10 MG, 20 MG, TABLET[DL] | 1 | QL (30 per 30 days) |
| PAROXETINE HCL 30 MG, 40 MG, TABLET[DL] | 1 | QL (60 per 30 days) |
| PERFOROMIST 20 MCG/2 ML, SOLUTION FOR NEBULIZATION[MD] | 3 | PA,QL (120 per 30 days) |
| PERSERIS 120 MG, 90 MG, ABDOMINAL SUBCUTANEOUS EXT. RELEASE SUSPENSION SYRINGE[DL] | 4 | QL (1 per 28 days) |
| PHENAZOPYRIDINE 100 MG, 200 MG, TAB[DL] | 1 | |
| PHENOBARBITAL-BELLADONNA ELIXR[DL] | 1 | |
| PHENOHYTRO 16.2 MG-0.1037 MG-0.0194 MG TABLET[DL] | 1 | |
| PHENOHYTRO 16.2 MG-0.1037 MG-0.0194 MG/5 ML ORAL ELIXIR[DL] | 1 | |
| PHOSPHASAL 81.6 MG-10.8 MG-40.8 MG TABLET[DL] | 1 | |
| PHYTONADIONE 5 MG, TABLET[DL] | 1 | |
| PIOGLITAZONE HCL 15 MG, 30 MG, 45 MG, TABLET[MD] | 1 | QL (30 per 30 days) |
| PIPERACIL-TAZOBACT 13.5 GM VL; PIPERACIL-TAZOBACT 13.5 GRAM, 2.25 GRAM, 3.375 GRAM, 4.5 GRAM, 40.5 GRAM,; PIPERACIL-TAZOBACT 2.25 GM VL; PIPERACIL-TAZOBACT 3.375 GM VL; PIPERACIL-TAZOBACT 4.5 GM VIAL[DL] | 1 | |
| PNV-DHA 27 MG IRON-1 MG-300 MG CAPSULE[DL] | 1 | |
| PNV-SELECT 27 MG-1 MG TABLET[DL] | 1 | |
| POLYMYXIN B SULFATE VIAL[DL] | 1 | |
| POTASSIUM CL ER 10 MEQ, 15 MEQ, 20 MEQ, TABLET[MD] | 1 | |
| PRADAXA 110 MG, 150 MG, 75 MG, CAPSULE[MD] | 3 | QL (60 per 30 days) |
| PRAMIPEXOLE 0.125 MG, 0.25 MG, 0.5 MG, 0.75 MG, 1 MG, 1.5 MG, TABLET[MD] | 1 | |
| PRAMOSONE 1 %-1 % TOPICAL OINTMENT; PRAMOSONE 2.5 %- 1 % TOPICAL OINTMENT[DL] | 3 | |
| PRAVASTATIN SODIUM 10 MG, 20 MG, 40 MG, 80 MG, TAB[MD] | 1 | |
| PREDNISOLONE AC 1% EYE DROP[DL] | 1 | |
| PREDNISONE 1 MG, 10 MG, 2.5 MG, 20 MG, 5 MG, 50 MG, TABLET[DL] | 1 | B vs D |
| PREGABALIN 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG, CAPSULE[MD] | 1 | QL (90 per 30 days) |
| PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG, TABLET[MD] | 3 | |
| PREMARIN 0.625 MG/GRAM, VAGINAL CREAM[MD] | 2 | |
| PRENATAL-U 106.5 MG-1 MG CAPSULE[DL] | 1 | |
| PROCORT 1.85 %-1.15 % RECTAL CREAM[DL] | 3 | |
| PROLASTIN-C 1,000 MG (+/-)/20 ML INTRAVENOUS SOLUTION; PROLASTIN-C 1,000 MG, 1,000 MG (+/-)/20 ML, INTRAVENOUS POWDER FOR SOLUTION[DL,LA] | 4 | PA |
| PROLIA 60 MG/ML, SUBCUTANEOUS SYRINGE[MD] | 3 | QL (1 per 180 days) |
| PROMACTA 12.5 MG, 75 MG, TABLET[DL,LA] | 4 | PA,QL (60 per 30 days) |
| PROMACTA 12.5 MG, ORAL POWDER PACKET[DL,LA] | 4 | PA,QL (360 per 30 days) |
| PROMACTA 25 MG, ORAL POWDER PACKET[DL,LA] | 4 | PA,QL (180 per 30 days) |

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|---|---|---|
| PROMACTA 25 MG, TABLET[DL,LA] | 4 | PA,QL (30 per 30 days) |
| PROMACTA 50 MG, TABLET[DL,LA] | 4 | PA,QL (90 per 30 days) |
| PROMETHAZINE 12.5 MG, 25 MG, 50 MG, TABLET[DL] | 1 | |
| PROMETHAZINE VC-CODEINE 6.25 MG-5 MG-10 MG/5 ML ORAL SYRUP[DL] | 1 | |
| PROMETHAZINE-CODEINE SYRUP[DL] | 1 | |
| PROMETHAZINE-DM 6.25-15 MG/5ML[DL] | 1 | |
| PROMETHAZINE-PE-CODEINE SYRUP[DL] | 1 | |
| PROPRANOLOL 10 MG, 20 MG, 40 MG, 60 MG, 80 MG, TABLET[MD] | 1 | |
| PYLERA 140 MG-125 MG-125 MG CAPSULE[DL] | 3 | QL (120 per 30 days) |
| PYRIDOSTIGMINE BR 30 MG, 60 MG, TABLET[DL] | 1 | |
| QUETIAPINE FUMARATE 200 MG, 25 MG, 50 MG, TAB[MD] | 1 | QL (120 per 30 days) |
| RAMIPRIL 1.25 MG, 10 MG, 2.5 MG, 5 MG, CAPSULE[MD] | 1 | |
| RECTIV 0.4 % (W/W), OINTMENT[DL] | 3 | QL (30 per 30 days) |
| REGRANEX 0.01 %, TOPICAL GEL[DL] | 4 | |
| RELAGARD 0.9 %-0.025 % VAGINAL GEL[DL] | 3 | |
| RELISTOR 12 MG/0.6 ML, SUBCUTANEOUS SOLUTION[DL] | 3 | QL (36 per 30 days) |
| RELISTOR 12 MG/0.6 ML, SUBCUTANEOUS SYRINGE[DL] | 3 | QL (36 per 28 days) |
| RELISTOR 150 MG, TABLET[DL] | 3 | QL (90 per 30 days) |
| RELISTOR 8 MG/0.4 ML, SUBCUTANEOUS SYRINGE[DL] | 3 | QL (12 per 30 days) |
| REPATHA PUSHTRONEX 420 MG/3.5 ML, SUBCUTANEOUS WEARABLE INJECTOR[MD] | 2 | PA,QL (3.5 per 28 days) |
| REPATHA SURECLICK 140 MG/ML, SUBCUTANEOUS PEN INJECTOR[MD] | 2 | PA,QL (3 per 28 days) |
| REPATHA SYRINGE 140 MG/ML, SUBCUTANEOUS SYRINGE[MD] | 2 | PA,QL (3 per 28 days) |
| RESTASIS 0.05 %, EYE DROPS IN A DROPPERETTE[MD] | 2 | QL (60 per 30 days) |
| RESTASIS MULTIDOSE 0.05 %, EYE DROPS[MD] | 2 | QL (5.5 per 25 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, 40,000 UNIT/ML, INJECTION SOLUTION[DL] | 3 | PA,QL (14 per 30 days) |
| REXULTI 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG, TABLET[DL] | 3 | PA,QL (30 per 30 days) |
| RHOPRESSA 0.02 %, EYE DROPS[DL] | 2 | ST,QL (2.5 per 25 days) |
| RIFABUTIN 150 MG, CAPSULE[DL] | 1 | |
| RIFAMPIN 150 MG, 300 MG, CAPSULE[DL] | 1 | |
| RINVOQ 15 MG, TABLET,EXTENDED RELEASE[DL] | 4 | PA,QL (30 per 30 days) |
| RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML, INTRAMUSCULAR SUSP,EXTENDED RELEASE[DL] | 3 | QL (2 per 28 days) |
| RISPERDAL CONSTA 50 MG/2 ML, INTRAMUSCULAR SUSP,EXTENDED RELEASE[DL] | 4 | QL (2 per 28 days) |
| RISPERIDONE 0.25 MG, 1 MG, 2 MG, 3 MG, 4 MG, ODT; RISPERIDONE 0.25 MG, 1 MG, 2 MG, 3 MG, 4 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| RITUXAN 10 MG/ML, CONCENTRATE,INTRAVENOUS[DL] | 4 | PA |
| ROCKLATAN 0.02 %-0.005 % EYE DROPS[DL] | 2 | ST,QL (2.5 per 25 days) |

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|---|---|---|
| ROPINIROLE HCL 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG, 5 MG, TABLET[MD] | 1 | |
| ROSUVASTATIN CALCIUM 10 MG, 20 MG, 40 MG, 5 MG, TAB[MD] | 1 | |
| RYBELSUS 14 MG, 3 MG, 7 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE; RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE[MD] | 3 | ST,QL (360 per 30 days) |
| RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE[MD] | 3 | ST,QL (270 per 30 days) |
| RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE[MD] | 3 | ST,QL (300 per 30 days) |
| SALSALATE 500 MG, 750 MG, TABLET[DL] | 1 | |
| SANCUSO 3.1 MG/24 HOUR, TRANSDERMAL PATCH[DL] | 3 | QL (4 per 30 days) |
| SANTYL 250 UNIT/GRAM, TOPICAL OINTMENT[DL] | 2 | QL (180 per 30 days) |
| SAVELLA 100 MG, 12.5 MG, 25 MG, 50 MG, TABLET[MD] | 2 | QL (60 per 30 days) |
| SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK[DL] | 2 | QL (60 per 30 days) |
| SEREVENT DISKUS 50 MCG/DOSE, POWDER FOR INHALATION[MD] | 2 | QL (60 per 30 days) |
| SERTRALINE HCL 100 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| SERTRALINE HCL 25 MG, 50 MG, TABLET[MD] | 1 | QL (90 per 30 days) |
| SHINGRIX (PF) 50 MCG/0.5 ML, INTRAMUSCULAR SUSPENSION, KIT[DL] | 1 | QL (2 per 999 days) |
| SIMPONI ARIA 12.5 MG/ML, INTRAVENOUS SOLUTION[DL] | 4 | PA,QL (20 per 28 days) |
| SIMVASTATIN 10 MG, 20 MG, 40 MG, 5 MG, 80 MG, TABLET[MD] | 1 | |
| SKYRIZI 150 MG/1.66 ML(75 MG/0.83 ML X 2) SUBCUTANEOUS SYRINGE KIT; SKYRIZI 150 MG/ML, 150MG/1.66ML(75 MG/0.83 ML X2), SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (6 per 365 days) |
| SOD SULFACE-SULFUR 9-4.5% WASH; SOD SULFACET-SULFUR 10-2% CLSR; SOD SULFACET-SULFUR 10-5% CLSR[DL] | 1 | |
| SOD SULFACET-SULFUR 10-4% PAD[DL] | 1 | |
| SOD SULFACETAMIDE-SULFUR LOTN[DL] | 1 | |
| SODIUM CHLORIDE 0.9% INHAL VL; SODIUM CHLORIDE 10% VIAL; SODIUM CHLORIDE 3% VIAL[DL] | 1 | B vs D |
| SODIUM SULF-SULFUR CLEANSER[DL] | 1 | |
| SODIUM SULFACETAMIDE 10% WASH[DL] | 1 | |
| SOFOSBUVIR-VELPATASVIR 400-100[DL] | 4 | PA,QL (28 per 28 days) |
| SOLIQUA 100/33 100 UNIT-33 MCG/ML, SUBCUTANEOUS INSULIN PEN[MD] | 2 | QL (15 per 24 days) |
| SOMATULINE DEPOT 120 MG/0.5 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (0.5 per 28 days) |
| SOMATULINE DEPOT 60 MG/0.2 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (0.2 per 28 days) |
| SOMATULINE DEPOT 90 MG/0.3 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (0.3 per 28 days) |
| SPIRIVA RESPIMAT 1.25 MCG/ACTUATION, 2.5 MCG/ACTUATION, SOLUTION FOR INHALATION[MD] | 2 | QL (4 per 28 days) |
| SPIRIVA WITH HANDIHALER 18 MCG, AND INHALATION CAPSULES[MD] | 2 | QL (30 per 30 days) |
| SPIRONOLACTONE 100 MG, 25 MG, 50 MG, TABLET[MD] | 1 | |
| SPRYCEL 100 MG, 50 MG, 70 MG, 80 MG, TABLET[DL] | 4 | PA,QL (60 per 30 days) |
| SPRYCEL 140 MG, TABLET[DL] | 4 | PA,QL (30 per 30 days) |
| SPRYCEL 20 MG, TABLET[DL] | 4 | PA,QL (90 per 30 days) |

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|---|---|---|
| SSKI 1 GRAM/ML, ORAL SOLUTION[DL] | 3 | |
| SSS 10-5 10 %-5 % (W/W) TOPICAL CREAM[DL] | 1 | |
| SSS 10-5 10 %-5 % TOPICAL FOAM[DL] | 1 | |
| STELARA 45 MG/0.5 ML, SUBCUTANEOUS SOLUTION[DL] | 4 | PA,QL (1.5 per 84 days) |
| STELARA 45 MG/0.5 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (1.5 per 84 days) |
| STELARA 90 MG/ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (3 per 84 days) |
| STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION[MD] | 2 | QL (4 per 28 days) |
| STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML, SUBCUTANEOUS SOLUTION[DL] | 4 | PA |
| STRIVERDI RESPIMAT 2.5 MCG/ACTUATION, SOLUTION FOR INHALATION[MD] | 2 | QL (4 per 30 days) |
| SUCRALFATE 1 GM TABLET[MD] | 1 | |
| SULFACETAMIDE-SULFUR 10-5% CRM[DL] | 1 | |
| SULFACLEANSE 8-4 8 %-4 % TOPICAL SUSPENSION[DL] | 1 | |
| SULFAMETHOXAZOLE-TMP DS TABLET; SULFAMETHOXAZOLE-TMP SS TABLET[DL] | 1 | |
| SUMATRIPTAN SUCC 100 MG, 25 MG, 50 MG, TABLET[DL] | 1 | QL (9 per 30 days) |
| SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION[DL] | 2 | |
| SUTAB 1.479-0.188-0.225 GRAM TABLET[DL] | 3 | |
| SYMAX DUOTAB 0.125 MG AND 0.25 MG (0.375 MG) TABLET,EXTENDED RELEASE[DL] | 3 | |
| SYMAX-SL 0.125 MG, SUBLINGUAL TABLET[DL] | 1 | |
| SYMAX-SR 0.375 MG, TABLET,EXTENDED RELEASE[DL] | 1 | |
| SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER[MD] | 2 | QL (10.2 per 30 days) |
| SYNJARDY 12.5 MG-1,000 MG TABLET; SYNJARDY 12.5 MG-500 MG TABLET; SYNJARDY 5 MG-1,000 MG TABLET; SYNJARDY 5 MG-500 MG TABLET[MD] | 2 | QL (60 per 30 days) |
| SYNJARDY XR 10 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 25 MG-1,000 MG TABLET, EXTENDED RELEASE[MD] | 2 | QL (30 per 30 days) |
| SYNJARDY XR 12.5 MG-1,000 MG TABLET, EXTENDED RELEASE; SYNJARDY XR 5 MG-1,000 MG TABLET, EXTENDED RELEASE[MD] | 2 | QL (60 per 30 days) |
| SYNTHROID 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG, TABLET[MD] | 2 | |
| TAMSULOSIN HCL 0.4 MG, CAPSULE[MD] | 1 | |
| TECFIDERA 120 MG (14)- 240 MG (46), 240 MG, CAPSULE,DELAYED RELEASE; TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE[MD] | 3 | QL (60 per 30 days) |
| TECFIDERA 120 MG, CAPSULE,DELAYED RELEASE[MD] | 3 | QL (14 per 30 days) |
| TEMAZEPAM 15 MG, 22.5 MG, 30 MG, CAPSULE[DL] | 1 | QL (30 per 30 days) |
| THYROID 120 MG, 15 MG, 30 MG, 60 MG, 90 MG, TABLET[MD] | 1 | |
| TIZANIDINE HCL 2 MG, 4 MG, TABLET[MD] | 1 | |

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B vs D - Part B vs Part D • PA - Prior Authorization • QL - Quantity Limit • ST - Step Therapy
DL – Dispensing Limit • LA – Limited Access • MD – Maintenance Drug

| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| TOBI PODHALER 28 MG, CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG, INHALE CAP[DL] | 4 | PA,QL (224 per 28 days) |
| TOPIRAMATE 100 MG, 200 MG, 50 MG, TABLET[MD] | 1 | QL (120 per 30 days) |
| TORSEMIDE 10 MG, 100 MG, 20 MG, 5 MG, TABLET[MD] | 1 | |
| TOUJEO MAX U-300 SOLOSTAR 300 UNIT/ML (3 ML), SUBCUTANEOUS INSULIN PEN[MD] | 2 | |
| TOUJEO SOLOSTAR U-300 INSULIN 300 UNIT/ML (1.5 ML), SUBCUTANEOUS PEN[MD] | 2 | |
| TOVIAZ 4 MG, 8 MG, TABLET,EXTENDED RELEASE[MD] | 2 | QL (30 per 30 days) |
| TRADJENTA 5 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| TRAMADOL HCL 50 MG, TABLET[DL] | 1 | QL (240 per 30 days) |
| TRAZODONE 100 MG, 150 MG, 300 MG, 50 MG, TABLET[MD] | 1 | |
| TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION; TRELEGY ELLIPTA 200 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION[DL] | 2 | QL (60 per 30 days) |
| TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML), SUBCUTANEOUS PEN[MD] | 2 | |
| TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML), SUBCUTANEOUS PEN[MD] | 2 | |
| TRESIBA U-100 INSULIN 100 UNIT/ML, SUBCUTANEOUS SOLUTION[MD] | 2 | |
| TRIAMCINOLONE 0.025% CREAM; TRIAMCINOLONE 0.1% CREAM; TRIAMCINOLONE 0.5% CREAM[DL] | 1 | |
| TRIAMCINOLONE 0.1% PASTE[DL] | 1 | |
| TRIAMTERENE-HCTZ 37.5-25 MG, 75-50 MG, TAB; TRIAMTERENE-HCTZ 37.5-25 MG, 75-50 MG, TB[MD] | 1 | |
| TRICARE PRENATAL DHA ONE SFTGL[DL] | 1 | |
| TRIJARDY XR 10 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY XR 25 MG-5 MG-1,000 MG TABLET, EXTENDED RELEASE[DL] | 2 | QL (30 per 30 days) |
| TRIJARDY XR 12.5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE; TRIJARDY XR 5 MG-2.5 MG-1,000 MG TABLET, EXTENDED RELEASE[DL] | 2 | QL (60 per 30 days) |
| TRINTELLIX 10 MG, 20 MG, 5 MG, TABLET[MD] | 3 | QL (30 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, SUBCUTANEOUS PEN INJECTOR[MD] | 2 | QL (2 per 28 days) |
| TYKERB 250 MG, TABLET[DL] | 4 | PA,QL (180 per 30 days) |
| TYMLOS 80 MCG/DOSE (3,120 MCG/1.56 ML) SUBCUTANEOUS PEN INJECTOR[DL] | 4 | PA,QL (1.56 per 30 days) |
| UDENYCA 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (1.2 per 28 days) |
| UMECTA 40 %, TOPICAL FOAM[DL] | 3 | |
| UREA 35% FOAM[DL] | 1 | |
| UREA 39% CREAM; UREA 40% CREAM; UREA 41% CREAM; UREA 45% CREAM; UREA 47% CREAM; UREA 50% CREAM[DL] | 1 | |
| UREA 40% LOTION[DL] | 1 | |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| UREA 45% NAIL GEL[DL] | 1 | |
| URIMAR-T 120 MG-0.12 MG-10.8 MG TABLET[DL] | 3 | |
| URO-458 81 MG-10.8 MG-40.8 MG TABLET[DL] | 1 | |
| UROGESIC-BLUE 81.6 MG-40.8 MG-0.12 MG TABLET[DL] | 1 | |
| USTELL 120 MG-0.12 MG CAPSULE[DL] | 1 | |
| V-GO 20 DEVICE[MD] | 1 | |
| V-GO 30 DEVICE[MD] | 1 | |
| V-GO 40 DEVICE[MD] | 1 | |
| VALSARTAN 160 MG, 320 MG, 40 MG, 80 MG, TABLET[MD] | 1 | QL (60 per 30 days) |
| VANCO 1 GRAM/200 ML, 500 MG/100 ML, 750 MG/150 ML,-0.9% NACL; VANCOMYCIN 1 G/200ML-0.9% NACL[DL] | 1 | |
| VASCEPA 0.5 GRAM, CAPSULE[MD] | 2 | QL (240 per 30 days) |
| VASCEPA 1 GRAM, CAPSULE[MD] | 2 | QL (120 per 30 days) |
| VENLAFAXINE HCL ER 150 MG, CAP[MD] | 1 | QL (60 per 30 days) |
| VENLAFAXINE HCL ER 75 MG, CAP[MD] | 1 | QL (90 per 30 days) |
| VENTOLIN HFA 90 MCG/ACTUATION, AEROSOL INHALER[MD] | 2 | QL (36 per 30 days) |
| VERZENIO 100 MG, 150 MG, 200 MG, 50 MG, TABLET[DL] | 4 | PA,QL (60 per 30 days) |
| VICTOZA 2-PAK 0.6 MG/0.1 ML (18 MG/3 ML), SUBCUTANEOUS PEN INJECTOR[MD] | 2 | QL (9 per 30 days) |
| VICTOZA 3-PAK 0.6 MG/0.1 ML (18 MG/3 ML), SUBCUTANEOUS PEN INJECTOR[MD] | 2 | QL (9 per 30 days) |
| VIMPAT 10 MG/ML, ORAL SOLUTION[MD] | 3 | QL (1395 per 30 days) |
| VIMPAT 100 MG, 150 MG, 200 MG, 50 MG, TABLET[MD] | 3 | QL (60 per 30 days) |
| VIMPAT 200 MG/20 ML, INTRAVENOUS SOLUTION[DL] | 3 | |
| VITAMIN D2 1,250 MCG (50,000 UNIT), CAPSULE[DL] | 1 | |
| VITAMIN D2 1.25MG(50,000 UNIT)[DL] | 1 | |
| VIVITROL 380 MG, INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE[DL] | 4 | QL (1 per 28 days) |
| VOSEVI 400 MG-100 MG-100 MG TABLET[DL] | 4 | PA,QL (28 per 28 days) |
| VYZULTA 0.024 %, EYE DROPS[DL] | 3 | QL (5 per 30 days) |
| WARFARIN SODIUM 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG, TABLET[MD] | 1 | |
| WESTHROID 130 MG, 195 MG, 32.5 MG, 65 MG, 97.5 MG, TABLET[MD] | 3 | |
| WIXELA INHUB 100 MCG-50 MCG/DOSE POWDER FOR INHALATION; WIXELA INHUB 250 MCG-50 MCG/DOSE POWDER FOR INHALATION; WIXELA INHUB 500 MCG-50 MCG/DOSE POWDER FOR INHALATION[MD] | 1 | QL (60 per 30 days) |
| WP THYROID 113.75 MG, 130 MG, 16.25 MG, 32.5 MG, 48.75 MG, 65 MG, 81.25 MG, 97.5 MG, TABLET[MD] | 3 | |
| XARELTO 10 MG, 20 MG, TABLET[MD] | 2 | QL (30 per 30 days) |
| XARELTO 15 MG, 2.5 MG, TABLET[MD] | 2 | QL (60 per 30 days) |
| XARELTO DVT-PE TREATMENT 30-DAY STARTER 15 MG(42)-20 MG(9) TABLET PACK[DL] | 2 | QL (51 per 30 days) |

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| DRUG NAME | TIER | UTILIZATION MANAGEMENT REQUIREMENTS |
|---|---|---|
| XGEVA 120 MG/1.7 ML (70 MG/ML), SUBCUTANEOUS SOLUTION[DL] | 4 | PA,QL (1.7 per 28 days) |
| XIFAXAN 200 MG, TABLET[DL] | 4 | PA,QL (9 per 30 days) |
| XIFAXAN 550 MG, TABLET[DL] | 4 | PA,QL (84 per 28 days) |
| XIGDUO XR 10 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 10 MG-500 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-500 MG TABLET,EXTENDED RELEASE[MD] | 3 | QL (30 per 30 days) |
| XIGDUO XR 2.5 MG-1,000 MG TABLET,EXTENDED RELEASE; XIGDUO XR 5 MG-1,000 MG TABLET,EXTENDED RELEASE[MD] | 3 | QL (60 per 30 days) |
| XOFLUZA 20 MG, 40 MG, TABLET[DL] | 2 | QL (10 per 365 days) |
| XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG, CAPSULE SPRINKLE[DL] | 2 | QL (60 per 30 days) |
| XTANDI 40 MG, CAPSULE[DL] | 4 | PA,QL (120 per 30 days) |
| XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN[MD] | 2 | QL (15 per 30 days) |
| XUREA 39 %, TOPICAL CREAM[DL] | 1 | |
| ZARXIO 300 MCG/0.5 ML, INJECTION SYRINGE[DL] | 4 | PA,QL (7 per 30 days) |
| ZARXIO 480 MCG/0.8 ML, INJECTION SYRINGE[DL] | 4 | PA,QL (11.2 per 30 days) |
| ZENPEP 10,000 UNIT-32,000 UNIT-42,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 15,000 UNIT-47,000 UNIT-63,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 20,000 UNIT-63,000 UNIT-84,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 25,000 UNIT-79,000 UNIT-105,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 3,000 UNIT-10,000 UNIT-14,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 40,000 UNIT-126,000 UNIT-168,000 UNIT CAPSULE,DELAYED RELEASE; ZENPEP 5,000 UNIT-17,000 UNIT-24,000 UNIT CAPSULE,DELAYED RELEASE[MD] | 2 | |
| ZIEXTENZO 6 MG/0.6 ML, SUBCUTANEOUS SYRINGE[DL] | 4 | PA,QL (1.2 per 28 days) |
| ZITHRANOL 1 %, SHAMPOO[DL] | 3 | |
| ZOLPIDEM TARTRATE 10 MG, 5 MG, TABLET[DL] | 1 | QL (30 per 30 days) |
| ZUBSOLV 0.7 MG-0.18 MG SUBLINGUAL TABLET; ZUBSOLV 1.4 MG-0.36 MG SUBLINGUAL TABLET; ZUBSOLV 2.9 MG-0.71 MG SUBLINGUAL TABLET; ZUBSOLV 5.7 MG-1.4 MG SUBLINGUAL TABLET[DL] | 1 | QL (90 per 30 days) |
| ZUBSOLV 11.4 MG-2.9 MG SUBLINGUAL TABLET[DL] | 1 | QL (30 per 30 days) |
| ZUBSOLV 8.6 MG-2.1 MG SUBLINGUAL TABLET[DL] | 1 | QL (60 per 30 days) |
| ZYPITAMAG 1 MG, 2 MG, 4 MG, TABLET[DL] | 2 | ST,QL (30 per 30 days) |

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# Important!

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

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- You may file a complaint, also known as a grievance:
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  If you need help filing a grievance, call **1-800-747-0008** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD).**
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

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

## Language assistance services, free of charge, are available to you. 1-800-747-0008 (TTY: 711)

**Español (Spanish):** Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
**繁體中文 (Chinese):** 撥打上面的電話號碼即可獲得免費語言援助服務。
**Tiếng Việt (Vietnamese):** Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
**한국어 (Korean):** 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
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**Kreyòl Ayisyen (French Creole):** Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
**Français (French):** Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
**Polski (Polish):** Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
**Português (Portuguese):** Ligue para o número acima indicado para receber serviços linguísticos, grátis.
**Italiano (Italian):** Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
**Deutsch (German):** Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
**日本語 (Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
**فارسی (Farsi)**
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
**Diné Bizaad (Navajo):** Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę́ę́ niká'adoowoł.
**العربية (Arabic)**
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

This abridged formulary was updated on 09/02/2021 and is not a complete list of drugs covered by our plan. For a complete listing, or other questions, please contact PEEHIP Humana Group Medicare Advantage Plan with any questions at 1-800-747-0008 or, for TTY users, 711, Monday through Friday, from 7 a.m. - 8 p.m. Central 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 **https://our.Humana.com/peehip/**.

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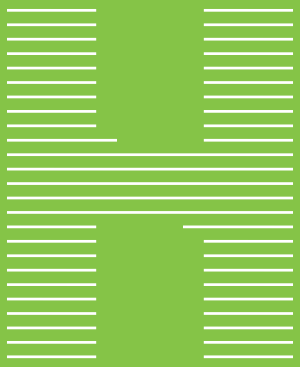

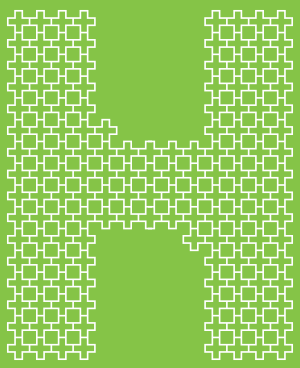

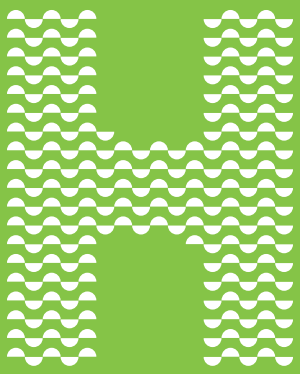

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# Important plan information

## We're here for you!

Humana Group Medicare Customer Care
**1-800-747-0008 (TTY: 711)**
Monday – Friday, 7 a.m. – 8 p.m., Central Time

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Limitations on telehealth services, also referred to as virtual visits or telemedicine, vary by state. These services are not a substitute for emergency care and are not intended to replace your primary care provider or other providers in your network. Any descriptions of when to use telehealth services is for informational purposes only and should not be construed as medical advice. Please refer to your evidence of coverage for additional details on what your plan may cover or other rules that may apply.

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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