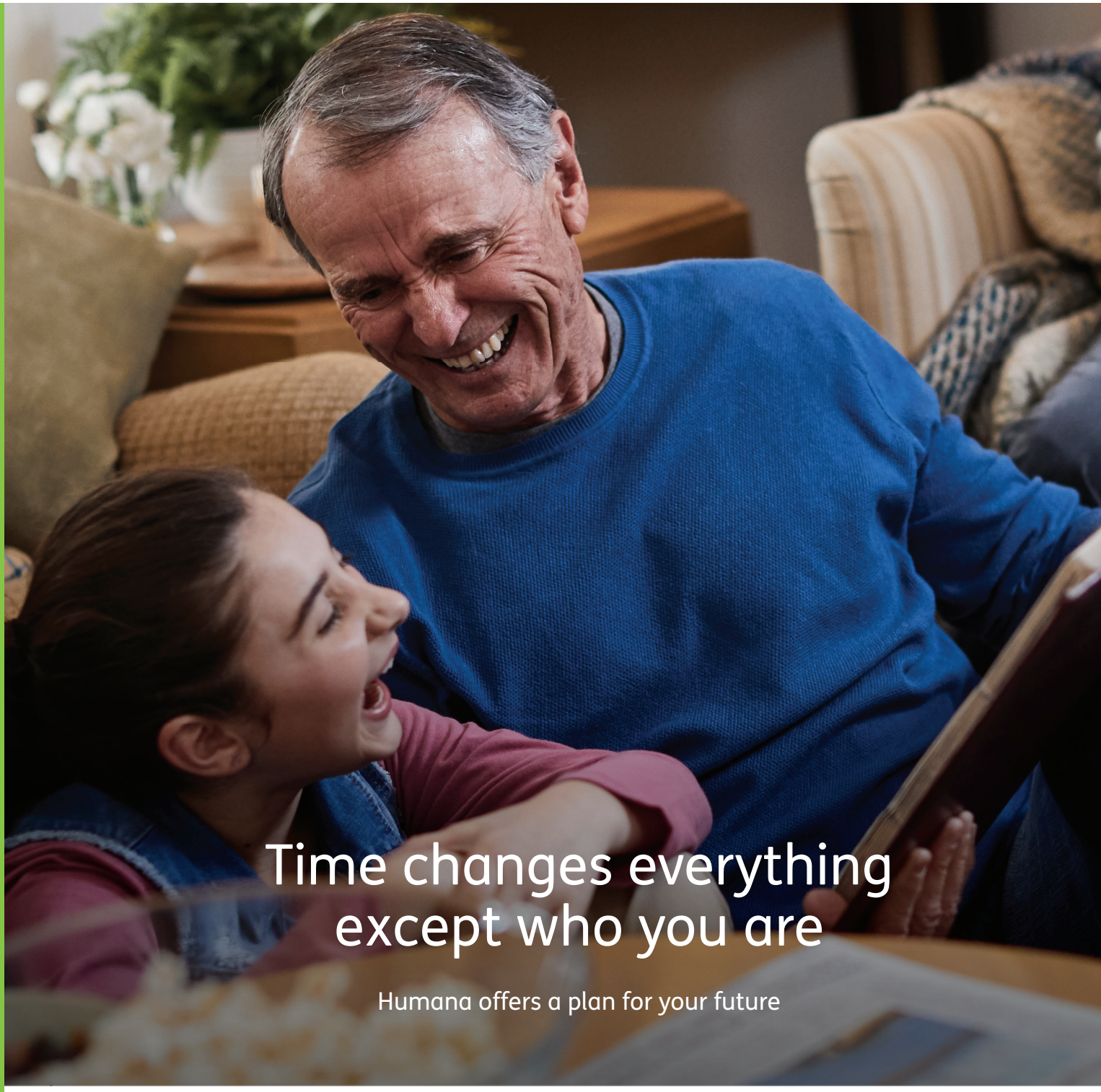
Humana

PEEHIP HUMANA GROUP MEDICARE ADVANTAGE PPO PLAN



Group Medicare PPO MAPD Plan
Public Education Employees' Health Insurance Plan

Humana

PEEHIP

PPO
MAPD

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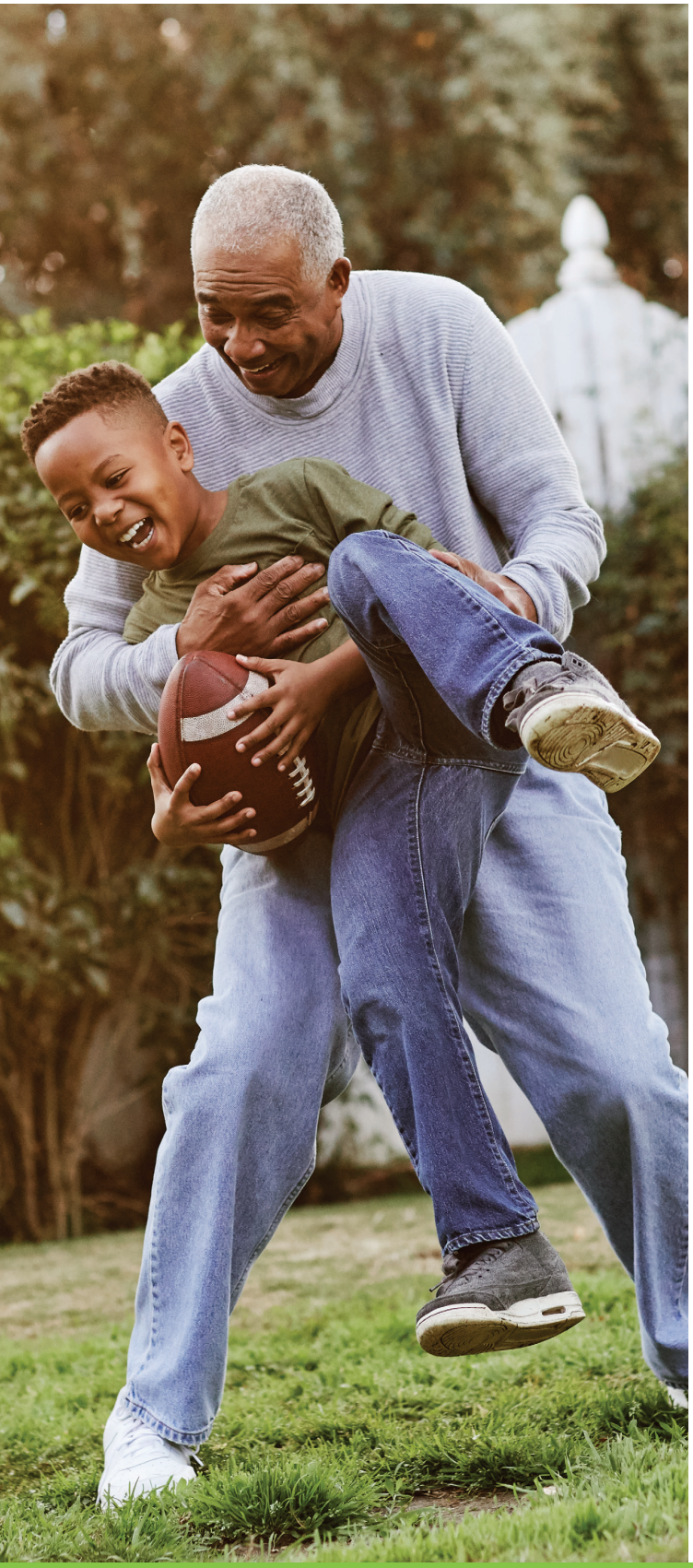

What's inside

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

What to expect after you enroll

Enrollment confirmation

You'll receive a letter from Humana in November 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 by the end of December.

Evidence of Coverage (EOC)

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

Medicare health survey

CMS requires Humana to ask new members to complete a health survey within their first few months of enrollment. Be on the lookout in January for information on how to access the survey. Your answers will help us better serve your health needs.

Why choose Humana?

We've earned the trust of millions of members since we offered our first Medicare plan in 1987. More than 8.8 million[1] Medicare customers have chosen us to be their healthcare partner.

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Important plan information

Extra services

Prescription drug formulary

PEEHIP Humana Group Medicare Advantage PPO Plan

Dear PEEHIP Group Medicare Retiree,

We're excited to let you know that the 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 SilverSneakers, Go365 and our Well Dine program.
- If you have any questions about your premium, please call PEEHIP at 1-334-517-7000 or toll free at 1-877-517-0020.

How do I enroll

- Enrolling is easy. There is nothing you have to do. 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 before December 31, 2019.
- 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 for many years to come.

Sincerely,
Group Medicare Operations

We're here for you even before you enroll

PEEHIP Humana Group Medicare Customer Care

1-800-747-0008 (TTY: 711)
Monday – Friday
7 a.m. – 8 p.m., Central time

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

PEEHIP website
https://our.Humana.com/peehip

Our automated phone system may answer your call on weekends and some public holidays. Please leave your name and telephone number and we'll call you back by the end of the next business day.

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 below. You must do this before December 31, 2019. **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 Advantage PPO Plan is a Medicare Advantage Plan. **You must also continue to pay your Part B premium**. You can be in only one Medicare Advantage Plan at a time. You must let Humana and PEEHIP 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 or I have questions about not enrolling?

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 at the following address prior to December 31, 2019.**

PEEHIP
P.O. Box 302150
Montgomery, Alabama 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 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 or toll free at 1-877-517-0020, Monday through Friday 8:00 a.m. to 5:00 p.m. Central time.**

If you chose 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 the plan, please contact PEEHIP at 1-334-517-7000 or toll free at 1-877-517-0020, 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 or toll free at 1-877-517-0020, 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.

PEEHIP_OORUHMAPD
(10/19)

HUMANA GROUP MEDICARE ADVANTAGE (PPO) PLAN
MAPD OPT-OUT REQUEST

Public Education Employees' Health Insurance Plan
P. O. Box 302150 ♦ Montgomery, Alabama 36130-2150
334-517-7000 or 877-517-0020
www.rsa-al.gov

You are automatically enrolled in the Humana Group Medicare Advantage (PPO) prescription drug and hospital medical coverage. To **opt out** of the prescription drug coverage but keep the hospital medical coverage (Option 1), or to completely opt out of this plan (Option 2), please complete the MAPD OPT-OUT REQUEST form and return to PEEHIP.

PEEHIP Member Requesting to Opt Out Information			
Social Security Number	First Name	Middle Initial	Last Name
Mailing Address			Email Address
Date of Birth _____/_____/_____	Home Phone _____-_____-_____	Work Phone _____-_____-_____	Relationship to Subscriber (Please check one) ☐ Self ☐ Spouse ☐ Other

PEEHIP Members May Choose From the Following Options

☐ **1.** Opt out of Humana Group Medicare Advantage (PPO) prescription drug coverage only and remain in the Humana Group Medicare Advantage (PPO) hospital medical coverage.
If enrolling in the PEEHIP plan without prescription drug coverage, please indicate any creditable prescription drug coverage you have:

☐ Tricare ☐ Federal Employees Health Benefits (FEHB) ☐ VA Benefits

☐ Other Group Part D Coverage _____

☐ Other creditable drug coverage _____

☐ **2.** Opt out of the Humana Group Medicare Advantage (PPO) plan completely.

Opt-Out Agreement

By completing this opt-out request, I understand that:

- If I select Option 1, I will not have prescription drug coverage with PEEHIP and will be enrolled in the Humana Group Medicare Advantage (PPO) plan hospital medical coverage only. If I do not have other prescription drug coverage as good as Medicare, I may have to pay a late enrollment penalty to obtain this coverage in the future.
- If I select Option 2, I will not have hospital medical or prescription drug coverage with PEEHIP. I will not be permitted to re-enroll in this plan until the next PEEHIP Open Enrollment period of July 1 through August 31 for an October 1 effective date. If I am the policy holder and I have family coverage, I will disenroll my entire family from both medical and prescription drug coverage.
- Opting out will impact my PEEHIP group eligibility status, and it is my responsibility to determine the consequences of this request.
- There are limited times in which I will be able to join other Medicare plans, unless I qualify for certain special circumstances.
- If I enroll in an Individual Part D plan, it will disenroll me from the Humana Group Medicare Advantage Plan and I will not have hospital medical and prescription drug coverage with PEEHIP.

_____ Date _____/_____/_____

Signature of Beneficiary or Authorized Representative*

*The signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this disenrollment and 2) documentation of this authority must be on file with PEEHIP.

Authorized Representative Information

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: _____-_____-_____ Relationship to Member: _____

2020

Summary of Benefits

PEEHIP Humana Group Medicare Advantage PPO Plan

PPO 079/445
PEEHIP

Humana®

PEEHIP

Our service area covers all 50 states and Puerto Rico.

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	**$185** per year for some combined in- and out-of-network services	**$185** per year for some combined in- and out-of-network services
Maximum out-of-pocket responsibility The most you pay for copays and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$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, Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Well Dine; Podiatry Services (Routine); Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium. 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** **$6,700** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, Chiropractic Services (Routine); Fitness Program; Health Education Services; Hearing Services (Routine); Well Dine; Podiatry Services (Routine); Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket. 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. Your limit for services received from in-network providers will count toward this limit. 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 **$25** copay per day for days 2-5 **$0** copay per day for days 6-365	**$200** copay per day for day 1 **$25** copay per day for days 2-5 **$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: 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 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 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	**$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 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 **$25** copay per day for days 2-5 **$0** copay per day for days 6-365	**$200** copay per day for day 1 **$25** copay per day for days 2-5 **$0** copay per day for days 6-365
Outpatient group and individual therapy visits	**Outpatient therapy visit:$18** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** **$18** copay **Partial Hospitalization:** **$0** copay
SKILLED NURSING FACILITY		
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-20 **$161** copay per day for days 21-100	**$0** copay per day for days 1-20 **$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
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 18 visit(s) per year for routine chiropractic services	**20%** of the cost 18 visit(s) per year for routine chiropractic services
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$18** copay	**$18** copay
Routine foot care	**$18** copay 6 visit(s) per year for routine podiatry services	**$18** copay 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:** **$18** copay **Partial Hospitalization:** **$0** copay	**Outpatient substance abuse treatment visit:** **$18** copay **Partial Hospitalization:** **$0** copay
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.	

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
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 identity, 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, 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**.

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.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-747-0008 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-747-0008 **(TTY: 711)** 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。 請致電 1-800-747-0008 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-747-0008 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-747-0008 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-747-0008 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-747-0008 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-747-0008 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-747-0008 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-747-0008 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-747-0008 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-747-0008 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-747-0008 **(TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-747-0008 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-747-0008 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-747-0008 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-747-0008 **(رقم هاتف الصم والبكم: 711)**.

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.

Humana®

PEEHIP

2020

Prescription Drug Summary of Benefits

PEEHIP Humana Group Medicare Advantage PPO Plan

Rx 339
PEEHIP

Humana®

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 **$4,020**. 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 47. 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 **$4,020**, 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 **$6,350**, you pay the greater of:

- **5%** coinsurance with a minimum of **$3.60** (**$6** maximum out-of-pocket per prescription for tier 1 drugs for a one-month supply).
- **$3.60** for generic (including brand drugs treated as generic) and **$8.95** 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 identity, 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, 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**.

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.

Multi-Language Interpreter Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-747-0008 **(TTY: 711)**... ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-747-0008 **(TTY: 711)** 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。 請致電 1-800-747-0008 **(TTY : 711)**。 ... CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-747-0008 **(TTY: 711)**.... 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 . 1-800-747-0008 **(TTY: 711)** 번으로 전화해 주십시오 .... PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-747-0008 **(TTY: 711)**.... ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-747-0008 **(телетайп: 711)**.... ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-747-0008 **(TTY: 711)**.... ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-747-0008 **(ATS: 711)**.... UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-747-0008 **(TTY: 711)**.... ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-747-0008 **(TTY: 711)**.... ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-747-0008 **(TTY: 711)**.... ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-747-0008 **(TTY: 711)**.... 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-747-0008 **(TTY: 711)** まで、お電話にてご連絡ください。...

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-747-0008 **(TTY: 711)** تماس بگیرید.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-747-0008 **(TTY: 711)**....

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-747-0008 **(رقم هاتف الصم والبكم: 711)**.

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/** 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

2020 PEEHIP Humana Group Medicare Advantage PPO Plan Guidebook

MAPD | PPO

Humana offers a plan for your future

Humana.

PEEHIP

What's inside...

Start here

You'll see how the PEEHIP Humana Group Medicare Advantage PPO with prescription drug plan offers you the value you deserve. After you are enrolled, Humana will mail you an Evidence of Coverage booklet that will have all of the 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
- Your benefit levels are the same for in-network and out-of-network providers
- Large network of doctors, specialists and hospitals to choose from
- You don't need 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 ones 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.

Total well-being starts with a complete approach to health

Support your health and your finances

Humana offers solid insurance products that help you support your healthcare needs, all provided by a Fortune 100 company with over 30 years of experience providing Medicare member plans.

Maximize your well-being

Our health and well-being tools and resources make it easy to set health goals, chart your progress, strengthen your mind and body, and build connections with others. The power to help you live a full, vibrant life is in your hands.

Manage your health

Complex or chronic health conditions often demand personal attention. A Humana nurse can meet you at home, in the hospital, by phone or email to help you manage your condition and minimize complications.

Extra benefits—offered at no additional cost to you

SilverSneakers fitness*

This program gives you access 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 www.SilverSneakers.com to find a convenient location near you at no additional cost.
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 At Home℠

Supports qualifying members with both short-term and long-term services that can help them remain independent at home. Humana At Home care managers support members by providing education about chronic conditions and medication adherence, helping with discharge instructions, accessing community resources, finding social support and more, all included in the plan at no additional cost.
Humana.com/caremgmt, 1-800-432-4803 (TTY: 711), Monday – Friday, 8:30 a.m. – 5:30 p.m., Eastern time

Humana Well Dine® meal program

After your overnight inpatient stay in a hospital or nursing facility, you're eligible to receive 10 frozen, packaged, low-sodium meals and 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 by Humana 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 that can help keep you on the right track. When you've completed qualified activities, you'll earn rewards in the Go365 Mall for items such as gift cards to Amazon, Walmart, Shell, Target, T.J. Maxx, Kohl's and much more. The more steps you take to improve your health, the more rewards you accumulate.

Go to **our.Humana.com/peehip/extra-benefits**, select the "Register Now" 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. The form can be found when you sign in at **MyHumana.com**, 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:

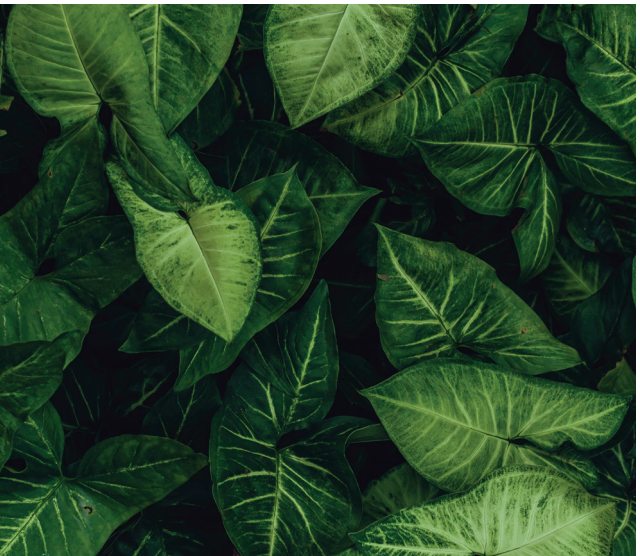
- Have three of the five multiple chronic conditions:
  - Congestive heart failure (CHF)
  - Dyslipidemia (high or low LDL cholesterol)
  - Diabetes
  - Chronic obstructive pulmonary disease (COPD)
  - Osteoporosis
- Take at least eight chronic/maintenance Part D drugs
- Spend more than $4,255 on prescription 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 40.

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.



Building healthy provider relationships

Your relationship with your provider is important in protecting and managing 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.

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 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.

Group Medicare

Provider information: 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 Humana 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 **1-800-626-2741**, 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.

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 a preauthorization. Doctors or hospitals will submit the preauthorization request to Humana. If you have questions regarding what medical services require preauthorization, you can call Customer Care at **1-800-747-0008 (TTY: 711)**.

Part B vs. Part D—Knowing how your coverage works can save you from paying out of your pocket for vaccines

Vaccinations covered by Part B

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
- Vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus

Vaccinations covered by Part D

The Medicare Part D portion of your plan pays for the following vaccines at your pharmacy:

- Shingles (Zostavax)
- Tdap
- 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.

Medicare Part B helps cover diabetic testing supplies, insulin pumps and insulin administered (or used) in insulin pumps. 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. Omnipods or VGO).

Go to **Humana.com/Diabetes** to learn more about managing your diabetes. MyDiabetesPath offers a complete guide to living with diabetes and gives you the information and resources to help you stay healthy.

Your PEEHIP Humana Group Medicare Advantage Plan covers a variety of diabetic glucose testing Supplies such as Roche Accu-Chek Nano®, Roche Accu-Chek Guide, Roche Accu-Chek Aviva Plus® 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, 8 a.m. – 8 p.m., Eastern time.

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 call **1-800-555-2546 (TTY: 711)** to speak with our Humana Clinical Pharmacy Review team. They are available 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.

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 the transition fill for your prescription requiring a prior authorization or step therapy, you'll receive a letter from Humana telling you about the requirements or limits on the prescription. The letter will also advise that you will need to get approval before future refills will be covered. A prior authorization will need to be approved or other alternative medicines should be tried if the medication requires step therapy.

“It’s about getting you the information you need, it’s about respecting your budget, it’s about encouraging you to use your insurance and really helping you take care of your health.”

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

1. Talk to your provider or call Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)** to see if your medications require prior authorization, step therapy is needed or if they have quantity limits.
2. If you have questions about your prescription drug benefits, please call Group Medicare Customer Care at **1-800-747-0008 (TTY: 711)**.

Your formulary drug categories

Tier 1 – Preferred generic

Essentially the same drugs, usually priced differently

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

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

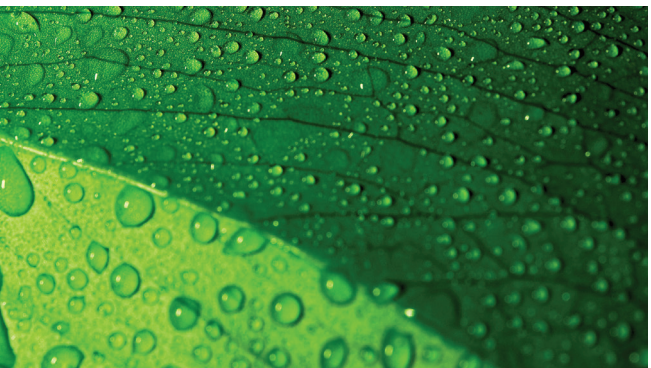
More expensive generic or brand-name prescription drugs that Humana offers at a higher cost to you than preferred drugs.

Tier 4 – Specialty

Drugs for specific uses

Some injectable and other high-cost drugs.

“Humana makes technology a user-friendly tool, and that helps make using your coverage easier. Your plan information is right there, online, available at the touch of your finger.”



Communication counts

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 that allows you to access your specific 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)**.

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 pharmacies in your network
- Find providers in your network
- Compare drug prices
- Access digital ID cards

Connect with us on Facebook

Find healthcare information for Medicare members and caregivers to help in your pursuit of lifelong well-being at **facebook.com/Humana**.

*Standard data rates may apply.

Allies in well-being

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.

"Humana focuses on meeting your changing needs and smoothing your move to Medicare, so you can focus on work and play and living your life."

SmartSummary is your personalized benefits statement

Humana believes Medicare members deserve a better way to understand, track, manage and possibly save money on their healthcare. Your SmartSummary will help you do just that. You'll receive these statements after each month in which you've had claims. You can also sign in to 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.

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 can receive your Medicare Part A and Part B benefits through the federal government.

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.

Medicare Part B

MEDICAL INSURANCE

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

Medicare Part C

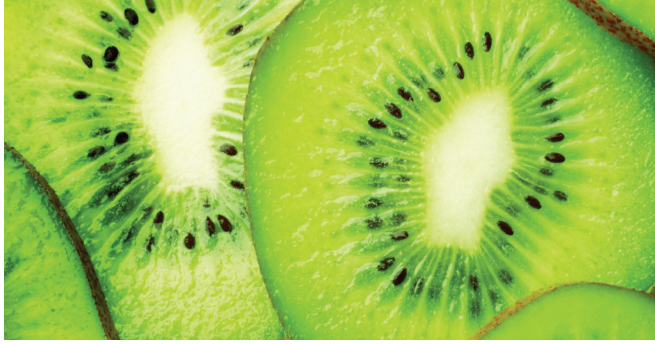
MEDICARE ADVANTAGE PLANS

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.

Medicare Part D

PRESCRIPTION DRUG COVERAGE

Like Part C Medicare Advantage plans, Part D is only available through private insurance companies, such as Humana. Many Part C Medicare Advantage plans include Medicare Part D prescription drug coverage. Part D covers the medications that your doctor prescribes. You can only join a Medicare Part D prescription drug plan if you are entitled to Medicare Part A and/or enrolled in Part B.



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 **1-334-517-7000** 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 **1-334-517-7000** 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 a prior authorization, your provider can contact Humana to request it. Your doctor 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 prior 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 **1-800-772-1213**. 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**.

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 deductible for your PEEHIP Humana Group Medicare Advantage PPO plan is $185.

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 $6,350
Once your pharmacy out-of-pocket costs reach the $6,350 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


Humana®

2020

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 11/13/2019 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 at 1-800-747-0008 or, for TTY users, 711, 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. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit https://our.Humana.com/peehip/.

Instructions for getting information about all covered drugs are inside.

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PEEHIP

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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, 2020. 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. 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/**. 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. Please leave your name and telephone number, and we'll call you back by the end of the next business day.

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:

- **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 below on page 52 entitled "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 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'll 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 below on page 52 entitled "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 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 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.

What if you're affected by a Drug List change?
We'll 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, 2020. We'll update the printed formularies each month and they'll be available on **https://our.Humana.com/peehip/**.

To get updated information about the drugs that Human a covers, please visit **https://our.Humana.com/peehip/**.

How do I use the formulary?
There are two ways to find your drug in the formulary:

Medical condition
The formulary starts on page 56. We've put the drugs into groups depending on the type of medical conditions that they're used to treat. For example, drugs that treat a heart condition are listed under the category "Cardiovascular Agents." If you know what medical condition your drug is used for, look for the category name in the list that begins on page 56. Then look under the category name for your drug. The formulary also lists the Tier and Utilization Management Requirements for each drug (see page 51 for more information on Utilization Management Requirements).

Alphabetical listing
If you're not sure about your drug's group, you should look for your drug in the Index that begins on page 87. The Index is an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed. Look in the Index to search for your drug. Next to each drug, you'll see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of the drug in the first column of the list.

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'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. 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 on page 56.

You can also visit **https://our.Humana.com/peehip/** to get more information about the restrictions applied to specific covered drugs.

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?**" on page 52 for information about how to request an exception.

What if my drug isn't on the formulary?
If your drug isn't included in this list of covered drugs, visit **https://our.Humana.com/peehip/** to see if your plan covers your drug. You can also call Group Medicare Customer Care and ask if your drug is covered.

If the Plan doesn't 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's 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.

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 wouldn't 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 doesn't 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're a member of the plan.

Here is what we'll do for each of your current Part D drugs that aren't on the formulary, or if you have limited ability to get your drugs:
- We'll temporarily cover a 30-day supply 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've been a member of the plan for less than 90 days, unless a formulary exception has been approved.

If you're a resident of a long-term care facility and you take Part D drugs that aren't on the formulary, we'll cover a 30-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 30 days of a drug) during the first 90 days you're a member of our plan. We'll 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's not on the formulary *or*
- You have limited ability to get your drugs *and*
- You're 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 30-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and receive approval for continued coverage of your drug. The Plan will review requests for continuation of therapy on a case-by-case basis understanding when you're 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 hasn't been processed by the end of your initial transition period. We'll 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.

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 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. If you have trouble finding your drug in the list, turn to the Index that begins on page 87.

Remember: This is only a partial list of drugs covered by Humana. If your prescription drug isn't listed in this partial formulary, please visit our website at **https://our.Humana.com/peehip/**. Our additional contact information is listed on the previous page.

Your plan has additional coverage of some drugs. These drugs aren't normally covered under Medicare Part D and aren't subject to the Medicare appeals process. These drugs are listed separately on page 83.

How to read your formulary
The first column of the chart lists categories of medical conditions in alphabetical order. The drug names are then listed in alphabetical order within each category. **Brand-name drugs are CAPITALIZED and generic drugs are listed in *lower-case italics***. Next to the drug name 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.

The second column lists the tier of the drug. See page 51 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 page 51 for more information about these requirements.

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 1 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.

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
Analgesics		
BELBUCA 150 MCG, 300 MCG, 450 MCG, 600 MCG, 75 MCG, 750 MCG BUCCAL FILM DL	3	QL (60 per 30 days)
BELBUCA 900 MCG BUCCAL FILM DL	4	QL (60 per 30 days)
butorphanol 1 mg/ml, 2 mg/ml vial DL	1	
celecoxib 100 mg, 200 mg, 400 mg, 50 mg capsule MD	1	QL (60 per 30 days)
diclofenac sod ec 25 mg, 50 mg, 75 mg tab MD	1	
diclofenac sodium 1% gel DL	1	
EMBEDA ER 100-4 MG, 20-0.8 MG, 30-1.2 MG, 50-2 MG, 60-2.4 MG, 80-3.2 MG CAPSULE DL	2	QL (60 per 30 days)
endocet 10 mg-325 mg tablet; endocet 2.5 mg-325 mg tablet; endocet 5 mg-325 mg tablet; endocet 7.5 mg-325 mg tablet DL	1	QL (360 per 30 days)
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)
hydrocodone-ibuprofen 10-200; hydrocodone-ibuprofen 10-200 mg, 5-200 mg, 7.5-200 mg; hydrocodone-ibuprofen 7.5-200 DL	1	QL (150 per 30 days)
ibuprofen 400 mg, 600 mg, 800 mg tablet MD	1	
meloxicam 15 mg, 7.5 mg tablet MD	1	
oxycodone hcl 10 mg, 15 mg, 20 mg, 30 mg, 5 mg tablet DL	1	QL (360 per 30 days)
oxycodon-acetaminophen 2.5-325; oxycodon-acetaminophen 7.5-325; oxycodone-acetaminophen 10-325; oxycodone-acetaminophen 5-325 DL	1	QL (360 per 30 days)
tramadol hcl 50 mg tablet DL	1	QL (240 per 30 days)
XTAMPZA ER 13.5 MG, 18 MG, 27 MG, 36 MG, 9 MG CAPSULE SPRINKLE DL	2	QL (60 per 30 days)
Anesthetics		
lidocaine 5% patch DL	1	PA,QL (90 per 30 days)
lidocaine hcl 0.5% vial; lidocaine hcl 1% ampul; lidocaine hcl 1.5% ampul; lidocaine hcl 2% ampul; lidocaine hcl 4% ampul DL	1	
lidocaine hcl 0.5% vial; lidocaine hcl 1% vial; lidocaine hcl 2% vial; lidocaine hcl 4% solution DL	1	
lidocaine hcl 2% jelly DL	1	
lidocaine viscous 2 % mucosal solution DL	1	
lidocaine-prilocaine cream DL	1	
Anti-Addiction/Substance Abuse Treatment Agents		
acamprosate calc dr 333 mg tab MD	1	
buprenorphine 2 mg, 8 mg tablet sl DL	1	QL (90 per 30 days)
CHANTIX 0.5 MG, 1 MG TABLET DL	2	
disulfiram 250 mg, 500 mg tablet MD	1	
naloxone 0.4 mg/ml vial DL	1	

Need more information about the indicators displayed by the drug names? Please go to page 55.

ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
naloxone 0.4 mg/ml, 1 mg/ml carpuject; naloxone 2 mg/2 ml syringe DL	1	
naltrexone 50 mg tablet DL	1	
NARCAN 4 MG/ACTUATION NASAL SPRAY DL	2	
VIVITROL 380 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE DL	4	
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)
Antibacterials		
amoxicillin 250 mg, 500 mg capsule DL	1	
amox-clav 250-125 mg, 500-125 mg, 875-125 mg tablet DL	1	
azithromycin 250 mg, 500 mg, 600 mg tablet DL	1	
aztreonam 1 gm vial DL	1	
baciim 50,000 unit vial DL	1	
bacitracin 50,000 unit vial DL	1	
BETHKIS 300 MG/4 ML SOLUTION FOR NEBULIZATION DL	4	PA
cefaclor 250 mg, 500 mg capsule DL	1	
cefdinir 300 mg capsule DL	1	
cefepime hcl 1 gm vial; cefepime hcl 1 gram, 2 gram vial DL	1	
cefotetan 1 gm vial; cefotetan 10 gm vial; cefotetan 2 gm vial DL	1	
cefoxitin 1 gm vial; cefoxitin 10 gm vial; cefoxitin 2 gm vial DL	1	
ceftriaxone 1 gm add-vant vial; ceftriaxone 1 gm vial; ceftriaxone 1 gram, 10 gram, 100 gram, 2 gram, 250 mg, 500 mg bulk bag; ceftriaxone 1 gram, 10 gram, 100 gram, 2 gram, 250 mg, 500 mg vial; ceftriaxone 10 gm vial; ceftriaxone 2 gm add vial; ceftriaxone 2 gm vial DL	1	
cefuroxime axetil 250 mg, 500 mg tab DL	1	
cephalexin 250 mg, 500 mg, 750 mg capsule DL	1	
ciprofloxacin hcl 100 mg, 250 mg, 500 mg, 750 mg tab DL	1	
clindamycin 1 %, 150 mg/ml, 300 mg/2 ml, 600 mg/4 ml, 900 mg/6 ml addvan; clindamycin ph 1% solution; clindamycin ph 900 mg/6 ml vl DL	1	
daptomycin 500 mg vial DL	1	
dicloxacillin 250 mg, 500 mg capsule DL	1	
DIFICID 200 MG TABLET DL	4	
doxycycline 100 mg, 20 mg, 50 mg tablet; doxycycline hyclate 100 mg, 20 mg, 50 mg tab DL	1	
doxycycline mono 100 mg, 150 mg, 50 mg, 75 mg cap; doxycycline mono 100 mg, 150 mg, 50 mg, 75 mg capsule DL	1	

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
ERYTHROCIN 500 MG INTRAVENOUS SOLUTION DL	3	
erythromycin 250 mg, 500 mg filmtab DL	1	
imipenem-cilastatin 250 mg, 500 mg vl DL	1	
linezolid 100 mg/5 ml susp DL	1	
linezolid 600 mg/300 ml-d5w DL	1	
meropenem iv 1 gm vial; meropenem iv 1 gram, 500 mg vial DL	1	
metronidazole 250 mg, 500 mg tablet DL	1	
metronidazole top 1% gel pump; metronidazole topical 0.75% gl; metronidazole topical 1% gel; metronidazole vaginal 0.75% gl DL	1	
mupirocin 2% ointment DL	1	
mupirocin 2% cream DL	1	
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	
nitrofurantoin mcr 100 mg, 25 mg, 50 mg cap DL	1	
nitrofurantoin mono-mcr 100 mg DL	1	
paromomycin 250 mg capsule DL	1	
penicillin vk 125 mg/5 ml, 250 mg/5 ml soln DL	1	
penicillin vk 250 mg, 500 mg tablet DL	1	
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	
polymyxin b sulfate vial DL	1	
silver sulfadiazine 1% cream DL	1	
sulfamethoxazole-tmp ds tablet; sulfamethoxazole-tmp ss tablet DL	1	
SUPRAX 400 MG CAPSULE DL	2	
TEFLARO 400 MG, 600 MG INTRAVENOUS SOLUTION DL	4	
tetracycline 250 mg, 500 mg capsule DL	1	
tigecycline 50 mg vial DL	1	
vancomycin 1 gm vial; vancomycin 1,000 mg, 1.25 gram, 1.5 gram, 10 gram, 100 gram, 250 mg, 5 gram, 500 mg, 750 mg vial; vancomycin hcl 1,000 mg, 1.25 gram, 1.5 gram, 10 gram, 100 gram, 250 mg, 5 gram, 500 mg, 750 mg vial; vancomycin hcl 10 gm vial; vancomycin hcl 100 gm smartpak; vancomycin hcl 5 gm vial DL	1	
vancomycin hcl 125 mg capsule DL	1	
Anticonvulsants		
CELONTIN 300 MG CAPSULE MD	3	
ethosuximide 250 mg capsule MD	1	
gabapentin 100 mg, 300 mg, 400 mg capsule MD	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
gabapentin 600 mg, 800 mg tablet **MD**	1	
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	
levetiracetam 1,000 mg, 250 mg, 500 mg, 750 mg tablet **MD**	1	
phenobarbital 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg tablet **DL**	1	
PHENYTEK 200 MG, 300 MG CAPSULE **MD**	3	
phenytoin sod ext 100 mg, 200 mg, 300 mg cap **MD**	1	
primidone 250 mg, 50 mg tablet **MD**	1	
topiramate 100 mg, 200 mg, 25 mg, 50 mg tablet **MD**	1	
VIMPAT 10 MG/ML ORAL SOLUTION **MD**	3	QL (1395 per 30 days)
VIMPAT 100 MG, 50 MG TABLET **MD**	3	QL (30 per 30 days)
VIMPAT 150 MG, 200 MG TABLET **MD**	3	QL (60 per 30 days)
VIMPAT 200 MG/20 ML INTRAVENOUS SOLUTION **DL**	3	
Antidementia Agents		
donepezil hcl 10 mg tablet **MD**	1	QL (60 per 30 days)
donepezil hcl 10 mg, 23 mg, 5 mg tablet; donepezil hcl odt 10 mg, 23 mg, 5 mg tablet **MD**	1	QL (30 per 30 days)
memantine hcl 10 mg, 5 mg tablet **MD**	1	PA,QL (60 per 30 days)
memantine hcl er 14 mg, 21 mg, 28 mg, 7 mg capsule **MD**	1	PA,QL (30 per 30 days)
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)
rivastigmine 1.5 mg, 3 mg capsule **MD**	1	QL (90 per 30 days)
Antidepressants		
amitriptyline hcl 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tab **DL**	1	PA
amoxapine 100 mg, 150 mg, 25 mg, 50 mg tablet **DL**	1	
bupropion hcl sr 100 mg, 150 mg, 200 mg tablet **MD**	1	
bupropion hcl xl 150 mg, 300 mg tablet **MD**	1	
citalopram hbr 10 mg, 20 mg, 40 mg tablet **MD**	1	
desipramine 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg tablet **DL**	1	PA
duloxetine hcl dr 20 mg, 30 mg, 40 mg, 60 mg cap **MD**	1	QL (60 per 30 days)
escitalopram 10 mg, 20 mg, 5 mg tablet **MD**	1	
fluoxetine dr 10 mg, 20 mg, 40 mg, 90 mg capsule; fluoxetine hcl 10 mg, 20 mg, 40 mg, 90 mg capsule **MD**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
phenelzine sulfate 15 mg tab MD	1	
sertraline hcl 100 mg, 25 mg, 50 mg tablet MD	1	
tranylcypromine sulf 10 mg tab MD	1	
trazodone 100 mg, 150 mg, 300 mg, 50 mg tablet MD	1	
TRINTELLIX 10 MG, 20 MG, 5 MG TABLET MD	3	QL (30 per 30 days)
venlafaxine hcl er 150 mg, 37.5 mg, 75 mg cap MD	1	
Antiemetics		
aprepitant 125 mg, 125 mg (1)- 80 mg (2), 40 mg, 80 mg capsule; aprepitant 125-80-80 mg pack DL	1	B vs D
dronabinol 10 mg, 2.5 mg, 5 mg capsule DL	1	B vs D
meclizine 12.5 mg, 25 mg tablet DL	1	
metoclopramide 10 mg, 5 mg tablet DL	1	
ondansetron hcl 24 mg, 4 mg, 8 mg tablet DL	1	B vs D
prochlorperazine 25 mg supp DL	1	
promethazine 12.5 mg suppos DL	1	PA
promethazine 12.5 mg, 25 mg, 50 mg tablet DL	1	PA
SANCUSO 3.1 MG/24 HOUR TRANSDERMAL PATCH DL	3	
Antifungals		
ciclopirox 0.77% gel DL	1	
ciclopirox 8% solution DL	1	
clotrimazole 10 mg troche DL	1	
fluconazole 100 mg, 150 mg, 200 mg, 50 mg tablet DL	1	
flucytosine 250 mg, 500 mg capsule DL	1	
griseofulvin micro 500 mg tab DL	1	
NATACYN 5 % EYE DROPS,SUSPENSION DL	3	
nystatin 100,000 unit/gm oint DL	1	
nystatin 100,000 unit/ml susp DL	1	
nystatin 500,000 unit oral tab DL	1	
nystatin-triamcinolone ointm DL	1	
nystop 100,000 unit/gram topical powder DL	1	
terbinafine hcl 250 mg tablet DL	1	
terconazole 0.4% cream; terconazole 0.8% cream DL	1	
Antigout Agents		
allopurinol 100 mg, 300 mg tablet MD	1	
COLCRYS 0.6 MG TABLET MD	2	QL (120 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
probenecid 500 mg tablet MD	1	
probenecid-colchicine tablet MD	1	
Antimigraine Agents		
dihydroergotamine 1 mg/ml amp DL	1	
dihydroergotamine 4 mg/ml spry DL	1	
ERGOMAR 2 MG SUBLINGUAL TABLET DL	4	
migergot 2 mg-100 mg rectal suppository DL	4	
sumatriptan succ 100 mg, 25 mg, 50 mg tablet DL	1	QL (9 per 30 days)
Antimyasthenic Agents		
guanidine hcl 125 mg tablet DL	2	
pyridostigmine br 30 mg, 60 mg tablet DL	1	
Antimycobacterials		
dapsone 100 mg, 25 mg tablet DL	1	
isoniazid 100 mg/ml, 50 mg/5 ml solution; isoniazid 100 mg/ml, 50 mg/5 ml vial DL	1	
PASER 4 GRAM GRANULES DELAYED-RELEASE PACKET DL	3	
RIFATER 50 MG-120 MG-300 MG TABLET DL	3	
Antineoplastics		
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)
anastrozole 1 mg tablet MD	1	
bicalutamide 50 mg tablet DL	1	
CABOMETYX 20 MG, 40 MG, 60 MG TABLET DL	4	PA,QL (30 per 30 days)
cyclophosphamide 25 mg, 50 mg capsule DL	1	B vs D
ELITEK 1.5 MG, 7.5 MG INTRAVENOUS SOLUTION DL	4	B vs D
ERIVEDGE 150 MG CAPSULE DL	4	PA,QL (28 per 28 days)
ERLEADA 60 MG TABLET DL	4	PA,QL (120 per 30 days)
etoposide 100 mg/5 ml vial DL	1	B vs D
hydroxyurea 500 mg capsule DL	1	
IBRANCE 100 MG, 125 MG, 75 MG CAPSULE DL	4	PA,QL (21 per 28 days)
INLYTA 1 MG TABLET DL	4	PA,QL (180 per 30 days)
INLYTA 5 MG TABLET DL	4	PA,QL (60 per 30 days)
letrozole 2.5 mg tablet MD	1	
leucovorin cal 500 mg/50 ml vl; leucovorin calcium 10 mg/ml, 100 mg, 200 mg, 350 mg, 50 mg, 500 mg vial; leucovorin calcium 10 mg/ml, 100 mg, 200 mg, 350 mg, 50 mg, 500 mg vl DL	1	B vs D

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
leucovorin calcium 10 mg, 15 mg, 25 mg, 5 mg tab DL	1	
LEUKERAN 2 MG TABLET DL	4	
mercaptopurine 50 mg tablet DL	1	
mesna 1 gram/10 ml vial DL	1	B vs D
MESNEX 400 MG TABLET DL	4	
ODOMZO 200 MG CAPSULE DL	4	PA,QL (30 per 30 days)
OPDIVO 100 MG/10 ML, 240 MG/24 ML, 40 MG/4 ML INTRAVENOUS SOLUTION DL	4	PA
REVLIMID 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG CAPSULE DL	4	PA,QL (28 per 28 days)
RITUXAN 10 MG/ML CONCENTRATE,INTRAVENOUS DL	4	PA
SPRYCEL 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG TABLET DL	4	PA
SUTENT 12.5 MG, 25 MG, 37.5 MG, 50 MG CAPSULE DL	4	PA
tamoxifen 10 mg, 20 mg tablet MD	1	
TARGRETIN 1 % TOPICAL GEL DL	4	PA
TARGRETIN 75 MG CAPSULE DL	4	PA
THALOMID 100 MG, 200 MG, 50 MG CAPSULE DL	4	PA,QL (30 per 30 days)
topotecan hcl 4 mg, 4 mg/4 ml (1 mg/ml) vial; topotecan hcl 4 mg/4 ml vial DL	1	B vs D
XTANDI 40 MG CAPSULE DL	4	PA
Antiparasitics		
DARAPRIM 25 MG TABLET DL	4	
hydroxychloroquine 200 mg tab DL	1	
ivermectin 3 mg tablet DL	1	
lindane 1% shampoo DL	1	
permethrin 5% cream DL	1	
primaquine 26.3 mg tablet DL	1	
quinine sulfate 324 mg capsule DL	1	PA
Antiparkinson Agents		
amantadine 100 mg capsule MD	1	
amantadine 100 mg tablet MD	1	
benztropine mes 0.5 mg, 1 mg, 2 mg tab; benztropine mes 0.5 mg, 1 mg, 2 mg tablet DL	1	PA
bromocriptine 2.5 mg tablet MD	1	
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	
carbidopa-levo er 25-100 tab; carbidopa-levo er 50-200 tab MD	1	
entacapone 200 mg tablet MD	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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	
pramipexole 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg tablet **MD**	1	
rasagiline mesylate 0.5 mg, 1 mg tab **MD**	1	
ropinirole hcl 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg tablet **MD**	1	
RYTARY 23.75 MG-95 MG CAPSULE,EXTENDED RELEASE; RYTARY 48.75 MG-195 MG CAPSULE,EXTENDED RELEASE **DL**	3	ST,QL (360 per 30 days)
RYTARY 36.25 MG-145 MG CAPSULE,EXTENDED RELEASE **DL**	3	ST,QL (270 per 30 days)
RYTARY 61.25 MG-245 MG CAPSULE,EXTENDED RELEASE **DL**	3	ST,QL (300 per 30 days)
selegiline hcl 5 mg capsule **MD**	1	
tolcapone 100 mg tablet **DL**	1	
trihexyphenidyl 2 mg/5 ml elx **DL**	1	PA
Antipsychotics		
ABILIFY MAINTENA 300 MG, 400 MG INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE **DL**	4	
ABILIFY MAINTENA 300 MG, 400 MG SUSPENSION,EXTENDED REL. INTRAMUSCULAR SYRINGE **DL**	4	
ARISTADA 1,064 MG/3.9 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	
ARISTADA 441 MG/1.6 ML, 662 MG/2.4 ML, 882 MG/3.2 ML SUSPENSION, EXTEND.REL. IM SYRINGE **DL**	4	
clozapine 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg, 50 mg tablet; clozapine odt 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg, 50 mg tablet **MD**	1	
fluphenazine 2.5 mg/5 ml elix **MD**	1	
haloperidol 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg tablet **MD**	1	
INVEGA SUSTENNA 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML INTRAMUSCULAR SYRINGE **DL**	4	
INVEGA SUSTENNA 39 MG/0.25 ML INTRAMUSCULAR SYRINGE **DL**	3	
INVEGA TRINZA 273 MG/0.875 ML, 410 MG/1.315 ML, 546 MG/1.75 ML, 819 MG/2.625 ML INTRAMUSCULAR SYRINGE **DL**	4	
loxapine 10 mg, 25 mg, 5 mg, 50 mg capsule **MD**	1	
PERSERIS 120 MG, 90 MG ABDOMINAL SUBCUTANEOUS EXTEND RELEASE SUSP SYRINGE KIT **DL**	4	QL (1 per 28 days)
pimozide 1 mg, 2 mg tablet **MD**	1	
quetiapine fumarate 200 mg, 25 mg, 50 mg tab **MD**	1	QL (120 per 30 days)
RISPERDAL CONSTA 12.5 MG/2 ML, 25 MG/2 ML, 37.5 MG/2 ML INTRAMUSCULAR SYRINGE **DL**	3	
RISPERDAL CONSTA 50 MG/2 ML INTRAMUSCULAR SYRINGE **DL**	4	
thioridazine 10 mg, 100 mg, 25 mg, 50 mg tablet **MD**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
thiothixene 1 mg, 10 mg, 2 mg, 5 mg capsule **MD**	1	
ziprasidone hcl 20 mg, 40 mg, 60 mg, 80 mg capsule **MD**	1	QL (60 per 30 days)
Antispasticity Agents		
baclofen 10 mg, 20 mg, 5 mg tablet **MD**	1	
dantrolene sodium 100 mg, 25 mg, 50 mg cap **DL**	1	
tizanidine hcl 2 mg, 4 mg tablet **MD**	1	
Antivirals		
abacavir-lamivudine-zidov tab **DL**	1	QL (60 per 30 days)
acyclovir 400 mg, 800 mg tablet **DL**	1	
acyclovir 5% ointment **DL**	1	
ATRIPLA 600 MG-200 MG-300 MG TABLET **DL**	4	QL (30 per 30 days)
BIKTARVY 50 MG-200 MG-25 MG TABLET **DL**	4	QL (30 per 30 days)
CRIXIVAN 200 MG CAPSULE **DL**	2	QL (450 per 30 days)
CRIXIVAN 400 MG CAPSULE **DL**	2	QL (270 per 30 days)
DESCOVY 200 MG-25 MG TABLET **DL**	4	QL (30 per 30 days)
entecavir 0.5 mg, 1 mg tablet **DL**	1	
EPCLUSA 400 MG-100 MG TABLET **DL**	4	PA,QL (28 per 28 days)
FUZEON 90 MG SUBCUTANEOUS SOLUTION **DL**	4	QL (60 per 30 days)
GENVOYA 150 MG-150 MG-200 MG-10 MG TABLET **DL**	4	QL (30 per 30 days)
HARVONI 45 MG-200 MG TABLET; HARVONI 90 MG-400 MG TABLET **DL**	4	PA,QL (28 per 28 days)
INTRON A 10 MILLION UNIT (1 ML), 10 MILLION UNIT/ML, 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML), 6 MILLION UNIT/ML INJECTION SOLUTION; INTRON A 10 MILLION UNIT (1 ML), 10 MILLION UNIT/ML, 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML), 6 MILLION UNIT/ML SOLUTION FOR INJECTION **DL**	4	PA
ISENTRESS 400 MG TABLET **DL**	4	QL (120 per 30 days)
ledipasvir-sofosbuvir 90-400mg **DL**	4	PA,QL (28 per 28 days)
MAVYRET 100 MG-40 MG TABLET **DL**	4	PA,QL (84 per 28 days)
ODEFSEY 200 MG-25 MG-25 MG TABLET **DL**	4	QL (30 per 30 days)
oseltamivir phos 30 mg, 45 mg, 75 mg capsule **DL**	1	
PEGINTRON 50 MCG/0.5 ML SUBCUTANEOUS KIT **DL**	4	PA
RELENZA DISKHALER 5 MG/ACTUATION POWDER FOR INHALATION **DL**	2	
ribavirin 200 mg capsule **DL**	1	
ribavirin 200 mg tablet **DL**	1	
rimantadine hcl 100 mg tablet **DL**	1	
SELZENTRY 300 MG, 75 MG TABLET **DL**	4	QL (120 per 30 days)
sofosbuvir-velpatasvir 400-100 **DL**	4	PA,QL (28 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TIVICAY 25 MG, 50 MG TABLET DL	4	QL (60 per 30 days)
trifluridine 1% eye drops DL	1	
TRUVADA 100 MG-150 MG TABLET; TRUVADA 133 MG-200 MG TABLET; TRUVADA 167 MG-250 MG TABLET; TRUVADA 200 MG-300 MG TABLET DL	4	QL (30 per 30 days)
valganciclovir 450 mg tablet DL	1	QL (120 per 30 days)
VEMLIDY 25 MG TABLET DL	4	QL (30 per 30 days)
XOFLUZA 20 MG, 40 MG TABLET DL	2	
ZIRGAN 0.15 % EYE GEL DL	3	
Anxiolytics		
alprazolam 0.25 mg, 0.5 mg, 1 mg tablet DL	1	QL (120 per 30 days)
buspirone hcl 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg tablet DL	1	
clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tab; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg dis tablet; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg odt; clonazepam 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg tablet DL	1	
diazepam 10 mg tablet DL	1	QL (120 per 30 days)
hydroxyzine hcl 10 mg, 25 mg, 50 mg tablet DL	1	
lorazepam 0.5 mg, 1 mg tablet DL	1	QL (90 per 30 days)
Bipolar Agents		
lithium carbonate 150 mg, 300 mg, 600 mg cap MD	1	
lithium carbonate er 300 mg, 450 mg tb MD	1	
Blood Glucose Regulators		
acarbose 100 mg, 25 mg, 50 mg tablet MD	1	
BYDUREON 2 MG VIAL MD	3	QL (4 per 28 days)
BYDUREON 2 MG/0.65 ML SUBCUTANEOUS PEN INJECTOR 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)
CYCLOSET 0.8 MG TABLET MD	3	
FARXIGA 10 MG, 5 MG TABLET MD	3	QL (30 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MD	2	
FIASP U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MD	2	
glipizide 10 mg, 5 mg tablet MD	1	
glipizide er 10 mg, 2.5 mg, 5 mg tablet; glipizide xl 10 mg, 2.5 mg, 5 mg tablet MD	1	
GLUCAGEN HYPOKIT 1 MG INJECTION DL	2	
GLUCAGON EMERGENCY KIT (HUMAN-RECOMB) 1 MG SOLUTION FOR INJECTION DL	2	
GLYXAMBI 10 MG-5 MG TABLET; GLYXAMBI 25 MG-5 MG TABLET MD	2	QL (30 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HUMALOG MIX 75-25 (U-100) INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION **MD**	2	
HUMULIN R U-500 (CONCENTRATED) INSULIN 500 UNIT/ML SUBCUTANEOUS SOLN **DL**	2	
HUMULIN R U-500 (CONC) INSULIN KWIKPEN 500 UNIT/ML (3 ML) SUBCUTANEOUS **DL**	2	
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)
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)
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)
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	
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	
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)
nateglinide 120 mg, 60 mg tablet **MD**	1	
NOVOLIN 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML (70-30) SUBCUTANEOUS **MD**	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOLIN 70/30 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SUSPENSION MD	2	
NOVOLIN N NPH U-100 INSULIN ISOPHANE 100 UNIT/ML SUBCUTANEOUS SUSP 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 U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS SOLUTION MD	2	
NOVOLOG MIX 70-30 FLEXPEN U-100 INSULIN 100 UNIT/ML SUBCUTANEOUS PEN MD	2	
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	
ONGLYZA 2.5 MG, 5 MG TABLET MD	3	QL (30 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)
OZEMPIC 1 MG/DOSE (2 MG/1.5 ML) SUBCUTANEOUS PEN INJECTOR MD	2	QL (3 per 28 days)
pioglitazone hcl 15 mg, 30 mg, 45 mg tablet MD	1	QL (30 per 30 days)
PROGLYCEM 50 MG/ML ORAL SUSPENSION DL	3	
repaglinide 0.5 mg, 1 mg, 2 mg tablet MD	1	
SOLIQUA 100/33 100 UNIT-33 MCG/ML SUBCUTANEOUS INSULIN PEN MD	2	QL (15 per 24 days)
SYMLINPEN 120 2,700 MCG/2.7 ML SUBCUTANEOUS PEN INJECTOR DL	4	
SYMLINPEN 60 1,500 MCG/1.5 ML SUBCUTANEOUS PEN INJECTOR DL	4	
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)
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	
TRADJENTA 5 MG TABLET MD	2	QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100 INSULIN 100 UNIT/ML (3 ML) SUBCUTANEOUS PEN MD	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TRESIBA FLEXTOUCH U-200 INSULIN 200 UNIT/ML (3 ML) SUBCUTANEOUS PEN **MD**	2	
TRULICITY 0.75 MG/0.5 ML, 1.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR **MD**	2	QL (2 per 28 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)
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)
XULTOPHY 100/3.6 100 UNIT-3.6 MG/ML (3 ML) SUBCUTANEOUS INSULIN PEN **DL**	2	QL (15 per 30 days)
Blood Products/Modifiers/Volume Expanders		
AMICAR 250 MG/ML (25 %) ORAL SOLUTION **DL**	4	
anagrelide hcl 0.5 mg, 1 mg capsule **MD**	1	
BRILINTA 60 MG, 90 MG TABLET **MD**	2	QL (60 per 30 days)
cilostazol 100 mg, 50 mg tablet **MD**	1	
clopidogrel 75 mg tablet **MD**	1	QL (30 per 30 days)
dipyridamole 25 mg, 50 mg, 75 mg tablet **DL**	1	
ELIQUIS 2.5 MG TABLET **MD**	2	QL (60 per 30 days)
ELIQUIS 5 MG (74 TABS) TABLETS IN A DOSE PACK **DL**	2	QL (74 per 30 days)
ELIQUIS 5 MG TABLET **MD**	2	QL (74 per 30 days)
enoxaparin 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml syr; enoxaparin 100 mg/ml, 120 mg/0.8 ml, 150 mg/ml, 40 mg/0.4 ml, 60 mg/0.6 ml, 80 mg/0.8 ml syringe **DL**	1	
enoxaparin 30 mg/0.3 ml syr **DL**	1	QL (16.8 per 28 days)
fondaparinux 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml syr **DL**	1	
fondaparinux 2.5 mg/0.5 ml syr **DL**	1	
FULPHILA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE **DL**	4	PA,QL (1.2 per 28 days)
NEULASTA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE; NEULASTA 6 MG/0.6 ML, 6 MG/0.6ML WITH WEARABLE SUBCUTANEOUS INJECTOR **DL**	4	PA
NEUPOGEN 300 MCG/0.5 ML, 480 MCG/0.8 ML INJECTION SYRINGE **DL**	4	PA
NEUPOGEN 300 MCG/ML, 480 MCG/1.6 ML INJECTION SOLUTION **DL**	4	PA
PRADAXA 110 MG, 150 MG, 75 MG CAPSULE **MD**	3	QL (60 per 30 days)
RETACRIT 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML INJECTION SOLUTION **DL**	3	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RETACRIT 40,000 UNIT/ML INJECTION SOLUTION DL	4	PA
tranexamic acid 1,000 mg/10 ml DL	1	B vs D
tranexamic acid 650 mg tablet DL	1	
UDENYCA 6 MG/0.6 ML SUBCUTANEOUS SYRINGE DL	4	PA
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	
XARELTO 10 MG, 20 MG TABLET MD	2	QL (30 per 30 days)
XARELTO 15 MG (42)-20 MG (9) TABLETS IN A STARTER PACK DL	2	QL (51 per 30 days)
XARELTO 15 MG, 2.5 MG TABLET MD	2	QL (60 per 30 days)
Cardiovascular Agents		
acetazolamide 125 mg, 250 mg tablet MD	1	
acetazolamide er 500 mg cap MD	1	
amiodarone hcl 100 mg, 200 mg, 400 mg tablet 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)
atenolol 100 mg, 25 mg, 50 mg tablet MD	1	
atorvastatin 10 mg, 20 mg, 40 mg, 80 mg tablet MD	1	QL (30 per 30 days)
BIDIL 20 MG-37.5 MG TABLET DL	2	QL (180 per 30 days)
bumetanide 0.5 mg, 1 mg, 2 mg tablet MD	1	
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)
cartia xt 120 mg, 180 mg, 240 mg, 300 mg capsule,extended release MD	1	
carvedilol 12.5 mg, 25 mg, 3.125 mg, 6.25 mg tablet MD	1	
chlorthalidone 25 mg, 50 mg tablet MD	1	
clonidine 0.1 mg/day patch; clonidine 0.2 mg/day patch; clonidine 0.3 mg/day patch MD	1	
clonidine hcl 0.1 mg, 0.2 mg, 0.3 mg tablet MD	1	
CORLANOR 5 MG, 7.5 MG TABLET MD	3	PA,QL (60 per 30 days)
digoxin 125 mcg tablet DL	1	QL (30 per 30 days)
digoxin 250 mcg tablet DL	1	
diltiazem 24h er(cd) 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg cp; diltiazem 24hr er 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg cap MD	1	
dofetilide 125 mcg, 250 mcg, 500 mcg capsule MD	1	
doxazosin mesylate 1 mg, 2 mg, 4 mg, 8 mg tab MD	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
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)
ezetimibe 10 mg tablet **MD**	1	
fenofibrate 120 mg, 160 mg, 40 mg, 54 mg tablet **MD**	1	
fenofibrate 145 mg, 48 mg tablet **MD**	1	
furosemide 20 mg, 40 mg, 80 mg tablet **MD**	1	
gemfibrozil 600 mg tablet **MD**	1	
hydralazine 10 mg, 100 mg, 25 mg, 50 mg tablet **MD**	1	
hydrochlorothiazide 12.5 mg cp **MD**	1	
hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tab; hydrochlorothiazide 12.5 mg, 25 mg, 50 mg tb **MD**	1	
indapamide 1.25 mg, 2.5 mg tablet **MD**	1	
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	
lisinopril 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg tablet **MD**	1	
losartan potassium 100 mg, 25 mg, 50 mg tab **MD**	1	QL (60 per 30 days)
metolazone 10 mg, 2.5 mg, 5 mg tablet **MD**	1	
metoprolol succ er 100 mg, 200 mg, 25 mg, 50 mg tab **MD**	1	
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	
mexiletine 150 mg, 200 mg, 250 mg capsule **MD**	1	
midodrine hcl 10 mg, 2.5 mg, 5 mg tablet **MD**	1	
moexipril-hctz 15-12.5 mg, 15-25 mg, 7.5-12.5 mg tab; moexipril-hctz 15-12.5 mg, 15-25 mg, 7.5-12.5 mg tablet **MD**	1	
MULTAQ 400 MG TABLET **MD**	2	
niacin er 1,000 mg, 500 mg, 750 mg tablet **MD**	1	
niacor 500 mg tablet **MD**	1	
nifedipine er 30 mg, 60 mg, 90 mg tablet **MD**	1	
NITROSTAT 0.3 MG, 0.4 MG, 0.6 MG SUBLINGUAL TABLET **DL**	2	
pacerone 200 mg tablet **MD**	1	
pentoxifylline er 400 mg tab **MD**	1	
PRALUENT PEN 150 MG/ML, 75 MG/ML SUBCUTANEOUS PEN INJECTOR **DL**	3	PA,QL (2 per 28 days)
pravastatin sodium 10 mg, 20 mg, 80 mg tab **MD**	1	QL (30 per 30 days)
pravastatin sodium 40 mg tab **MD**	1	QL (60 per 30 days)
propafenone hcl er 225 mg, 325 mg, 425 mg cap **MD**	1	
REPATHA PUSHTRONEX 420 MG/3.5 ML SUBCUTANEOUS WEARABLE INJECTOR **DL**	2	PA,QL (3.5 per 28 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
REPATHA SURECLICK 140 MG/ML SUBCUTANEOUS PEN INJECTOR DL	2	PA,QL (3 per 28 days)
REPATHA SYRINGE 140 MG/ML SUBCUTANEOUS SYRINGE DL	2	PA,QL (3 per 28 days)
rosuvastatin calcium 10 mg, 20 mg, 40 mg, 5 mg tab MD	1	QL (30 per 30 days)
simvastatin 10 mg, 20 mg, 40 mg, 5 mg, 80 mg tablet MD	1	QL (30 per 30 days)
spironolactone-hctz 25-25 tab MD	1	
spironolactone 100 mg, 25 mg, 50 mg tablet MD	1	
telmisartan 20 mg, 40 mg tablet MD	1	QL (30 per 30 days)
telmisartan-hctz 40-12.5 mg, 80-25 mg tab; telmisartan-hctz 40-12.5 mg, 80-25 mg tb MD	1	QL (30 per 30 days)
terazosin 1 mg, 10 mg, 2 mg, 5 mg capsule MD	1	
triamterene-hctz 37.5-25 mg, 50-25 mg cap; triamterene-hctz 37.5-25 mg, 50-25 mg cp MD	1	
triamterene-hctz 37.5-25 mg, 75-50 mg tab; triamterene-hctz 37.5-25 mg, 75-50 mg tb MD	1	
valsartan-hctz 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg tab MD	1	QL (30 per 30 days)
VASCEPA 0.5 GRAM, 1 GRAM CAPSULE MD	3	
verapamil er 120 mg, 180 mg, 240 mg tablet MD	1	
WELCHOL 3.75 GRAM ORAL POWDER PACKET DL	2	
WELCHOL 625 MG TABLET DL	2	
Central Nervous System Agents		
AUSTEDO 12 MG, 9 MG TABLET DL	4	PA,QL (120 per 30 days)
AUSTEDO 6 MG TABLET DL	4	PA,QL (60 per 30 days)
BETASERON 0.3 MG SUBCUTANEOUS KIT DL	4	
COPAXONE 20 MG/ML, 40 MG/ML SUBCUTANEOUS SYRINGE DL	4	
dexmethylphenidate 10 mg, 2.5 mg, 5 mg tab DL	1	QL (60 per 30 days)
dextroamp-amphet er 10 mg, 15 mg, 5 mg cap DL	1	QL (30 per 30 days)
dextroamp-amphet er 20 mg, 25 mg, 30 mg cap DL	1	QL (60 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)
dextroamp-amphetamin 30 mg tab DL	1	QL (60 per 30 days)
GILENYA 0.25 MG, 0.5 MG CAPSULE DL	4	QL (30 per 30 days)
NUEDEXTA 20 MG-10 MG CAPSULE DL	3	PA
REBIF (WITH ALBUMIN) 22 MCG/0.5 ML, 44 MCG/0.5 ML SUBCUTANEOUS SYRINGE DL	4	
REBIF TITRATION PACK 8.8 MCG/0.2 ML-22 MCG/0.5 ML SUBCUTANEOUS SYRINGE DL	4	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
riluzole 50 mg tablet DL	1	
SAVELLA 100 MG, 12.5 MG, 25 MG, 50 MG TABLET MD	2	
SAVELLA 12.5 MG (5)-25 MG(8)-50MG(42) TABLETS IN A DOSE PACK DL	2	
TECFIDERA 120 MG (14)-240 MG (46) CAPSULE,DELAYED RELEASE DL	4	
TECFIDERA 120 MG CAPSULE,DELAYED RELEASE DL	4	QL (14 per 30 days)
TECFIDERA 240 MG CAPSULE,DELAYED RELEASE DL	4	QL (60 per 30 days)
Dental & Oral Agents		
chlorhexidine 0.12% rinse DL	1	
periogard 0.12 % mouthwash DL	1	
pilocarpine hcl 5 mg, 7.5 mg tablet MD	1	
triamcinolone 0.1% paste DL	1	
Dermatological Agents		
ammonium lactate 12% cream DL	1	
ammonium lactate 12% lotion DL	1	
COSENTYX 150 MG/ML SUBCUTANEOUS SYRINGE DL	4	PA
COSENTYX 300 MG/2 SYRINGES (150 MG/ML) SUBCUTANEOUS DL	4	PA
COSENTYX PEN 150 MG/ML SUBCUTANEOUS DL	4	PA
COSENTYX PEN 300 MG/2 PENS (150 MG/ML) SUBCUTANEOUS DL	4	PA
ENSTILAR 0.005 %-0.064 % TOPICAL FOAM DL	3	QL (120 per 30 days)
fluorouracil 2% topical soln; fluorouracil 5% topical soln DL	1	
methoxsalen 10 mg capsule DL	1	
PICATO 0.015 %, 0.05 % TOPICAL GEL DL	2	
RECTIV 0.4 % (W/W) OINTMENT DL	3	QL (30 per 30 days)
REGRANEX 0.01 % TOPICAL GEL DL	4	
SANTYL 250 UNIT/GRAM TOPICAL OINTMENT DL	3	
STELARA 130 MG/26 ML, 45 MG/0.5 ML INTRAVENOUS SOLUTION; STELARA 130 MG/26 ML, 45 MG/0.5 ML SUBCUTANEOUS SOLUTION DL	4	PA
STELARA 45 MG/0.5 ML, 90 MG/ML SUBCUTANEOUS SYRINGE DL	4	PA
TOLAK 4 % TOPICAL CREAM DL	2	
tretinoin 0.01% gel; tretinoin 0.025% gel; tretinoin 0.05% gel DL	1	PA
tretinoin 0.025% cream; tretinoin 0.05% cream; tretinoin 0.1% cream DL	1	PA
Electrolytes/Minerals/Metals/Vitamins		
AURYXIA 210 MG IRON TABLET MD	3	PA
calcium acetate 667 mg gelcap MD	1	
CLINIMIX 5 % IN 20 % DEXTROSE (SULFITE-FREE) INTRAVENOUS SOLUTION DL	3	B vs D
CLINIMIX E 2.75%-10% SOLUTION DL	3	B vs D

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
EXJADE 125 MG, 250 MG, 500 MG DISPERSIBLE TABLET DL	4	PA
kionex powder DL	1	
KLOR-CON 10 MEQ TABLET,EXTENDED RELEASE MD	1	
klor-con m10 meq tablet,extended release MD	1	
potassium cl er 10 meq, 20 meq tablet MD	1	
potassium cl er 10 meq, 8 meq capsule MD	1	
potassium citrate er 10 meq (1,080 mg), 15 meq, 5 meq (540 mg) tb; potassium citrate er 10 meq tb; potassium citrate er 5 meq tab DL	1	
pr natal 400 ec 29 mg-1 mg-400 mg tablet-capsule,delayed release DL	1	
PRENATABS FA 29 MG-1 MG TABLET DL	1	
RENVELA 0.8 GRAM, 2.4 GRAM ORAL POWDER PACKET DL	2	
RENVELA 800 MG TABLET DL	2	
SAMSCA 15 MG, 30 MG TABLET DL	4	
sodium lactate 50 meq/10 ml vl DL	1	
SPS (WITH SORBITOL) 15 GRAM-20 GRAM/60 ML ORAL SUSPENSION DL	1	
Gastrointestinal Agents		
AMITIZA 24 MCG, 8 MCG CAPSULE MD	2	QL (60 per 30 days)
CARAFATE 100 MG/ML ORAL SUSPENSION MD	3	
cimetidine 200 mg, 300 mg, 400 mg, 800 mg tablet MD	1	
DEXILANT 30 MG, 60 MG CAPSULE, DELAYED RELEASE MD	3	QL (30 per 30 days)
dicyclomine 10 mg capsule DL	1	
dicyclomine 20 mg tablet DL	1	
diphenoxylat-atrop 2.5-0.025/5 DL	1	
diphenoxylate-atrop 2.5-0.025 DL	1	
generlac 10 gram/15 ml oral solution DL	1	
lactulose 10 gm/15 ml solution; lactulose 20 gm/30 ml solution DL	1	
lansoprazole dr 30 mg capsule MD	1	QL (30 per 30 days)
LINZESS 145 MCG, 290 MCG, 72 MCG CAPSULE MD	2	QL (30 per 30 days)
misoprostol 100 mcg, 200 mcg tablet MD	1	
MOVANTIK 12.5 MG, 25 MG TABLET DL	3	QL (30 per 30 days)
MYALEPT 5 MG/ML (FINAL CONCENTRATION) SUBCUTANEOUS SOLUTION DL	4	PA
omeprazole dr 20 mg, 40 mg capsule MD	1	
pantoprazole sod dr 20 mg, 40 mg tab MD	1	QL (60 per 30 days)
PYLERA 140 MG-125 MG-125 MG CAPSULE DL	3	QL (144 per 30 days)
ranitidine 150 mg, 300 mg tablet MD	1	
RELISTOR 12 MG/0.6 ML SUBCUTANEOUS SOLUTION DL	3	
RELISTOR 12 MG/0.6 ML, 8 MG/0.4 ML SUBCUTANEOUS SYRINGE DL	3	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
RELISTOR 150 MG TABLET DL	3	
sucralfate 1 gm tablet MD	1	
SUPREP BOWEL PREP KIT 17.5 GRAM-3.13 GRAM-1.6 GRAM ORAL SOLUTION DL	2	
trilyte with flavor packets 420 gram oral solution DL	1	
ursodiol 250 mg, 500 mg tablet MD	1	
VIBERZI 100 MG, 75 MG TABLET DL	4	PA,QL (60 per 30 days)
XIFAXAN 200 MG, 550 MG TABLET DL	4	PA
Genetic/Enzyme Disorder: Replacement, Modifiers, Treatment		
ARALAST NP 1,000 MG, 500 MG INTRAVENOUS SOLUTION DL	4	PA
CERDELGA 84 MG CAPSULE DL	4	PA
CEREZYME 400 UNIT INTRAVENOUS SOLUTION DL	4	PA
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	
ELELYSO 200 UNIT INTRAVENOUS SOLUTION DL	4	PA
GLASSIA 1 GRAM/50 ML (2 %) INTRAVENOUS SOLUTION DL	4	PA
STRENSIQ 18 MG/0.45 ML, 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML SUBCUTANEOUS SOLUTION DL	4	PA
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; ZENPEP DR 10,000 UNIT CAPSULE; ZENPEP DR 15,000 UNIT CAPSULE; ZENPEP DR 20,000 UNIT CAPSULE; ZENPEP DR 25,000 UNIT CAPSULE; ZENPEP DR 3,000 UNIT CAPSULE; ZENPEP DR 40,000 UNIT CAPSULE; ZENPEP DR 5,000 UNIT CAPSULE MD	2	
Genitourinary Agents		
alfuzosin hcl er 10 mg tablet MD	1	
bethanechol 10 mg, 25 mg, 5 mg, 50 mg tablet DL	1	
dutasteride 0.5 mg capsule MD	1	QL (30 per 30 days)
ELMIRON 100 MG CAPSULE DL	4	
finasteride 5 mg tablet MD	1	
MYRBETRIQ 25 MG, 50 MG TABLET,EXTENDED RELEASE MD	2	

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
oxybutynin 5 mg tablet MD	1	
oxybutynin cl er 10 mg, 15 mg, 5 mg tablet MD	1	QL (60 per 30 days)
tamsulosin hcl 0.4 mg capsule MD	1	
TOVIAZ 4 MG, 8 MG TABLET,EXTENDED RELEASE MD	3	QL (30 per 30 days)
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
ACTHAR 80 UNIT/ML INJECTION GEL DL	4	PA,QL (30 per 30 days)
desonide 0.05% cream DL	1	
desoximetasone 0.05% cream; desoximetasone 0.25% cream DL	1	
methylprednisolone 4 mg dosepk DL	1	
prednisone 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg tablet DL	1	B vs D
triderm 0.1 %, 0.5 % topical cream DL	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)		
chorionic gonad 10,000 unit vl DL	1	PA
desmopressin acetate 0.1 mg, 0.2 mg tb DL	1	
EGRIFTA 1 MG SUBCUTANEOUS SOLUTION DL	4	PA
INCRELEX 10 MG/ML SUBCUTANEOUS SOLUTION DL	4	PA
OMNITROPE 10 MG/1.5 ML (6.7 MG/ML), 5 MG/1.5 ML (3.3 MG/ML) SUBCUTANEOUS CARTRIDGE DL	4	PA
OMNITROPE 5.8 MG SUBCUTANEOUS SOLUTION DL	4	PA
Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)		
HEMABATE 250 MCG/ML INTRAMUSCULAR SOLUTION DL	3	
Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormones/Modifiers)		
danazol 100 mg, 200 mg, 50 mg capsule DL	1	
DUAVEE 0.45 MG-20 MG TABLET DL	3	PA,QL (30 per 30 days)
ELLA 30 MG TABLET DL	2	
estradiol 0.5 mg, 1 mg, 2 mg tablet DL	1	
ESTRING 2 MG (7.5 MCG/24 HOUR) VAGINAL RING MD	3	
medroxyprogesterone 10 mg, 2.5 mg, 5 mg tab MD	1	
MENEST 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG TABLET DL	3	
norg-ee 0.18-0.215-0.25/0.025; norg-ee 0.18-0.215-0.25/0.035; norg-ethin estra 0.25-0.035 mg MD	1	
nortrel 1/35 (21) 1 mg-35 mcg tablet MD	1	
oxandrolone 10 mg tablet DL	1	PA
oxandrolone 2.5 mg tablet DL	1	PA
PREMARIN 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG TABLET DL	3	
PREMARIN 0.625 MG/GRAM VAGINAL CREAM MD	2	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
PREMARIN 25 MG SOLUTION FOR INJECTION DL	3	
raloxifene hcl 60 mg tablet MD	1	
Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)		
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	
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	
UNITHROID 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	
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN 500 MG TABLET DL	4	
Hormonal Agents, Suppressant (Pituitary)		
octreotide 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml vial; octreotide acet 0.05 mg/ml vl; octreotide acet 1,000 mcg/ml, 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml vl DL	1	PA
SOMATULINE DEPOT 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3 ML SUBCUTANEOUS SYRINGE DL	4	
SOMAVERT 10 MG, 15 MG, 20 MG SUBCUTANEOUS SOLUTION DL	4	PA,QL (60 per 30 days)
SYNAREL 2 MG/ML NASAL SPRAY DL	4	
Hormonal Agents, Suppressant (Thyroid)		
methimazole 10 mg, 5 mg tablet MD	1	
propylthiouracil 50 mg tablet MD	1	
Immunological Agents		
ACTIMMUNE 100 MCG (2 MILLION UNIT)/0.5 ML SUBCUTANEOUS SOLUTION DL	4	
BOOSTRIX TDAP 2.5 LF UNIT-8 MCG-5 LF/0.5 ML INTRAMUSCULAR SUSPENSION DL	1	
CINRYZE 500 UNIT (5 ML) INTRAVENOUS SOLUTION DL	4	PA
cyclosporine modified 100 mg, 25 mg, 50 mg MD	1	B vs D
ENBREL 25 MG (1 ML) SUBCUTANEOUS SOLUTION DL	4	PA
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
ENBREL MINI 50 MG/ML (1 ML) SUBCUTANEOUS CARTRIDGE DL	4	PA
ENBREL SURECLICK 50 MG/ML (1 ML) SUBCUTANEOUS PEN INJECTOR DL	4	PA
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
HAEGARDA 2,000 UNIT, 3,000 UNIT SUBCUTANEOUS SOLUTION DL	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
HIZENTRA 1 GRAM/5 ML (20 %), 10 GRAM/50 ML (20 %), 2 GRAM/10 ML (20 %), 4 GRAM/20 ML (20 %) SUBCUTANEOUS SOLUTION DL	4	PA
HUMIRA 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT DL	4	PA
HUMIRA PEDIATRIC CROHN'S STARTER 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT DL	4	PA
HUMIRA PEN 40 MG/0.8 ML SUBCUTANEOUS KIT DL	4	PA
HUMIRA PEN CROHN'S-ULC COLITIS-HID SUP STARTER 40 MG/0.8 ML SUBCUT KIT DL	4	PA
HUMIRA PEN PSORIASIS-UVEITIS-ADOL HID SUP START 40 MG/0.8 ML SUBCUT KT DL	4	PA
HUMIRA(CF) 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT DL	4	PA
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
HUMIRA(CF) PEN 40 MG/0.4 ML, 80 MG/0.8 ML SUBCUTANEOUS KIT DL	4	PA
HUMIRA(CF) PEN CROHN'S-ULC COLITIS-HID SUP STRT 80 MG/0.8 ML SUBCUT KT DL	4	PA
HUMIRA(CF) PEN PS-UV-ADOL HS 80 MG/0.8 ML(1)-40 MG/0.4 ML(2)SUBCUT KIT DL	4	PA
HYPERRAB S/D (PF) 150 UNIT/ML INTRAMUSCULAR SOLUTION DL	3	B vs D
IMOGAM RABIES-HT (PF) 150 UNIT/ML INTRAMUSCULAR SOLUTION DL	3	B vs D
INFANRIX (DTAP) (PF) 25 LF UNIT-58 MCG-10 LF/0.5ML INTRAMUSCULAR SUSP DL	1	
INFLECTRA 100 MG INTRAVENOUS SOLUTION DL	4	PA
IPOL 40 UNIT-8 UNIT-32 UNIT/0.5 ML SUSPENSION FOR INJECTION DL	1	
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)
leflunomide 10 mg, 20 mg tablet DL	1	
methotrexate 2.5 mg tablet DL	1	B vs D
mycophenolate 250 mg capsule MD	1	B vs D
REMICADE 100 MG INTRAVENOUS SOLUTION DL	4	PA
RIDAURA 3 MG CAPSULE DL	4	
RUCONEST 2,100 UNIT INTRAVENOUS SOLUTION DL	4	PA
SHINGRIX (PF) 50 MCG/0.5 ML INTRAMUSCULAR SUSPENSION, KIT DL	1	
SIMPONI 100 MG/ML, 50 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR DL	4	PA
SIMPONI 100 MG/ML, 50 MG/0.5 ML SUBCUTANEOUS SYRINGE DL	4	PA

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
SIMPONI ARIA 12.5 MG/ML INTRAVENOUS SOLUTION DL	4	PA
SYNAGIS 100 MG/ML, 50 MG/0.5 ML INTRAMUSCULAR SOLUTION DL	4	PA
TYPHIM VI 25 MCG/0.5 ML INTRAMUSCULAR SOLUTION DL	2	
ZOSTAVAX (PF) 19,400 UNIT/0.65 ML SUBCUTANEOUS SUSPENSION DL	3	
Inflammatory Bowel Disease Agents		
APRISO 0.375 GRAM CAPSULE,EXTENDED RELEASE MD	2	QL (120 per 30 days)
balsalazide disodium 750 mg cp DL	1	
budesonide ec 3 mg capsule DL	1	
CANASA 1,000 MG RECTAL SUPPOSITORY DL	4	
hydrocortisone 100 mg/60 ml DL	1	
Metabolic Bone Disease Agents		
alendronate sodium 10 mg, 35 mg, 40 mg, 5 mg, 70 mg tab; alendronate sodium 10 mg, 35 mg, 40 mg, 5 mg, 70 mg tablet MD	1	
BINOSTO 70 MG EFFERVESCENT TABLET MD	3	
calcitonin-salmon 200 units sp MD	1	
calcitriol 0.25 mcg, 0.5 mcg capsule MD	1	
doxercalciferol 0.5 mcg, 1 mcg, 2.5 mcg cap; doxercalciferol 0.5 mcg, 1 mcg, 2.5 mcg capsule MD	1	
FORTEO 20 MCG/DOSE (600 MCG/2.4 ML) SUBCUTANEOUS PEN INJECTOR DL	3	PA,QL (2.4 per 28 days)
PROLIA 60 MG/ML SUBCUTANEOUS SYRINGE DL	3	B vs D,QL (1 per 180 days)
RAYALDEE 30 MCG CAPSULE,EXTENDED RELEASE DL	4	QL (60 per 30 days)
SENSIPAR 30 MG, 60 MG TABLET DL	4	PA,QL (60 per 30 days)
SENSIPAR 90 MG TABLET DL	4	PA,QL (120 per 30 days)
Miscellaneous Therapeutic Agents		
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)
AIMOVIG 140 MG DOSE-2 AUTOINJ DL	3	PA,QL (2 per 30 days)
ALCOHOL SWAB MD	1	
BD SAFETYGLIDE INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64" MD	1	
BD ULTRA-FINE ORIGINAL PEN NEEDLE 29 GAUGE X 1/2" MD	1	
BOTOX 100 UNIT, 200 UNIT INJECTION DL	3	B vs D
EMGALITY PEN 120 MG/ML SUBCUTANEOUS PEN INJECTOR DL	3	PA,QL (2 per 30 days)
EMGALITY 120 MG/ML SUBCUTANEOUS SYRINGE DL	3	PA,QL (2 per 30 days)
NOVOFINE 30G X 1/3" NEEDLES MD	1	
NOVOFINE 32 32 GAUGE X 1/4" NEEDLE MD	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
NOVOFINE AUTOCOVER 30 GAUGE X 1/3" NEEDLE MD	1	
NOVOFINE PLUS 32 GAUGE X 1/6" NEEDLE MD	1	
NOVOTWIST 32 GAUGE X 1/5" NEEDLE MD	1	
OMNIPOD DASH INSULIN POD SUBCUTANEOUS CARTRIDGE MD	2	
OMNIPOD INSULIN MANAGEMENT MD	2	
OMNIPOD INSULIN REFILL SUBCUTANEOUS CARTRIDGE MD	2	
PHYSIOLYTE 140 MEQ-5 MEQ-3 MEQ-98 MEQ/L IRRIGATION SOLUTION DL	3	
V-GO 20 DEVICE MD	1	
V-GO 30 DEVICE MD	1	
V-GO 40 DEVICE MD	1	
Ophthalmic Agents		
ALPHAGAN P 0.1 % EYE DROPS MD	2	
atropine 1% eye drops DL	1	
azelastine hcl 0.05% drops DL	1	
AZOPT 1 % EYE DROPS,SUSPENSION MD	2	
BEPREVE 1.5 % EYE DROPS DL	3	
brimonidine 0.2% eye drop; brimonidine tartrate 0.15% drp MD	1	
COMBIGAN 0.2 %-0.5 % EYE DROPS MD	2	
dorzolamide hcl 2% eye drops MD	1	
DUREZOL 0.05 % EYE DROPS DL	2	
epinastine hcl 0.05% eye drops DL	1	
ILEVRO 0.3 % EYE DROPS,SUSPENSION DL	2	
ketorolac 0.4% ophth solution; ketorolac 0.5% ophth solution DL	1	
latanoprost 0.005% eye drops MD	1	
LOTEMAX 0.5 % EYE DROPS,SUSPENSION; LOTEMAX 0.5 % EYE GEL DROPS DL	3	
LOTEMAX 0.5 % EYE OINTMENT DL	3	
LUMIGAN 0.01 % EYE DROPS MD	2	
olopatadine hcl 0.1% eye drops; olopatadine hcl 0.2% eye drop DL	1	
PAZEO 0.7 % EYE DROPS DL	2	
PHOSPHOLINE IODIDE 0.125 % EYE DROPS MD	3	
pilocarpine 1% eye drops; pilocarpine 2% eye drops; pilocarpine 4% eye drops MD	1	
prednisolone ac 1% eye drop DL	1	
proparacaine 0.5% eye drops DL	1	
RESTASIS 0.05 % EYE DROPS IN A DROPPERETTE DL	2	QL (60 per 30 days)
RESTASIS MULTIDOSE 0.05 % EYE DROPS DL	2	
timolol maleate 0.25% eye drop; timolol maleate 0.5% eye drops MD	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
tobramycin-dexameth ophth susp DL	1	
TRAVATAN Z 0.004 % EYE DROPS MD	2	
XIIDRA 5 % EYE DROPS IN A DROPPERETTE DL	3	QL (60 per 30 days)
Otic Agents		
neomycin-polymyxin-hc ear soln DL	1	
neomycin-polymyxin-hc ear susp DL	1	
Respiratory Tract/Pulmonary Agents		
acetylcysteine 10% vial; acetylcysteine 20% vial DL	1	B vs D
ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLET DL	4	PA
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)
albuterol 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml sol; albuterol 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml solution; albuterol sul 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml, 5 mg/ml sol; albuterol sul 2.5 mg/3 ml soln MD	1	B vs D
ANORO ELLIPTA 62.5 MCG-25 MCG/ACTUATION POWDER FOR INHALATION MD	2	QL (60 per 30 days)
ARNUITY ELLIPTA 100 MCG/ACTUATION, 200 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION MD	2	QL (30 per 30 days)
azelastine 0.1% (137 mcg) spry DL	1	
BEVESPI AEROSPHERE 9 MCG-4.8 MCG HFA AEROSOL INHALER DL	3	QL (10.7 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)
BROVANA 15 MCG/2 ML SOLUTION FOR NEBULIZATION DL	4	PA,QL (120 per 30 days)
CAYSTON 75 MG/ML SOLUTION FOR NEBULIZATION DL	4	PA
cetirizine hcl 1 mg/ml soln DL	1	
COMBIVENT RESPIMAT 20 MCG-100 MCG/ACTUATION SOLUTION FOR INHALATION MD	2	
cromolyn 100 mg/5 ml oral conc DL	1	
cromolyn 20 mg/2 ml neb soln DL	1	B vs D
cyproheptadine 2 mg/5 ml syrup DL	1	
cyproheptadine 4 mg tablet DL	1	
DALIRESP 250 MCG, 500 MCG TABLET MD	2	
epinephrine 0.15 mg auto-injct; epinephrine 0.3 mg auto-inject DL	2	QL (4 per 30 days)

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
EPIPEN 2-PAK 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR DL	3	QL (4 per 30 days)
EPIPEN JR 2-PAK 0.15 MG/0.3 ML INJECTION,AUTO-INJECTOR DL	3	QL (4 per 30 days)
ESBRIET 267 MG CAPSULE DL	4	PA,QL (270 per 30 days)
ESBRIET 267 MG TABLET DL	4	PA,QL (270 per 30 days)
ESBRIET 801 MG TABLET DL	4	PA,QL (90 per 30 days)
FLOVENT DISKUS 100 MCG/ACTUATION, 250 MCG/ACTUATION, 50 MCG/ACTUATION POWDER FOR INHALATION MD	2	
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)
fluticasone prop 50 mcg spray DL	1	
INCRUSE ELLIPTA 62.5 MCG/ACTUATION POWDER FOR INHALATION DL	2	QL (30 per 30 days)
ipratropium 0.03% spray MD	1	
ipratropium 0.06% spray DL	1	
iprat-albut 0.5-3(2.5) mg/3 ml MD	1	B vs D
KALYDECO 150 MG TABLET DL	4	PA
KALYDECO 50 MG, 75 MG ORAL GRANULES IN PACKET DL	4	PA
LETAIRIS 10 MG, 5 MG TABLET DL	4	PA,QL (30 per 30 days)
levocetirizine 5 mg tablet DL	1	
montelukast sod 10 mg tablet MD	1	QL (30 per 30 days)
montelukast sod 4 mg, 5 mg tab chew MD	1	QL (30 per 30 days)
OFEV 100 MG, 150 MG CAPSULE DL	4	PA,QL (60 per 30 days)
OPSUMIT 10 MG TABLET DL	4	PA
PERFOROMIST 20 MCG/2 ML SOLUTION FOR NEBULIZATION MD	3	PA,QL (120 per 30 days)
PULMOZYME 1 MG/ML SOLUTION FOR INHALATION DL	4	B vs D
QVAR 40 MCG ORAL INHALER; QVAR 80 MCG ORAL INHALER MD	3	ST
SEREVENT DISKUS 50 MCG/DOSE POWDER FOR INHALATION MD	2	QL (60 per 30 days)
sildenafil 20 mg tablet DL	1	PA
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)
STIOLTO RESPIMAT 2.5 MCG-2.5 MCG/ACTUATION SOLUTION FOR INHALATION MD	2	
STRIVERDI RESPIMAT 2.5 MCG/ACTUATION SOLUTION FOR INHALATION MD	3	
SYMBICORT 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER; SYMBICORT 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER DL	2	QL (10.2 per 30 days)
theophylline er 100 mg, 200 mg, 300 mg, 450 mg tab; theophylline er 100 mg, 200 mg, 300 mg, 450 mg tablet MD	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
TOBI PODHALER 28 MG CAPSULE WITH INHALATION DEVICE; TOBI PODHALER 28 MG CAPSULES FOR INHALATION DL	4	PA,QL (224 per 28 days)
TRACLEER 125 MG, 62.5 MG TABLET DL	4	PA,QL (60 per 30 days)
TRELEGY ELLIPTA 100 MCG-62.5 MCG-25 MCG POWDER FOR INHALATION DL	2	QL (60 per 30 days)
TUDORZA PRESSAIR 400 MCG/ACTUATION BREATH ACTIVATED MD	3	
VENTAVIS 10 MCG/ML, 20 MCG/ML SOLUTION FOR NEBULIZATION DL	4	PA
VENTOLIN HFA 90 MCG/ACTUATION AEROSOL INHALER DL	2	
zafirlukast 10 mg, 20 mg tablet MD	1	
Skeletal Muscle Relaxants		
carisoprodol 350 mg tablet DL	1	QL (120 per 30 days)
cyclobenzaprine 10 mg, 5 mg, 7.5 mg tablet DL	1	PA
methocarbamol 500 mg, 750 mg tablet DL	1	
orphenadrine 30 mg/ml vial DL	1	
Sleep Disorder Agents		
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)
modafinil 100 mg, 200 mg tablet DL	1	PA,QL (60 per 30 days)
zolpidem tartrate 10 mg, 5 mg tablet DL	1	QL (30 per 30 days)

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PEEHIP Humana Group Medicare Advantage Plan Coverage of Additional Prescription Drugs

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
FERTILITY		
CETROTIDE 0.25 MG SUBCUTANEOUS KIT **DL**	3	
clomiphene citrate 50 mg tab **DL**	1	
FOLLISTIM AQ 300 UNIT/0.36 ML, 600 UNIT/0.72 ML, 900 UNIT/1.08 ML SUBCUTANEOUS CARTRIDGE **DL**	3	
ganirelix acet 250 mcg/0.5 ml **DL**	3	
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	
MENOPUR 75 UNIT SUBCUTANEOUS SOLUTION **DL**	3	
OVIDREL 250 MCG/0.5 ML SUBCUTANEOUS SYRINGE **DL**	3	
CUSTOM DRUGS		
anucort-hc 25 mg suppository **DL**	1	
belladonna-opium 16.2-30 supp; belladonna-opium 16.2-60 supp **DL**	3	
benzonatate 100 mg, 150 mg, 200 mg capsule **DL**	1	
cheratussin ac syrup **DL**	1	
chlordiazepoxide-clidinium cap **DL**	1	
choline mag trisal liquid **DL**	1	
codeine-guaifen 10-100 mg/5 ml **DL**	1	
cyanocobalamin 1,000 mcg/ml **DL**	1	
dermazene 1 %-1 % topical cream **DL**	1	
DONNATAL 16.2 MG-0.1037 MG-0.0194 MG/5 ML ORAL ELIXIR; DONNATAL 16.2 MG-0.1037 MG/5 ML (5 ML), 16.2-0.1037 -0.0194 MG/5 ML ORAL ELIXIR **DL**	3	
EFFER-K 10 MEQ EFFERVESCENT TABLET **DL**	3	
FLUORIDEX SENSITIVITY RELIEF 1.1 %-5 % DENTAL PASTE **DL**	1	
folic acid 1 mg tablet **MD**	1	
g tussin ac 10 mg-100 mg/5 ml oral liquid **DL**	1	
GALZIN 25 MG (ZINC), 50 MG (ZINC) CAPSULE **DL**	3	

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ST - Step Therapy • QL - Quantity Limit • PA - Prior Authorization • B vs D - Part B versus Part D

DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
CUSTOM DRUGS		
guaiatussin ac 10 mg-100 mg/5 ml oral liquid **DL**	1	
guaifenesin ac 10 mg-100 mg/5 ml oral liquid **DL**	1	
guaifenesin dac 30 mg-10 mg-100 mg/5 ml oral syrup **DL**	1	
hemmorex-hc 25 mg, 30 mg rectal suppository; hemmorex-hc 25 mg, 30 mg suppository **DL**	1	
hydrocodone-chlorphen er susp **DL**	1	
hydrocod-cpm-pseudoep 5-4-60/5 **DL**	1	
hydrocodone-homatropine 5-1.5 **DL**	1	
hydrocodone-homatropine syrup **DL**	1	
hydrocortisone ac 25 mg, 30 mg supp **DL**	1	
hydrocortisone-iodoquinol crm **DL**	1	
hydrocort-pramoxine 2.5%-1% cm **DL**	1	
hyophen 81.6 mg-0.12 mg-10.8 mg tablet **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	
lidocaine-hc 3-0.5% cream **DL**	1	
lidocaine-prilocaine cream **DL**	1	
me-naphos-mb-hyo 1 tablet **DL**	1	
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	
phenazopyridine 100 mg, 200 mg tab **DL**	1	
belladonna-phenobarbital 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	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
CUSTOM DRUGS		
phytonadione 5 mg tablet **DL**	1	
potassium cl 25 meq tab eff **DL**	1	
pot citrate-citric acid packet **DL**	1	
promethazine vc-codeine syrup **DL**	1	
promethazine-codeine syrup **DL**	1	
promethazine-dm solution **DL**	1	
promethazine-pe-codeine syrup **DL**	1	
robafen ac 10 mg-100 mg/5 ml oral liquid **DL**	1	
salsalate 500 mg, 750 mg tablet **DL**	1	
sod sulfacetam 10% clnsng gel; sodium sulfacetamide 10% wash **DL**	1	
sod sulfacetamide 10% shampoo **DL**	1	
sod sulfac-sulfur 9.8-4.8% crm; sulfacetamide-sulfur 10-2% crm; sulfacetamide-sulfur 10-5% crm **DL**	1	
sod sulfac-sulfur 9.8-4.8% lot; sod sulfacetamide-sulfur lotn **DL**	1	
sod sulface-sulf 9.8-4.8% clsr; sod sulface-sulfur 9-4.5% wash; sod sulfacet-sulfur 10-2% clsr; sod sulfacet-sulfur 10-5% clsr; sodium sulfacet-sulfur wash **DL**	1	
sod sulfacet-sulfur 10-4% pad **DL**	1	
sod sulfacetamide-sulfur susp; sulfacetamide-sulfur 8-4% susp **DL**	1	
thyroid 120 mg, 15 mg, 30 mg, 60 mg, 90 mg tablet **MD**	1	
TUSSICAPS 10 MG-8 MG CAPSULE,EXTENDED RELEASE; TUSSICAPS 5 MG-4 MG CAPSULE,EXTENDED RELEASE **DL**	3	
tussigon 5-1.5 mg tablet **DL**	1	
umecta 40 % topical foam **DL**	3	
ur n-c tablet **DL**	1	
urea 40% cream **DL**	1	
URELLE 81 MG-10.8 MG-40.8 MG TABLET **DL**	1	
URETRON D-S 81.6 MG-10.8 MG-40.8 MG TABLET **DL**	1	
URIBEL 118 MG-10 MG-40.8 MG-36 MG CAPSULE **DL**	1	
urimar-t 120 mg-0.12 mg-10.8 mg tablet **DL**	3	
urin ds 81.6 mg-10.8 mg-40.8 mg tablet **DL**	1	
uro-458 81 mg-10.8 mg-40.8 mg tablet **DL**	1	

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DRUG NAME	TIER	UTILIZATION MANAGEMENT REQUIREMENTS
CUSTOM DRUGS		
uro-mp 118 mg-10 mg-40.8 mg-36 mg capsule **DL**	1	
UROGESIC-BLUE 81.6 MG-40.8 MG-0.12 MG TABLET **DL**	1	
uryl 81.6 mg-40.8 mg-0.12 mg tablet **DL**	1	
ustell 120 mg-0.12 mg capsule **DL**	1	
utira-c 81.6 mg-10.8 mg-40.8 mg tablet **DL**	1	
UTOPIC 41 % TOPICAL CREAM **DL**	3	
vilamit mb 118 mg-10 mg-40.8 mg-36 mg capsule **DL**	1	
vilevev mb 81 mg-10.8 mg-40.8 mg tablet **DL**	1	
virtussin ac 10 mg-100 mg/5 ml oral liquid **DL**	1	
virtussin dac 30 mg-10 mg-100 mg/5 ml oral syrup **DL**	1	
WESTHROID 130 MG, 195 MG, 32.5 MG, 65 MG, 97.5 MG TABLET **DL**	3	
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 **DL**	3	
ZITHRANOL 1 % SHAMPOO **DL**	3	

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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 identity, 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 the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, 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**.

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'dęę́ nika'adoowoł.

العربية (Arabic)

الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

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This abridged formulary was updated on 11/13/2019 and is not a complete list of drugs covered by our plan. For a complete listing, more recent information or other questions, please contact PEEHIP Humana Group Medicare Advantage Plan at 1-800-747-0008 or, for TTY users, 711, 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. Please leave your name and telephone number, and we'll call you back by the end of the next business day, or visit https://our.Humana.com/peehip/.

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