Providence
Medicare Advantage Plans

Providence Medicare Advantage Plans Dual Plus + Rx (HMO D-SNP) 2026 Formulary (List of Covered Drugs or "Drug List")

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

Formulary ID: 00026069

This formulary was updated on 09/02/2025.

If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th, we are closed Saturdays and Sundays, or visit ProvidenceHealthAssurance.com.

PROVIDENCE MEDICARE ADVANTAGE PLANS

DUAL PLUS + RX (HMO D-SNP)

2026 Formulary

(List of Covered Drugs or "Drug List")

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this Drug List (formulary) refers to "we," "us", or "our," it means Providence Health Assurance. When it refers to "plan" or "our plan," it means Providence Medicare Dual Plus + Rx (HMO D-SNP).

This document includes a Drug List (formulary) for our plan which is current as of 09/2025. For an updated Drug List (formulary), please contact us. Our contact information, along with the date we last updated the Drug List (formulary), appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2027, and from time to time during the year.

What is the Providence Medicare Advantage Plans Dual Plus + Rx (HMO D-SNP) formulary?

In this document, we use the terms Drug List and formulary to mean the same thing. A formulary is a list of covered drugs selected by Providence Medicare Dual Plus + Rx (HMO D-SNP) in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Providence Medicare Dual Plus + Rx (HMO D-SNP) will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Providence Medicare Dual Plus + Rx (HMO D-SNP) network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary change?

Most changes in drug coverage happen on January 1, but Providence Medicare Dual Plus + Rx (HMO D-SNP) may add or remove drugs on the formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted monthly to our website here: www.ProvidenceHealthAssurance.com/formulary.

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

- **Immediate substitutions of certain new versions of brand name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary but immediately move it to a different cost-sharing tier or add new restrictions.

  We can make these immediate changes only if we are adding a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

  If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

  If we make such a change, you or your prescriber can ask us to make an exception and continue to cover for you the drug that is being changed. For more

information, see the section titled “How do I request an exception to the Providence Medicare Dual Plus + Rx (HMO D-SNP)’s Formulary?”

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **Drugs removed from the market.** If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may remove a brand name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand name drug or original biological product or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a 30-day supply of the drug at retail or mail-order or 31-day supply of the drug at long-term care (LTC) and notice of the change.

  If we make these other changes, you or your prescriber can ask us to make an exception for you and continue to cover the drug you have been taking. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the Providence Medicare Dual Plus + Rx (HMO D-SNP)’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2026 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2026 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 09/2025. To get updated information about the drugs covered by Providence Medicare Dual Plus + Rx (HMO D-SNP), please contact us. Our contact information appears on the front and back cover pages. In the

event of mid-year non-maintenance formulary changes, we will either notify you via the Explanation of Benefits (EOBs) or errata sheet of changes.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 3. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents". If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 120. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Providence Medicare Dual Plus + Rx (HMO D-SNP) covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs work just as well as and usually cost less than brand name drugs. There are generic drug substitutes available for many brand name drugs. Generic drugs usually can be substituted for the brand name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

- For discussion of drug types, please see the Evidence of Coverage, Chapter 5, Section 3.1, “The ‘Drug List’ tells which Part D drugs are covered.”

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Providence Medicare Dual Plus + Rx (HMO D-SNP) requires you or your prescriber to get prior authorization for certain drugs. This means that you will need to get approval from Providence Medicare Dual Plus + Rx (HMO D-SNP) before you fill your prescriptions. If you don’t get approval, Providence Medicare Dual Plus + Rx (HMO D-SNP) may not cover the drug.

- **Quantity Limits:** For certain drugs, Providence Medicare Dual Plus + Rx (HMO D-SNP) limits the amount of the drug that Providence Medicare Dual Plus + Rx (HMO D-SNP) will cover. For example, Providence Medicare Dual Plus + Rx (HMO D-SNP) provides 2 tablets per day per prescription for Xtampza ER®. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, Providence Medicare Dual Plus + Rx (HMO D-SNP) requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Providence Medicare Dual Plus + Rx (HMO D-SNP) may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Providence Medicare Dual Plus + Rx (HMO D-SNP) will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 3. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Providence Medicare Dual Plus + Rx (HMO D-SNP) to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the Providence Medicare Advantage Plans Dual Plus + Rx (HMO D-SNP)’s formulary?” on page vii for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service and ask if your drug is covered.

If you learn that Providence Medicare Dual Plus + Rx (HMO D-SNP) does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Providence Medicare Dual Plus + Rx (HMO D-SNP). When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Providence Medicare Dual Plus + Rx (HMO D-SNP).

- You can ask Providence Medicare Dual Plus + Rx (HMO D-SNP) to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Providence Medicare Advantage Plans Dual Plus + Rx (HMO D-SNP)'s Formulary?

You can ask Providence Medicare Dual Plus + Rx (HMO D-SNP) to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to waive a coverage restriction including prior authorization, step therapy, or a quantity limit on your drug. For example, for certain drugs, Providence Medicare Dual Plus + Rx (HMO D-SNP) limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Providence Medicare Dual Plus + Rx (HMO D-SNP) will only approve your request for an exception if the alternative drugs included on the plan's formulary or applying the restriction would not be as effective for you and/or would cause you to have adverse medical effects.

You or your prescriber should contact us to ask us for formulary exception, including an exception to a coverage restriction. ***When you request an exception, your prescriber will need to explain the medical reasons why you need the exception*.** Generally, we must make our decision within 72 hours of getting your prescriber's

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

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

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary but has a coverage restriction, such as prior authorization. You should talk to your prescriber about requesting a coverage decision to show that you meet the criteria for approval, switching to an alternative drug that we cover, or requesting a formulary exception so that we will cover the drug you take. While you and your doctor determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or has a coverage restriction, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. If coverage is not approved, after your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Level of care change:	**Day Supply**
For members transitioning from a SNF to LTC:	31-day supply
SNF to Home (Retail):	30-day supply
LTC-LTC:	31-day supply
Hospital to Home (Retail):	30-day supply

For more information

For more detailed information about your Providence Medicare Dual Plus + Rx (HMO D-SNP) prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Providence Medicare Dual Plus + Rx (HMO D-SNP), please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or visit http://www.medicare.gov.

Providence Medicare Dual Plus + Rx (HMO D-SNP)'s Formulary

The formulary that begins on page 4 provides coverage information about the drugs covered by Providence Medicare Dual Plus + Rx (HMO D-SNP). If you have trouble finding your drug in the list, turn to the Index that begins on page 120.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., JANUVIA®) and generic drugs are listed in lower-case italics (e.g., *lisinopril*).

The information in the Requirements/Limits column tells you if Providence Medicare Dual Plus + Rx (HMO D-SNP) has any special requirements for coverage of your drug.

The following abbreviations may be found within the body of this document

COVERAGE NOTES ABBREVIATIONS

ABBREVIATION	DESCRIPTION	EXPLANATION
Utilization Management Restrictions		
PA	Prior Authorization Restriction	You (or your physician) are required to get prior authorization from Providence Medicare Dual Plus + Rx (HMO D-SNP) before you fill your prescription for this drug. Without prior approval, Providence Medicare Dual Plus + Rx (HMO D-SNP) may not cover this drug.
QL	Quantity Limit Restriction	Providence Medicare Dual Plus + Rx (HMO D-SNP) limits the amount of this drug that is covered per prescription, or within a specific time frame.
ST	Step Therapy Restriction	Before Providence Medicare Dual Plus + Rx (HMO D-SNP) will provide coverage for this drug, you must first try another drug to treat your medical condition. This drug may only be covered if the other drug does not work for you.
Other Special Requirements for Coverage		
LA	Limited Access Drug	This prescription may be available only at certain pharmacies. If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th, we are closed Saturdays and Sundays. Or visit www.providencehealthassurance.com.

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Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-603-2340 (TTY: 711) or speak to your provider."

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-603-2340 (TTY: 711) o hable con su proveedor.

Việt (Vietnamese)
LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-603-2340 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn."

中文 (Chinese-Simplified)
注意：如果您说 中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-603-2340（文本电话：711）或咨询您的服务提供商。"

中文 (Chinese- Traditional)
注意：如果您說 中文，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-800-603-2340（TTY：711）或與您的提供者討論。」

РУССКИЙ (Russian)
ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-603-2340 (TTY: 711) или обратитесь к своему поставщику услуг.

한국어 (Korean)

주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-603-2340 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오."

українська мова (Ukrainian)

УВАГА: Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-603-2340 (TTY: 711) або зверніться до свого постачальника».

日本語 (Japanese)

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-603-2340（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1- 800-603-2340 (711) أو تحدث إلى مقدم الخدمة".

ភាសាខ្មែរ (Khmer)

សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយ *ភាសាខ្មែរ* សេវាកម្មជំនួយភាសាឥតគិតថ្លៃគឺមានសម្រាប់អ្នក។ ជំនួយ និងសេវាកម្មដែលជាការជួយជ័សមរម្យក្នុងការផ្តល់ព័ត៌មានតាមទម្រង់ដែលអាចចូលប្រើប្រាស់បាន ក៏អាចរកបានដោយឥតគិតថ្លៃផងដែរ។ ហៅទូរសព្ទទៅ 1-800-603-2340 (TTY: 711) ឬនិយាយទៅកាន់អ្នកផ្តល់សេវារបស់អ្នក។"

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-603-2340 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.“

فارسي (Farsi)
توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-800-603-2340 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

Français (French)
ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-603-2340 (TTY : 711) ou parlez à votre fournisseur. »

ไทย (Thai)
หมายเหตุ: หากคุณใช้ภาษา ไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-800-603-2340 (TTY: 711) หรือปรึกษาผู้ให้บริการของคุณ”

Tagalog
PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-603-2340 (TTY: 711) o makipag-usap sa iyong provider.”

አማርኛ (Amharic)
ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-603-2340 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።”

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-800-603-2340 (TTY: 711) ‘ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।”

ລາວ (Laos)
ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ
ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-603-2340 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ."

ՀԱՅԵՐԵՆ (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, Դուք կարող եք օգտվել լեզվական աջակցության անվճար ծառայություններից: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես տրամադրվում են անվճար: Զանգահարեք 1-800-603-2340 հեռախոսահամարով (TTY՝ 711) կամ խոսեք Ձեր մատակարարի հետ:

Lus Hmoob (Hmong)
LUS CEEV TSHWJ XEEB: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 1-800-603-2340 (TTY: 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob."

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-603-2340 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।"

Table of Contents

List of Abbreviations
1: Generic: $0, $1.60, or $5.10

2: BRAND: $0, $4.90, or $12.65

Insulins: Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

PDMS: Preferred diabetic medical supplies. Diabetes supplies are available through any participating pharmacy. Benefits for diabetes supplies are paid under your Part B benefit. Please refer to your Benefit Summary for additional information.

Vaccines: Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information.

Below is a list of drug name formatting patterns that may appear in the following pages.

List of Patterns

lowercase italics: Generic drugs

UPPERCASE: Brand name drugs

Drug Name	Tier	Requirements/Limits
ANTIVIRALS		
Antiviral, Coronavirus Agents		
PAXLOVID ORAL TABLETS,DOSE PACK 150 MG (6)- 100 MG (5)	2	
CARDIOVASCULAR AGENTS		
Cardiovascular Agents, Other		
ENTRESTO ORAL TABLET 97-103 MG	2	
ELECTROLYTES/MINERALS/METALS/VITAMINS		
Electrolyte/Mineral/Metal Modifiers		
JYNARQUE ORAL TABLETS, SEQUENTIAL 15 MG (AM)/ 15 MG (PM), 30 MG (AM)/ 15 MG (PM), 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM)	2	
NON-FRF		
Non-Frf		
ACCU-CHEK AVIVA CONTROL SOLN SOLUTION	PDMS	
ACCU-CHEK FASTCLIX LANCET DRUM	PDMS	
ACCU-CHEK GUIDE GLUCOSE METER	PDMS	QL (1 EA per 365 days)
ACCU-CHEK GUIDE L1-L2 CTRL SOL SOLUTION	PDMS	
ACCU-CHEK GUIDE ME GLUCOSE MTR	PDMS	QL (1 EA per 365 days)
ACCU-CHEK GUIDE TEST STRIPS STRIP	PDMS	QL (5 EA per 1 day)
ACCU-CHEK SMARTVIEW CONTRL SOL SOLUTION	PDMS	
ACCU-CHEK SOFTCLIX LANCETS	PDMS	
CONTOUR METER	PDMS	
CONTOUR NEXT EZ METER	PDMS	
CONTOUR NEXT GEN METER	PDMS	
CONTOUR NEXT METER	PDMS	
CONTOUR NEXT ONE METER	PDMS	
CONTOUR NEXT TEST STRIPS STRIP	PDMS	
CONTOUR PLUS BLUE METER	PDMS	
CONTOUR PLUS TEST STRIP STRIP	PDMS	
CONTOUR TEST STRIPS STRIP	PDMS	
DEXCOM G6 SENSOR DEVICE	PDMS	PA; QL (0.1 EA per 1 day)
DEXCOM G6 TRANSMITTER DEVICE	PDMS	PA; QL (1 EA per 90 days)
DEXCOM G7 SENSOR DEVICE	PDMS	PA; QL (0.1 EA per 1 day)
DROPLET GENTEEL LANCING DEVICE	PDMS	
DROPLET LANCETS 30 GAUGE	PDMS	
FREESTYLE FREEDOM LITE KIT	PDMS	

Drug Name	Tier	Requirements/Limits
FREESTYLE INSULINX	PDMS	
FREESTYLE INSULINX STRIP	PDMS	
FREESTYLE INSULINX TEST STRIPS STRIP	PDMS	
FREESTYLE LIBRE 14 DAY SENSOR KIT	PDMS	PA; QL (0.08 EA per 1 day)
FREESTYLE LIBRE 2 PLUS SENSOR DEVICE	PDMS	PA; QL (0.08 EA per 1 day)
FREESTYLE LIBRE 2 READER	PDMS	PA
FREESTYLE LIBRE 2 SENSOR KIT	PDMS	PA; QL (0.08 EA per 1 day)
FREESTYLE LIBRE 3 PLUS SENSOR DEVICE	PDMS	PA; QL (0.08 EA per 1 day)
FREESTYLE LIBRE 3 READER	PDMS	PA
FREESTYLE LIBRE 3 SENSOR DEVICE	PDMS	PA; QL (0.08 EA per 1 day)
FREESTYLE LITE METER KIT	PDMS	
FREESTYLE LITE STRIPS STRIP	PDMS	
FREESTYLE PRECISION NEO STRIPS STRIP	PDMS	
FREESTYLE TEST STRIP	PDMS	
GLUCOCARD EXPRESSION	PDMS	
GLUCOCARD EXPRESSION KIT	PDMS	
GLUCOCARD EXPRESSION STRIP	PDMS	
GLUCOCARD SHINE CONNEX METER	PDMS	
GLUCOCARD SHINE EXPRESS METER	PDMS	
GLUCOCARD SHINE METER	PDMS	
GLUCOCARD SHINE METER KIT KIT	PDMS	
GLUCOCARD SHINE TEST STRIPS STRIP	PDMS	
GLUCOCARD SHINE XL METER	PDMS	
GLUCOCARD VITAL KIT	PDMS	
GLUCOCARD VITAL SENSOR STRIP	PDMS	
MICROLET LANCET	PDMS	
MICROLET NEXT LANCING DEVICE KIT	PDMS	
OMNIPOD 5 (G6/LIBRE 2 PLUS) SUBCUTANEOUS CARTRIDGE	PDMS	PA; QL (0.5 EA per 1 day)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS) SUBCUTANEOUS CARTRIDGE	PDMS	PA; QL (0.5 EA per 1 day)
ONETOUCH DELICA PLUS LANCET 30 GAUGE, 33 GAUGE	PDMS	
ONETOUCH ULTRA TEST STRIP	PDMS	QL (5 EA per 1 day)
ONETOUCH ULTRA2 METER	PDMS	QL (1 EA per 365 days)
ONETOUCH ULTRASOFT 2 LANCET 30 GAUGE	PDMS	
ONETOUCH VERIO FLEX METER	PDMS	QL (1 EA per 365 days)
ONETOUCH VERIO REFLECT METER	PDMS	QL (1 EA per 365 days)

Drug Name	Tier	Requirements/Limits
ONETOUCH VERIO TEST STRIPS STRIP	PDMS	QL (5 EA per 1 day)
PRECISION XTRA MONITOR	PDMS	
PRECISION XTRA TEST STRIP	PDMS	
RENTHYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG	1	
TECHLITE PLUS PEN NEEDLE NEEDLE 32 GAUGE X 5/32"	PDMS	
TRUE METRIX AIR GLUCOSE METER	PDMS	
TRUE METRIX GLUCOSE METER	PDMS	
TRUE METRIX GLUCOSE TEST STRIP STRIP	PDMS	
UNIFINE SAFECONTROL PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16"	PDMS	
OPHTHALMIC AGENTS		
Ophthalmic Intraocular Pressure Lowering Agents, Other		
pilocarpine hcl ophthalmic (eye) drops 1.25 %	1	

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Providence
Medicare Advantage Plans

Health For All

We are committed to working alongside the communities we serve, learning about unique healthcare challenges, and creating tangible solutions to make healthcare more equitable and accessible.

We're here to help.

This formulary was updated on 09/02/2025. If you have any questions, please call Providence Medicare Advantage Plans at 503-574-8000 or 1-800-603-2340. TTY users should call 711. We are open seven days a week, between 8 a.m. and 8 p.m. (Pacific Time). Between April 1st and September 30th, we are closed Saturdays and Sundays, or visit ProvidenceHealthAssurance.com.

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