July 1, 2019

Changes to your prescription drug coverage

There will be changes to the **Aetna Premier Plan** drug list that start on **July 1, 2019**. It's important that you review and understand the changes in the chart below. Talk to your health care provider about how these changes might impact you.

What if I need a prescription drug that requires a medical exception?
In certain cases, you or your prescriber can request a medical exception to the precertification, step therapy or quantity limits requirements. And also for a prescription drug that's not covered in your plan.

We'll contact you or your prescriber with our decision. If your exception is approved, you only need to pay the copay after the deductible. This amount is based on your pharmacy plan design.

How to find a preferred medicine that's right for you
You can visit the website that's on your member ID card and sign in to your account. Your doctor can also request a medical exception if your drug has been removed from the formulary. If you have any questions, you can call us at the toll-free number on your member ID card.

The changes made to the prescription drugs in this chart are based on the plan you're currently a member of at the time this letter was sent. These changes apply to all plans unless noted.

UPPER CASE = brand-name medication **lower case** = generic medication
* Changes apply if your plan includes this feature.

Prescription Drug	**Change(s)**
abacavir sol	You can fill up to 30/ day*
abacavir tab	You can fill up to 2/ day*
ACIPHEX	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization has been removed; You can fill up to one 90-day supply every 365 days

Prescription Drug	Change(s)
ACIPHEX SPRINKLE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
ADEMPAS	Must be filled through a specialty network pharmacy
ADZENYS XR-ODT	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
AIMOVIG	Preferred brand drug; You must first try 1 of antiepileptics (ie, topiramate, divalproex) or beta blockers (ie, propranolol, timolol) or antidepressants (ie, amitriptyline, bupropion)*
AJOVY	Preferred brand drug; You must first try 1 of antiepileptics (ie, topiramate, divalproex) or beta blockers (ie, propranolol, timolol) or antidepressants (ie, amitriptyline, bupropion)*
AKTIPAK	You can fill up to 2/day*
ALUNBRIG	Must be filled through a specialty network pharmacy
AMPYRA	Must be filled through a specialty network pharmacy
APTIVUS CAP	You can fill up to 4/ day*
APTIVUS SOL	You can fill up to 10.2/ day*
ARALAST NP	Must be filled through a specialty network pharmacy
ARCALYST	Must be filled through a specialty network pharmacy
atazanavir cap 150mg	You can fill up to 1/ day*
atazanavir cap 200mg	You can fill up to 2/ day*
atazanavir cap 300mg	You can fill up to 1/ day*
AUBAGIO	Must be filled through a specialty network pharmacy
AUSTEDO	Must be filled through a specialty network pharmacy
AVONEX	Must be filled through a specialty network pharmacy

Prescription Drug	Change(s)
AVONEX PEN	Must be filled through a specialty network pharmacy
BELBUCA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
BERINERT	You can fill up to 10/month*; Must be filled through a specialty network pharmacy
betamethasone dipropionate	You can fill up to 120gm/ month*
betamethasone valerate	You can fill up to 120gm/ month*
BETASERON	Must be filled through a specialty network pharmacy
BIVIGAM	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered; Must be filled through a specialty network pharmacy
BROVANA	You must first try STRIVERDI or SEREVENT*
CABOMETYX	Must be filled through a specialty network pharmacy
calcipotriene	You can fill up to 120gm/ month*
chorionic gonadotropin	Must be filled through a specialty network pharmacy
CINRYZE	Must be filled through a specialty network pharmacy
CLEOCIN-T SOL	You can fill up to 2/ day*
clindamycin phosphate	You can fill up to 2/ day*
clotrimazole/betamethasone dipropionate	You can fill up to 45gm/ month*
CODITUSSIN AC	Preauthorization required; You can fill up to 60ml/day over 5 days in a 30 day period
COPAXONE INJ 20MG/ML	You can fill up to 1/ day*; Must be filled through a specialty network pharmacy
COPAXONE INJ 40MG/ML	You can fill up to 12/ 28 days*; Must be filled through a specialty network pharmacy
CRIXIVAN CAP 200MG	You can fill up to 15/ day*

Prescription Drug	Change(s)
CRIXIVAN CAP 400MG	You can fill up to 6/ day*
CUPRIMINE	Step therapy has been removed
CUVITRU	Must be filled through a specialty network pharmacy
cvs omeprazole/sodium bicarbonate	You can fill up to one 90-day supply every 365 days
D-PENAMINE	Non-preferred specialty drug
dalfampridine er	Must be filled through a specialty network pharmacy
DEPEN TITRATABS	Non-preferred specialty drug
desoximetasone	You can fill up to 120gm/ month*
DEXILANT	You can fill up to one 90-day supply every 365 days
didanosine	You can fill up to 1/ day*
DOVONEX	You can fill up to 120gm/ month*
DYMISTA	Preferred brand drug
ECOZA	You can fill up to 70gm/ month*
efavirenz cap 200mg	You can fill up to 3/ day*
efavirenz cap 50mg	You can fill up to 3/ day*
efavirenz tab 600mg	You can fill up to 1/ day*
ELELYSO	Must be filled through a specialty network pharmacy
EMGALITY	Preferred brand drug; You must first try 1 of antiepileptics (ie, topiramate, divalproex) or beta blockers (ie, propranolol, timolol) or antidepressants (ie, amitriptyline, bupropion)*
EMTRIVA	You can fill up to 24.3/ day*
EPIVIR SOL 10MG/ML	You can fill up to 30/ day*
EPIVIR TAB 150MG	You can fill up to 2/ day*
EPIVIR TAB 300MG	You can fill up to 1/ day*
epoprostenol sodium	Must be filled through a specialty network pharmacy

Prescription Drug	Change(s)
ESBRIET	Must be filled through a specialty network pharmacy
esomeprazole magnesium 20mg	You can fill up to one 90-day supply every 365 days
esomeprazole magnesium 40mg	You can fill up to one 90-day supply every 365 days
esomeprazole otc 20mg	You can fill up to one 90-day supply every 365 days
ESOMEPRAZOLE STRONTIUM	Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
EUCRISA	You can fill up to 60 grams/month*
EVZIO	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
EXTAVIA	Must be filled through a specialty network pharmacy
FARESTON	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try toremifene*
FINACEA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
FIRAZYR	You can fill up to 6/month*
FLEBOGAMMA DIF	Must be filled through a specialty network pharmacy
FLOLAN	Must be filled through a specialty network pharmacy
fosamprenavir calcium	You can fill up to 4/ day*
FUZEON	You can fill up to 2/ day*
GAMMAPLEX	Must be filled through a specialty network pharmacy
GANIRELIX ACETATE	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
GATTEX	Must be filled through a specialty network pharmacy
GILENYA	Must be filled through a specialty network pharmacy

Prescription Drug	Change(s)
glatiramer inj 20mg/ml	You can fill up to 1/ day*; Must be filled through a specialty network pharmacy
glatiramer inj 40mg/ml	You can fill up to 12/ 28 days*; Must be filled through a specialty network pharmacy
glatopa inj 20mg/ml	You can fill up to 1/ day*; Must be filled through a specialty network pharmacy
glatopa inj 40mg/ml	You can fill up to 12/ 28 days*; Must be filled through a specialty network pharmacy
H.P. ACTHAR	Must be filled through a specialty network pharmacy
HAEGARDA	Must be filled through a specialty network pharmacy
heartburn treatment esomeprazole 20mg	You can fill up to one 90-day supply every 365 days
heartburn treatment lansoprazole 15mg	You can fill up to one 90-day supply every 365 days
IDHIFA	Must be filled through a specialty network pharmacy
ILARIS	Must be filled through a specialty network pharmacy
INCRELEX	Must be filled through a specialty network pharmacy
INTELENCE TAB 100MG	You can fill up to 4/ day*
INTELENCE TAB 200MG	You can fill up to 2/ day*
INTELENCE TAB 25MG	You can fill up to 4/ day*
INVIRASE TAB 500MG	You can fill up to 4/ day*
INVIRASE CAP 200MG	You can fill up to 10/ day*
IRESSA	Must be filled through a specialty network pharmacy
ISENTRESS CHW	You can fill up to 6/ day*
ISENTRESS POW	You can fill up to 2/ day*
ISENTRESS TAB	You can fill up to 4/ day*
JAKAFI	Must be filled through a specialty network pharmacy
JUBLIA	You can fill up to 4ml/ month*

Prescription Drug	Change(s)
KALBITOR	You can fill up to 12/month*; Must be filled through a specialty network pharmacy
KALETRA SOL	You can fill up to 13/ day*
KALETRA TAB 100-25MG	You can fill up to 8/ day*
KALETRA TAB 200-50MG	You can fill up to 4/ day*
KANUMA	Must be filled through a specialty network pharmacy
KAZANO	You must first try metformin/ XR*
ketoconazole	You can fill up to 2/ day*
KOMBIGLYZE XR	Non-preferred brand drug; You must first try metformin/ XR*
KORLYM	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
KUVAN	Must be filled through a specialty network pharmacy
lamivudine sol 10mg/ml	You can fill up to 30/ day*
lamivudine tab 150mg	You can fill up to 2/ day*
lamivudine tab 300mg	You can fill up to 1/ day*
lansoprazole 15mg	You can fill up to one 90-day supply every 365 days
lansoprazole 30mg	You can fill up to one 90-day supply every 365 days
lansoprazole odt	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
LEXIVA SUS	You can fill up to 57/ day*
LEXIVA TAB	You can fill up to 4/ day*
LILETTA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered

Prescription Drug	Change(s)
LONSURF	Must be filled through a specialty network pharmacy
lopinavir/ritonavir sol	You can fill up to 13/ day*
LOTRISONE	You can fill up to 45gm/ month*
LYNPARZA	Must be filled through a specialty network pharmacy
MEBOLIC	Not covered under pharmacy benefit
MEKTOVI	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
miglustat	Must be filled through a specialty network pharmacy
MINOLIRA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
NAGLAZYME	Must be filled through a specialty network pharmacy
NAMENDA XR TITRATION PACK	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NATAZIA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
NATPARA	Must be filled through a specialty network pharmacy
NEOPHE	Not covered under pharmacy benefit
NERLYNX	Must be filled through a specialty network pharmacy
NESINA	You must first try metformin/ XR*
nevirapine sus	You can fill up to 40/ day*
nevirapine 400mg er	You can fill up to 1/ day*
nevirapine tab 100mg	You can fill up to 3/ day*
nevirapine tab 200mg	You can fill up to 2/ day*
NEXIUM	You can fill up to one 90-day supply every 365 days

Prescription Drug	Change(s)
NEXIUM 24HR CLEAR MINIS	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered; You can fill up to one 90-day supply every 365 days
NEXIUM 24HR OTC 20MG	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
NICAPRIN	Not covered under pharmacy benefit
NOCTIVA	Non-preferred brand drug
NORTHERA	Must be filled through a specialty network pharmacy
NORVIR CAP	You can fill up to 12/ day*
NORVIR POW	You can fill up to 12/ day*
NORVIR SOL	You can fill up to 16/ day*
NORVIR TAB	You can fill up to 12/ day*
novarel	Must be filled through a specialty network pharmacy
NPLATE	Must be filled through a specialty network pharmacy
NUPLAZID	Must be filled through a specialty network pharmacy
nystatin/triamcinolone	You can fill up to 60gm/ month*
OCALIVA	Must be filled through a specialty network pharmacy
OCTAGAM	Must be filled through a specialty network pharmacy
OFEV	Must be filled through a specialty network pharmacy
omepra/bicar cap 20-1100	You can fill up to one 90-day supply every 365 days
omepra/bicar cap 40-1100	Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
omepra/bicar pow 20-1680	Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
omepra/bicar pow 40-1680	Preauthorization has been removed; You can fill up to one 90-day supply every 365 days

Prescription Drug	Change(s)
omeprazole	You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
omeprazole-sod bicarb 20-1100 mg	You can fill up to one 90-day supply every 365 days
omeprazole-sod bicarb 40-1100 mg	Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
OMNIVEX	Not covered under pharmacy benefit
ONGLYZA	Non-preferred brand drug; You must first try JANUVIA, JANUMET/ XR, TRADJENTA, JENTADUETO/ XR, and alogliptin/ combinations*
OPSUMIT	Must be filled through a specialty network pharmacy
ORENITRAM	Must be filled through a specialty network pharmacy
OSENI	You must first try metformin/ XR*
OTREXUP	Must be filled through a specialty network pharmacy
OVIDREL	Must be filled through a specialty network pharmacy
OZEMPIC	Preferred brand drug
pantoprazole sodium	You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
pantoprazole sodium dr	You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PERFOROMIST	You must first try STRIVERDI or SEREVENT*
PLEGRIDY	Must be filled through a specialty network pharmacy
PLEGRIDY STARTER PACK	Must be filled through a specialty network pharmacy
pregnyl w/diluent benzyl alcohol/nacl	Must be filled through a specialty network pharmacy
PREVACID 24HR OTC 15MG	You can fill up to one 90-day supply every 365 days
PREVACID CAP 15MG DR	You can fill up to one 90-day supply every 365 days

Prescription Drug	Change(s)
PREVACID CAP 30MG DR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization has been removed; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to one 90-day supply every 365 days
PREVACID SOLUTAB	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
PREZISTA SUS 100MG/ML	You can fill up to 13.4/ day*
PREZISTA TAB 150MG	You can fill up to 6/ day*
PREZISTA TAB 600MG	You can fill up to 2/ day*
PREZISTA TAB 75MG	You can fill up to 10/ day*
PREZISTA TAB 800MG	You can fill up to 1/ day*
PRILOSEC CAP 10MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PRILOSEC CAP 20MG	You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PRILOSEC CAP 40MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PRILOSEC POW 10MG	Preauthorization has been removed; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days

Prescription Drug	Change(s)
PRILOSEC POW 2.5MG	Preauthorization has been removed; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PRIVIGEN	Must be filled through a specialty network pharmacy
PROLASTIN-C	Must be filled through a specialty network pharmacy
PROLENSA	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
PROLEVA	Not covered under pharmacy benefit
PROTEOLIN	Not covered under pharmacy benefit
PROTEOLIN DS	Not covered under pharmacy benefit
PROTONIX PAK	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PROTONIX TAB 20MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PROTONIX TAB 40MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PURIXAN	Must be filled through a specialty network pharmacy
rabeprazole sodium	You can fill up to one 90-day supply every 365 days
RASUVO	Must be filled through a specialty network pharmacy
RAVICTI	Must be filled through a specialty network pharmacy

Prescription Drug	Change(s)
REBIF	Must be filled through a specialty network pharmacy
REBIF REBIDOSE	Must be filled through a specialty network pharmacy
REBIF REBIDOSE TITRATION PACK	Must be filled through a specialty network pharmacy
REBIF TITRATION PACK	Must be filled through a specialty network pharmacy
REMODULIN	Must be filled through a specialty network pharmacy
RESCRIPTOR	You can fill up to 15/ day*
RETROVIR CAP	You can fill up to 6/ day*
RETROVIR SYP	You can fill up to 60/ day*
REYATAZ CAP 150MG	You can fill up to 1/ day*
REYATAZ CAP 200MG	You can fill up to 2/ day*
REYATAZ CAP 300MG	You can fill up to 1/ day*
REYATAZ POW	You can fill up to 6/ day*
ritonavir	You can fill up to 12/ day*
RUBRACA	Must be filled through a specialty network pharmacy
RUCONEST	You can fill up to 8/month*; Must be filled through a specialty network pharmacy
SABRIL	Must be filled through a specialty network pharmacy
SAMSCA	Must be filled through a specialty network pharmacy
SAVELLA	Non-preferred brand drug
SAVELLA TITRATION PACK	Non-preferred brand drug
SELZENTRY TAB 150MG	You can fill up to 2/ day*
SELZENTRY TAB 300MG	You can fill up to 4/ day*
stavudine	You can fill up to 2/ day*
stavudine sol	You can fill up to 80/ day*

Prescription Drug	Change(s)
STAXYN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay if this drug is a covered benefit
STELARA	Must be filled through a specialty network pharmacy
STENDRA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay if this drug is a covered benefit
STRIVERDI RESPIMAT	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
SUSTIVA CAP	You can fill up to 3/ day*
SUSTIVA TAB	You can fill up to 1/ day*
TAGRISSO	Must be filled through a specialty network pharmacy
TAKHZYRO	Must be filled through a specialty network pharmacy
TALTZ	You can fill up to 1/ month*
TARGRETIN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try bexarotene*
TARGRETIN GEL 1%	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
TECFIDERA	Must be filled through a specialty network pharmacy
TECFIDERA STARTER PACK	Must be filled through a specialty network pharmacy
TEKTURNA HCT	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered
tenofovir	You can fill up to 1/ day*
tetrabenazine	Must be filled through a specialty network pharmacy
THIOLA	Step therapy has been removed
TIVICAY	You can fill up to 2/ day*

Prescription Drug	Change(s)
TOLAK	Preferred brand drug; Step therapy has been removed
TOPICORT	You can fill up to 120gm/ month*
treprostinil	Must be filled through a specialty network pharmacy
triamcinolone cre 0.1%	You can fill up to 60gm/ month*
triamcinolone oin 0.1%	You can fill up to 60gm/ month*
triderm	You can fill up to 60gm/ month*
TRULICITY	You must first try metformin/ XR*
TUSSICAPS	Preauthorization required; You can fill up to 2/ day; max 20 in 30 days
TYSABRI	You can fill up to 1/ month*
TYVASO	Must be filled through a specialty network pharmacy
TYVASO REFILL	Must be filled through a specialty network pharmacy
TYVASO STARTER	Must be filled through a specialty network pharmacy
ULORIC	You must first try allopurinol*
UPTRAVI	Must be filled through a specialty network pharmacy
VASCULERA	Not covered under pharmacy benefit
VELETRI	Must be filled through a specialty network pharmacy
VENTAVIS	Must be filled through a specialty network pharmacy
VIAGRA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay if this drug is a covered benefit
VICTOZA	You must first try metformin/ XR*
VIDEX SOL	You can fill up to 40/ day*
VIDEX EC	You can fill up to 1/ day*
vigabatrin	Must be filled through a specialty network pharmacy
vigadrone	Must be filled through a specialty network pharmacy

Prescription Drug	Change(s)
VIMIZIM	Must be filled through a specialty network pharmacy
VIRACEPT TAB 250MG	You can fill up to 10/ day*
VIRACEPT TAB 625MG	You can fill up to 4/ day*
VIRAMUNE SUS 50MG/5ML	You can fill up to 40/ day*
VIRAMUNE TAB 200MG	You can fill up to 2/ day*
VIRAMUNE XR TAB 100MG	You can fill up to 3/ day*
VIRAMUNE XR TAB 400MG	You can fill up to 1/ day*
VIREAD POW	You can fill up to 8/ day*
VIREAD TAB	You can fill up to 1/ day*
VITRAKVI	Must be filled through a specialty network pharmacy
VUSION	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
XALKORI	Must be filled through a specialty network pharmacy
XENAZINE	Must be filled through a specialty network pharmacy
XTANDI	Must be filled through a specialty network pharmacy
XYZBAC	Not covered under pharmacy benefit
ZAVESCA	Must be filled through a specialty network pharmacy
ZEGERID CAP 20-1100	You can fill up to one 90-day supply every 365 days
ZEGERID CAP 40-1100	Preauthorization has been removed; You can fill up to one 90-day supply every 365 days
ZEGERID OTC	You can fill up to one 90-day supply every 365 days
ZEGERID POWDER	Preauthorization has been removed; You must first try 3 of pantoprazole, esomeprazole, lansoprazole or omeprazole*; You can fill up to one 90-day supply every 365 days
ZEMAIRA	Must be filled through a specialty network pharmacy

Prescription Drug	Change(s)
ZERIT CAP	You can fill up to 2/ day*
ZERIT SOL	You can fill up to 80/ day*
ZIAGEN SOL	You can fill up to 30/ day*
ZIAGEN TAB	You can fill up to 2/ day*
zidovudine cap	You can fill up to 6/ day*
zidovudine syp	You can fill up to 60/ day*
zidovudine tab	You can fill up to 2/ day*
ZYDELIG	Must be filled through a specialty network pharmacy
ZYKADIA	Must be filled through a specialty network pharmacy
ZYVEXOL	Not covered under pharmacy benefit
ZYVIT	Not covered under pharmacy benefit

Please note that if your prescription drug benefits plan changes, the information in this letter may no longer apply.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Some health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Aetna receives rebates from drug manufacturers that may be taken into account in determining the Aetna Pharmacy Plan and Specialty Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Information is subject to change. For more information about your pharmacy plan, refer to your plan's website that is on your member ID card.

In accordance with state law, commercial fully insured (including HMO) members in Louisiana and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are added or removed from the Aetna Pharmacy Plan and Specialty Drug List will continue to have those medications covered at the same benefit level until their plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In accordance with state law, fully insured commercial California HMO members (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are to receive preauthorization or step-therapy reviews will continue to have those medications covered, for as long as the treating physician continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.

In accordance with state law, fully insured commercial Connecticut PPO members (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are to receive preauthorization or step-therapy reviews will continue to have those medications covered for as long as the treating physician prescribes them, provided the drug is medically necessary and more medically beneficial than other covered drugs. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

The drugs on the Aetna Pharmacy Plan and Specialty Drug List including formulary exclusions, preauthorization, quantity limit and step-therapy reviews are subject to change. The quantity limits and step-therapy drug coverage review programs are not available in all service areas. For example, step-therapy programs do not apply to fully insured members in Indiana. Step therapy does not apply to fully insured members in New Jersey. However, these programs are available to self-funded plans.

Aetna Pharmacy Management administers, but does not offer, insure or otherwise underwrite the prescription drug benefit portion of your health plan and has no financial responsibility therefor. Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC.

This material is for information only. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. For more information you can refer to your plan's website.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í bikáá’ áajı̨’ hólne’. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք ձեր ինքնության (ID) քարտի վրա նշված հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z’indimi atakiguzi, Hamagara inumero iri kuri karangamuntu kawe. (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করুন। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa numero sa nimong ID card. (Bisayan-Visayan)

သင့်အနေဖြင့် အခကြေးငွေ မပေးရပဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပတ်အား ခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al número indicat a la seva targeta d’identificació. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

ᏣᎩᏍᏗ ᎦᏬᏂᎯᏍᏗ ᎢᏳᎾᏓᏛᏁᏗ Ꮭ ᎠᎱᏍᏗ ᏗᏣᎬᏩᎳᏁᏗ ᏥᎩ, ᏫᎨᎯᏏᏔᏮᏏ ᎾᏍᎩ ᏗᏎᏍᏗ ᏂᎦᎪᏊᎵ ᎤᎾᎢ ID ᏆᏂᏲᏍᏗ ᏣᏙᎵᎢ. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla kvt chi holisso iskitini holhtena takanli ma I paya. (Choctaw)

Tajaajiiloota afaanii gatii bilisaa ati argaachuuf,lakkoofsa duugda waraaqaa eenyummaa (ID) kee irraa jiruun bilbili. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bel het nummer op uw ID-kaart. (Dutch)

Pou jwenn sèvis lang gratis, rele nimewo telefòn ki sou kat idantite ou a. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό που αναγράφεται στην κάρτα σας προνομίων μέλους. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, તમારા આઇડી કાર્ડ ઉપરના નંબરને કોલ કરો. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिये नम्बर पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ nọmba no na kaadị ID gị. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti numero idiay ID cardyo. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi nomor telepon di kartu identitas Anda. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero sulla tessera identificativa. (Italian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。(Japanese)

လၢတၢ်ကမၤန့ၢ်ကျိာ်အတၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပ္ှၤလၢနကဘၣ်ဟ့ၣ်အီၤဘၣ်နှၣ်,ကိးဘၣ်လီတဲစိနီၢ်ဂံၢ်လၢအိၣ်လၢနတၢ်ဂ့ၤခိၣ် (ID) အခးလီၤန့ၣ်တက့ၢ် (Karen)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́uń nì pídyi ní, nìí, ɖá nɔ̀ɓà nìà nì ID káàɔ̀ kɔ̃ɛ. (Kru-Bassa)

بۆ دەستپێڕاگەیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی(ID) کارتی خۆت.
(Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ,
ໃຫ້ໂທຫາເບີໂທທີ່ບອກໄວ້ໃນບັດປະຈໍາຕົວຂອງທ່ານ. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, तुमच्या ID कार्डावरील क्रमांकावर फोन करा. (Marathi)

Nan etal nan jikin jiban ko ikijen kajin ilo an ejelok onen nan kwe, kirlok nomba eo ilo ID kaat eo am. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID. (Micronesian-Pohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់
លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न आफ्नो परिचयपत्रमा भएको नम्बरमा टेलिफोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wëër de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny në nɔmba de abac tɔ̈ në ID kard du kɔ̈u. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić numer telefonu na Twojej Karcie Identykującej (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para o número que consta na sua identidade. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul dvs. de identificare. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей карточке участника плана. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le numera I luga o lau pepa ID. (Samoan)

Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde, apelou lamba djey do windi ha dereji Maada. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho. (Swahili)

ܟܬܒ ܠܗ ܒܟܠ ܫܦܬ ܕܐܝܟ ܕܐܢ ܒܥܝ ܠܗ ܕܬܪܓܡܢܘܬ ܒܠܐ ܡܚܐܠ ܒܟܠ ܫܦܬ ܕܐܝܟ ܕܐܢ ܒܥܝ ܠܗ ܕܬܪܓܡܢܘܬ ܒܠܐ ܡܚܐܠ. (Syriac-Assyrian)

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, మీ ID కార్డుపై ఉన్న నంబరుకు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he fika 'oku hā atu 'i ho'o ID kaati. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori ewe nampa mei mak won noum ena katen ID (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, kartınızdaki numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером, вказаним на Вашій ідентифікайній картці. (Ukrainian)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، اپنے شناختی کارڈ پر درج نمبرپر بات کریں۔ (Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)

צוטריט שפּראַך באַדינונגען אין קיין פּריַז צו איר, רופן די נומער אויף דיין שיַין קאָרט. (Yiddish)

Lati wọnú awọn isẹ èdè l'ọfẹ fun ọ, pe nọmba ori káádi idánimọ rẹ. (Yoruba)