aetna™

July 1, 2019

Changes to your prescription drug coverage

There will be changes to the **Aetna Value Plus 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*
acetaminophen/caffeine/dihydrocodeine bitartrate	Step therapy has been removed
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

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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	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 1 of antiepileptics (ie, topiramate, divalproex) or beta blockers (ie, propranolol, timolol) or antidepressants (ie, amitriptyline, bupropion) AND 1 of AJOVY or EMGALITY*
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*
allergy relief 24hr	Preferred generic drug
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
ARCAPTA NEOHALER	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Step therapy has been removed
AUBAGIO	Must be filled through a specialty network pharmacy

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Prescription Drug	Change(s)
AUSTEDO	Must be filled through a specialty network pharmacy
AVONEX	Must be filled through a specialty network pharmacy
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*
budesonide otc nasal spray	Preferred generic drug
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

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Prescription Drug	Change(s)
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*
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 budesonide nasal spray	Preferred generic drug
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
DENAVIR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
DEPEN TITRATABS	Non-preferred specialty drug
desoximetasone	You can fill up to 120gm/ month*
DEXILANT	Preauthorization has been removed; 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; Step therapy has been removed
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

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Prescription Drug	Change(s)
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
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	You can fill up to 1/ day*; 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

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Prescription Drug	Change(s)
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
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 1/ day*; 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
INVIRASE TAB 500MG	You can fill up to 4/ day*
INVIRASE CAP 200MG	You can fill up to 10/ day*

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Prescription Drug	Change(s)
IRESSA	Must be filled through a specialty network pharmacy
ISENTRESS POW	You can fill up to 2/ day*
JAKAFI	Must be filled through a specialty network pharmacy
JENTADUETO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
JENTADUETO XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
JUBLIA	You can fill up to 4ml/ month*
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	You must first try JANUVIA, JANUMET/ XR, and alogliptin/ combinations*
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*

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Prescription Drug	Change(s)
lansoprazole 15mg	You can fill up to 1/ day*; 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 must first try 3 of pantoprazole, esomeprazole, lansoprazole cap or omeprazole*; You can fill up to one 90-day supply every 365 days
levocetirizine dihydrochloride	Preferred generic drug
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
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

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Prescription Drug	Change(s)
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
NEBUSAL	Non-preferred brand drug
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 tab 200mg	You can fill up to 2/ day*
NEXIUM	You can fill up to one 90-day supply every 365 days
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*

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Prescription Drug	Change(s)
novarel	Must be filled through a specialty network pharmacy
NOXAFIL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
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	You can fill up to one 90-day supply every 365 days
omepra/bicar pow 20-1680	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
omepra/bicar pow 40-1680	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
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	You can fill up to one 90-day supply every 365 days
OMNIVEX	Not covered under pharmacy benefit
ONGLYZA	You must first try JANUVIA, JANUMET/ XR, and alogliptin/ combinations*
OPSUMIT	Must be filled through a specialty network pharmacy

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Prescription Drug	Change(s)
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; You must first try metformin/ XR*
panlor	Step therapy has been removed
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*
PICATO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
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 1/ day*; You can fill up to one 90-day supply every 365 days
PREVACID CAP 15MG DR	You can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PREVACID CAP 30MG DR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; 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

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Prescription Drug	Change(s)
PRILOSEC CAP 10MG	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
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 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 can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days
PRILOSEC POW 2.5MG	Preauthorization has been removed; 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 can fill up to 1/ day*; You can fill up to one 90-day supply every 365 days

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Prescription Drug	Change(s)
PROTONIX TAB 40MG	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
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
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 POW	You can fill up to 6/ day*
rhinocort allergy	Preferred generic drug
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
SELZENTRY TAB 300MG	You can fill up to 4/ day*

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Prescription Drug	Change(s)
SEREVENT DISKUS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
stavudine	You can fill up to 2/ day*
stavudine sol	You can fill up to 80/ day*
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*
TARGADOX	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
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

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Prescription Drug	Change(s)
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
tetrabenazine	Must be filled through a specialty network pharmacy
THIOLA	Step therapy has been removed
TOLAK	Preferred brand drug; Step therapy has been removed
TOPICORT	You can fill up to 120gm/ month*
TRADJENTA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
tramadol hcl er	Step therapy has been removed
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
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

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Prescription Drug	Change(s)
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
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*
VIREAD POW	You can fill up to 8/ 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
XERESE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
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

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Prescription Drug	Change(s)
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
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

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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.

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