

Abbreviation Key

Refer to your plan documents for a complete description of benefits, exclusions and limitations of coverage

*	Some plans may not cover this drug. Alternatives are available.
Expect Gen Expect Generic	Expect generic drugs to become available in the near future. When this happens, we may cover the brand-name drug at a higher copayment, add the brand-name drug to the precertification, quantity limit or step-therapy lists, or add the brand-name drug to the formulary exclusions list..
FE Formulary Exclusion	These drugs are not covered under your pharmacy benefit plan due to a formulary exclusion. You can still get these drugs but will need to pay the full cost of the drug.
HCR - Health Care Reform	There is no copay for these drugs.
Medical	These drugs are not covered under your Pharmacy benefit but may be covered under your Medical benefit.
NC Not-Covered	These drugs are not covered under your pharmacy benefit plan due to benefit exclusion. You can still get these drugs but will need to pay the full cost of the drug.
NPB/G - Non-preferred brand or non-preferred generic drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred brand-name or non-preferred generic drug.
NPS Non-preferred specialty drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred drug on the Aetna Specialty Drug List.
PA - Preauthorization (Precertification)	Preauthorization only applies if your plan includes precertification. This means that we have to approve some drugs before we cover them. If this is required, your doctor must contact us to request approval of coverage.
PB Preferred brand-name drug	These are brand-name drugs that are covered at your 2 nd Tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
PS Preferred specialty drugs	You may pay lower out-of-pocket costs when you use preferred drugs on the Aetna Specialty Drug List.
PG Preferred generic	These are generic drugs that are covered at your 1 st tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
QL Quantity limits	Quantity limits only applies if your plan includes preauthorization. Quantity limits help ensure that you get a safe amount of your drug. If you go past the quantity limit, your doctor must contact us to request approval of coverage.
SE Safety edit	The drugs on this list require clinical checks for all plans. These drugs have the greatest potential for harm according to the U.S. Food and Drug Administration (FDA). Overuse and abuse of these drugs can have harmful side effects and they must be used within the guidelines set by the FDA.
SPB Specialty pharmacy coverage	You may pay higher out of pocket costs and may be required to get these products at an Aetna Specialty Pharmacy network provider, like Aetna Specialty Pharmacy. Specialty products are limited to a 30 day supply.
ST Step therapy	Step therapy only applies if your plan includes this option. This means that you must try one or more prerequisite drug(s) before we cover a step-therapy drug. Step therapy protocol complies with all mandated requirements which include disclosing an exceptions request process to the enrollee; and disclosing an enrollee's expedited adverse determination appeal rights and independent review organization (IRO) rights for denials of exception requests.

On October 1, 2017, the following edits will be added to certain opioid drugs.

The following drugs will require pre-authorization for safety:

ARYMO ER	<i>fentanyl patch</i>	METHADOSE SF	<i>oxymorphone er tab</i>
AVINZA	FENTORA* (Expect Gen)	<i>morphine sulfate er cap</i>	<i>tramadol er</i>
BUTRANS	<i>hydromorphone er tab</i>	<i>morphine sulfate er tab</i>	ULTRAM ER
CONZIP	HYSINGLA ER (Expect Gen)	MS CONTIN	XTAMPZA ER
DOLOPHINE	KADIAN	NUCYNTA ER	ZOHYDRO ER
DURAGESIC	<i>methadone</i>	OPANA ER	
EMBEDA	METHADOSE	<i>oxycodone er tab</i>	
EXALGO	<i>methadose</i>	OXYCONTIN	

* Safety pre-authorization already applies, generic is expected.

The following drugs will have safety limits of 120 doses per 30 days supply:

<i>apap/caf/dihydro cap</i>	<i>hydrocod/ibu</i>	OXAYDO	<i>tramadol/apap</i>
<i>apap/caf/dihydro tab</i>	<i>hydromorphone tab</i>	<i>oxycod/apap</i>	<i>tramadol tab</i>
<i>apap/codeine</i>	IBUDONE	<i>oxycod/asa</i>	TREZIX
<i>ascomp/cod</i>	<i>ibudone</i>	<i>oxycod/ibu</i>	TYLENOL/COD
<i>but/apap/caf/cod</i>	<i>levorphanol</i>	<i>oxycodone cap</i>	ULTRACET
<i>but/asa/caf/cod</i>	<i>lorcet</i>	<i>oxycodone tab</i>	ULTRAM
<i>codeine tab</i>	<i>lorcet hd</i>	<i>oxymorphone tab</i>	<i>verdrocet</i>
DEMEROL TAB	<i>lorcet plus</i>	<i>pentaz/nalox</i>	<i>vicodin</i>
<i>dihydrocod/asa/caf</i>	<i>lortab</i>	PERCOCET	<i>vicodin es</i>
DILAUDID TAB	<i>meperidine tab</i>	PRIMLEV	<i>vicodin hp</i>
<i>endocet</i>	<i>morphine sulfate tab</i>	REPREXAIN	VICOPROFEN
FIORICET/COD	NORCO	<i>reprexain</i>	XARTEMIS XR
FIORINAL/COD	NUCYNTA	ROXICODONE	XODOL
<i>hydroco/apap</i>	OPANA	SYNALGOS-DC	

The following drugs will require step therapy:

AVINZA	DURAGESIC	KADIAN	MS CONTIN
BELBUCA	EXALGO		

UPPERCASE = brand-name drug; lower case *italics* = generic drug

**Aetna Commercial Self-Insured and
Fully-Insured Non-Standard Plans
October 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 10/1/17	Formulary Alternative(s)	Notes
ACCOLATE	NPB/G	NPB/G		Add QL
ADRENALINE	NPB/G	NPB/G		Change QL
ADYPHREN AMP KIT	NPB/G	NPB/G		Change QL
ADYPHREN II KIT	NPB/G	NPB/G		Change QL
ADYPHREN KIT	NPB/G	NPB/G		Change QL
ALBENZA	NPB/G	NPB/G		Add QL
ALINIA	NPB/G	NPB/G		Add QL
ANDROGEL 1.62%	PB	PB		Expect Gen
ANTARA	NPB/G	NPB/G		Add QL
ATROVENT HFA	NPB/G	NPB/G		Add QL
AXIRON	NPB/G	NPB/G		Expect Gen
BETOPTIC-S	PB	NPB/G	<i>betaxolol</i>	
BYETTA	NPB/G	NPB/G		Expect Gen
<i>calcipotriene-betamethasone dipropionate ointment</i>	PG	PG		Add QL
CAPEX	NPB/G	NPB/G	<i>fluocinolone</i>	Add ST, Add QL
COMBIVENT	PB	PB		Add QL
DIFFERIN GEL 0.3%	PB	NPB/G	<i>adapalene</i>	
DUREZOL	PB	PB		Expect Gen
EFFIENT	PB	PB		Expect Gen
EFUDEX CREAM 5%	NPB/G	NPB/G	<i>fluorouracil 5% crm</i>	Add ST
ELMIRON	PB	PB		Add QL
<i>emverm</i>	PG	PG		Add QL
ENSTILAR	NPB/G	NPB/G		Add QL
<i>epinephrine auto-injector</i>	PG	PG		Change QL
EPIPEN 2-PAK	PB	PB		Change QL
EPIPEN-JR	PB	PB		Change QL
EPISNAP KIT	NPB/G	NPB/G		Change QL
ERTACZO	NPB/G	NPB/G	<i>ketoconazole crm</i>	Add ST, Add QL
EXELDERM	NPB/G	NPB/G	<i>ketoconazole crm</i>	Add ST, Add QL
EXTINA	NPB/G	NPB/G	<i>ketoconazole crm</i>	Add ST, Add QL
<i>fenofibrate capsule</i>	PG	PG		Add QL
<i>fenofibrate tablet</i>	PG	PG		Add QL
FENOGLIDE	NPB/G	NPB/G		Add QL
FLUOROPLEX CREAM 1%	NPB/G	NPB/G	<i>fluorouracil 5% crm</i>	Add ST
FULYZAQ	NPB/G	NPB/G	<i>loperamide, diphenoxylate/atropine, bismuth subsalicylate</i>	Add ST
HALOTIN	NPB/G	NC	<i>ketoconazole crm</i>	
INDERAL LA	NPB/G	NPB/G	<i>propranolol sr</i>	Add ST
<i>ketoconazole aerosol 2%</i>	PG	PG		Add QL
<i>ketodan</i>	PG	PG		Add QL

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October 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 10/1/17	Formulary Alternative(s)	Notes
LEVULAN KERA	NPB/G	NPB/G		Add QL
LIPOFEN	NPB/G	NPB/G		Add QL
LOFIBRA	NPB/G	NPB/G		Add QL
LUZU	NPB/G	NPB/G	<i>ketoconazole crm</i>	Add ST, Add QL
MENOSTAR	NPB/G	NPB/G		Expect Gen
<i>methergine</i>	PG	PG		Add QL
<i>methylergonovine</i>	PG	PG		Add QL
MYTESI	NPB/G	NPB/G	<i>loperamide, diphenoxylate/atropine, bismuth subsalicylate</i>	Add ST
<i>naftifine hcl cream 2%</i>	PG	PG		Add QL
NAFTIN	NPB/G	NPB/G	<i>naftifine 1% crm</i>	Add ST, Add QL, Expect Gen
NAMENDA XR	PB	PB		Expect Gen
NAPRELAN	NPB/G	NPB/G	<i>naproxen 275mg, 550mg</i>	Add ST
NASCOBAL	NPB/G	NPB/G	<i>cyanocobalamine inj</i>	Add ST
NEUPRO	NPB/G	NPB/G		Expect Gen
NUVARING	PB	PB		Expect Gen
<i>oxiconazole</i>	PG	PG		Add QL
OXISTAT	NPB/G	NPB/G	<i>ketoconazole crm</i>	Add ST, Add QL
PREPOIK	NPB/G	NPB/G		Expect Gen
PROCTOCORT CREAM 1%	NPB/G	NPB/G	<i>hydrocortisone rectal crm</i>	Add ST
PROVENTIL	NPB/G	NPB/G		Expect Gen
SABRIL	NPS	NPS		Expect Gen
SAFYRAL	NPB/G	NPB/G		Expect Gen
<i>sodium sulfacetamide/sulfur susp 10-5%</i>	PG	NC	<i>topical metronidazole, sulfacetamide, tretinoin</i>	
<i>sodium sulfacetamide/sulfur susp 8-4%</i>	PG	NC	<i>topical metronidazole, sulfacetamide, tretinoin</i>	
SORILUX	NPB/G	NPB/G		Add QL
SPRIX	NPB/G	NPB/G	<i>ketorolac tablets</i>	Add ST, Expect Gen
<i>sulfacleanse</i>	PG	NC	<i>topical metronidazole, sulfacetamide, tretinoin</i>	
SUMAXIN TS	NPB/G	NC	<i>topical metronidazole, sulfacetamide, tretinoin</i>	
SYNAGEX	NPB/G	NC		
SYNATEK	NPB/G	NC		
SYPRINE	NPS	NPS		Expect Gen
TACLONEX OINTMENT	NPB/G	NPB/G	<i>calcipotriene crm/oint, betamethasone crm/oint</i>	Add ST, Add QL
TACLONEX SUSP	NPB/G	NPB/G		Add QL
TOLAK	NPB/G	NPB/G	<i>fluorouracil 5% crm</i>	Add ST

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TRACLEER	PS	PS		Expect Gen
TRAVATAN Z	PB	PB		Expect Gen
TRICOR	NPB/G	NPB/G		Add QL
<i>triderm 0.1% cream</i>	PG	NC	<i>triamcinolone crm</i> by other manufacturers	
TRIGLIDE	NPB/G	NPB/G		Add QL
UCERIS	NPB/G	NPB/G		Expect Gen
VERDESO	NPB/G	NPB/G	<i>desonide</i>	Add QL
VIGAMOX	NPB/G	NPB/G		Expect Gen
XANAX	NPB/G	NPB/G	<i>alprazolam</i>	Add ST
XANAX XR	NPB/G	NPB/G	<i>alprazolam</i>	Add ST
XOLEGEL	NPB/G	NPB/G	<i>ketoconazole crm</i>	Add ST, Add QL
<i>xylon</i>	PG	NC	<i>hydrocodone/ibuprofen</i> by other manufacturers	
<i>zafirlukast</i>	PG	PG		Add QL
ZELAPAR	NPB/G	NPB/G	<i>selegiline</i>	Add ST
<i>zileuton er</i>	PG	PG		Add QL
ZOVIRAX OINTMENT	NPB/G	NPB/G	<i>acyclovir oint</i>	Add ST
ZYFLO	NPB/G	NPB/G		Add QL
ZYFLO CR	NPB/G	NPB/G		Add QL

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

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.

Abbreviation Key

Refer to your plan documents for a complete description of benefits, exclusions and limitations of coverage

*	Some plans may not cover this drug. Alternatives are available.
Expect Gen Expect Generic	Expect generic drugs to become available in the near future. When this happens, we may cover the brand-name drug at a higher copayment, add the brand-name drug to the precertification, quantity limit or step-therapy lists, or add the brand-name drug to the formulary exclusions list.
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HCR - Health Care Reform	There is no copay for these drugs.
Medical	These drugs are not covered under your Pharmacy benefit but may be covered under your Medical benefit.
NC Not-Covered	These drugs are not covered under your pharmacy benefit plan due to benefit exclusion. You can still get these drugs but will need to pay the full cost of the drug.
NPB/G - Non-preferred brand or non-preferred generic drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred brand-name or non-preferred generic drug.
NPS Non-preferred specialty drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred drug on the Aetna Specialty Drug List.
PA - Preauthorization (Precertification)	Preauthorization only applies if your plan includes precertification. This means that we have to approve some drugs before we cover them. If this is required, your doctor must contact us to request approval of coverage.
PB Preferred brand-name drug	These are brand-name drugs that are covered at your 2 nd Tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
PS Preferred specialty drugs	You may pay lower out-of-pocket costs when you use preferred drugs on the Aetna Specialty Drug List.
PG Preferred generic	These are generic drugs that are covered at your 1 st tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
QL Quantity limits	Quantity limits only applies if your plan includes preauthorization. Quantity limits help ensure that you get a safe amount of your drug. If you go past the quantity limit, your doctor must contact us to request approval of coverage.
SE Safety edit	The drugs on this list require clinical checks for all plans. These drugs have the greatest potential for harm according to the U.S. Food and Drug Administration (FDA). Overuse and abuse of these drugs can have harmful side effects and they must be used within the guidelines set by the FDA. These guidelines limit quantities for long-acting narcotics and require approvals for drugs that are used to treat substance abuse or used for cancer pain management or for attention deficit hyperactivity disorder (ADHD).
SPB Specialty pharmacy coverage	You may pay higher out of pocket costs and may be required to get these products at an Aetna Specialty Pharmacy network provider, like Aetna Specialty Pharmacy. Specialty products are limited to a 30 day supply.
ST Step therapy	Step therapy only applies if your plan includes this option. This means that you must try one or more prerequisite drug(s) before we cover a step-therapy drug.

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July 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 7/1/2017	Formulary Alternative(s)	Notes
ABANEU-SL	NPB/G	NC		
ACTIVE FE	NPB/G	NC		
<i>airavite</i>	PG	NC		
AKTEN	NPB/G	NC		
<i>alphatrex</i>	PG	PG		Add QL
<i>ana-lex</i>	PG	NC		
ANIMI-3	NPB/G	NC		
ASTERO	NC	NC		Moved to Benefit Exclusion
ATRALIN	NPB/G	NPB/G	<i>tretinoin</i> , EPIDUO	Change ST
<i>augmented betameth gel, lot, oint</i>	PG	PG		Add QL
<i>av-vite fb</i>	PG	NC		
<i>b6 folic acid</i>	PG	NC		
BIFERARX	NPB/G	NC		
BONIVA	NPB/G	NPB/G	<i>alendronate 70mg</i>	Add ST
BP VIT 3	NPB/G	NC		
BYSTOLIC	PB	PB	<i>metoprolol, atenolol, nadolol</i>	Add QL
CEM-UREA	NPB/G	NC		
CENFOL	NPB/G	NC		
CENTRATAX	NPB/G	NC		
<i>clobetasol</i>	PG	PG		Add QL
<i>clobetasol e</i>	PG	PG		Add QL
CLOBEX LOT, SHAMPOO	NPB/G	NPB/G		Add QL
CLOBEX SPRAY	PB	NPB/G		Add QL
<i>clodan</i>	PG	PG		Add QL
CORDRAN TAPE	NPB/G	NPB/G		Add QL
<i>cormax scalp</i>	PG	PG		Add QL
<i>corvita 150</i>	PG	NC		
CORVITE 150	NPB/G	NC		
<i>diclofenac gel 3%</i>	PG	PG		Change QL
<i>dihydroergotamine spray</i>	PG	PG	<i>naratriptan, rizatriptan, sumatriptan, zolmitriptan</i>	Add ST
DIPROLENE LOT, OINT	NPB/G	NPB/G		Add QL
DIVISTA	NPB/G	NC		
<i>doxercalciferol cap</i>	PS	PG		Add QL, Remove SPB
<i>doxercalciferol inj</i>	PS	NC		Remove SPB
DRISDOL	HCR	NPB/G		
ED CYTE F	NPB/G	NC		
EPANED ORAL SOLN	NPB/G	NPB/G	<i>enalapril tablets</i>	Add PA, Add QL
EPANED PWD FOR ORAL SOLN	NPB/G	NPB/G	<i>enalapril tablets</i>	Add PA, Add QL
<i>ergocalciferol cap 50000unt</i>	HCR	PG		
<i>fa-b6-b12</i>	PG	NC		
<i>fabb</i>	PG	NC		

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Drug Name	Current Tier	Tier as of 7/1/2017	Formulary Alternative(s)	Notes
FE 90 PLUS	NPB/G	NC		
FERIVA	NPB/G	NC		
<i>ferocon</i>	PG	NC		
<i>ferottrinsic</i>	PG	NC		
FERRALET 90	NPB/G	NC		
FERRAPLUS 90	NPB/G	NC		
<i>ferrocite</i>	PG	NC		
FERRO-PLEX	NPB/G	NC		
FERROTRIN	NPB/G	NC		
<i>fluocinonide</i>	PG	PG		Add QL
FOCALGIN DSS	NPB/G	NC		
<i>folbee</i>	PG	NC		
FOLGARD RX	NPB/G	NC		
FOLIVANE-F	NPB/G	NC		
FOLIVANE-PLS	NPB/G	NC		
<i>folplex 2.2</i>	PG	NC		
<i>foltrin</i>	PG	NC		
FUSION PLUS	NPB/G	NC		
<i>halobetasol</i>	PG	PG		Add QL
HECTOROL CAP	NPS	NPB/G	<i>doxercalciferol</i> and <i>calcitriol</i>	Add ST, Add QL, Remove SPB
HECTOROL INJ	NPS	NC		Remove SPB
<i>hematinic pl</i>	PG	NC		
<i>hematinic/fa</i>	PG	NC		
<i>hematogen</i>	PG	NC		
HEMATOGEN FA	NPB/G	NC		
HEMETAB	NPB/G	NC		
<i>hemocyte</i>	PG	NC		
HEMOCYTE PLS	NPB/G	NC		
<i>hemocyte-f</i>	PG	NC		
HORIZANT	NPB/G	NPB/G	<i>gabapentin</i>	Add PA
<i>hydrocort ac pow</i>	PG	NC		
INDOCIN SUSPENSION	PB	NPB/G	<i>indomethacin capsules</i>	
INTEGRA F	NPB/G	NC		
INTEGRA PLUS	NPB/G	NC		
IROSPAN 24/6	NPB/G	NC		
IS 24/6	NPB/G	NC		
<i>k-tan plus</i>	PG	NC		
LANCETS (all Brands currently at preferred Brand tier)	PB	NPB/G	<i>generic lancets</i>	
LDO PLUS	NC	NC		Moved to Benefit Exclusion
<i>levorphanol</i>	PG	PG		Add QL, Add SE

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<i>lidazone</i>	PG	NC		
<i>lidocaine cre tetracai</i>	PG	PG		Add QL
<i>lidocaine pad 5%</i>	PG	PG	<i>gabapentin</i>	Add PA
<i>lidocaine/hc cre 3%-0.5%</i>	PG	NC		
<i>lidocaine/hc kit 2-2%</i>	PG	NC		
<i>lidocaine/hc kit 3%-0.5% 2-2%</i>	PG	NC		
<i>lidocaine/hc kit 3%-1%</i>	PG	NC		
<i>lidocaine/hc kit 3-2.5%</i>	PG	NC		
LIDODERM	NPB/G	NPB/G	<i>gabapentin</i>	Add ST
<i>lido-hydro gel 2.8-0.54</i>	PG	NC		
LIDOVIN	NPB/G	NC		
LIDOZOL	NPB/G	NC		
MAXARON	NPB/G	NC		
MAXFE	NPB/G	NC		
MEPHYTON	PB	PB		Add QL
MULTIGEN	NPB/G	NC		
MULTIGEN PLS	NPB/G	NC		
NEPHRON FA	NPB/G	NC		
NEURIN-SL	NPB/G	NC		
NITROSTAT	PB	NPB/G	NITROGLYCERN	Add ST
<i>nufol</i>	PG	NC		
OLUX	NPB/G	NPB/G		Add QL
OLUX-E	NPB/G	NPB/G		Add QL
<i>paricalcitol cap</i>	PS	PG		Add QL, Remove SPB
<i>paricalcitol inj</i>	PS	NC		Remove SPB
PERFOROMIST	NPB/G	NPB/G	SEREVENT	Add PA
PLIAGLIS	NPB/G	NPB/G		Add QL
PRE-FOLIC	NPB/G	NC		
PROFERRIN	NPB/G	NC		
PROTECTIRON	NPB/G	NC		
PROVENTIL HFA	NPB/G	NPB/G	VENTOLIN HFA and PROAIR	Expect Gen
PUREFE	NPB/G	NC		
<i>purevit dual</i>	PG	NC		
<i>quetiapine tab 50mg er</i>	PG	PG		Change QL
RAVICTI	NPS	NPS	<i>phenylbutyrate , BUPHENYL</i>	Add ST
RAYALDEE	HCR	NPB/G		
REGRANEX	NPB/G	NPB/G	SANTYL	Add PA, Add QL
RETIN-A CRE	NPB/G	NPB/G	<i>tretinoin , EPIDUO</i>	Add ST
RETIN-A MICR	NPB/G	NPB/G	<i>tretinoin , EPIDUO</i>	Add ST
SANTYL	NPB/G	NPB/G		Add QL

UPPERCASE = brand-name drug; lower case *italics* = generic drug

**Aetna Commercial Self-Insured and
Fully-Insured Non-Standard Plans
July 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 7/1/2017	Formulary Alternative(s)	Notes
<i>selenium sul shampoo 2.25%</i>	PG	NC		
SELRX	NPB/G	NC		
SENSIPAR	NPS	NPB/G		Add QL, Remove SPB, Expect Gen
SEROQUEL XR TAB 50MG	PB	PB		Change QL
<i>se-tan plus</i>	PG	NC		
SOLARAZE	NPB/G	NPB/G		Change QL
SYMAX DUOTAB	NPB/G	NC	<i>dicyclomine,</i> <i>glycopyrrolate</i>	
SYNERA	NPB/G	NPB/G		Add QL
TANDEM F	NPB/G	NC		
TANDEM PLUS	NPB/G	NC		
TARON FORTE	NPB/G	NC		
TEMOVATE	NPB/G	NPB/G		Add QL
TEMOVATE E	NPB/G	NPB/G		Add QL
TERSI FOAM	NPB/G	NC		
<i>tl gard rx</i>	PG	NC		
<i>tl icon</i>	PG	NC		
TRETIN-X	NPB/G	NPB/G	<i>tretinoin</i> , EPIDUO	Add ST
<i>tricon</i>	PG	NC		
<i>trigels-f</i>	PG	NC		
TRULICITY	PB	PB		Add QL
ULTRAVATE	NPB/G	NPB/G		Add QL
URAMAXIN	NPB/G	NC		
UREA NAIL	NPB/G	NC		
VANOS	NPB/G	NPB/G		Add QL
VASCEPA	PB	PB		Add QL
VENIPUNCTURE CPI KIT	NPB/G	NC		
<i>virt-gard</i>	PG	NC		
<i>virt-vite</i>	PG	NC		
<i>vitamin D cap 50000IU</i>	HCR	PG		
VITAMIN D (all OTC products greater than 1200IU, currently covered under HCR)	HCR	NC	OTC Vitamin D 400IU-1200IU	
ZEMPLAR CAP	NPS	NPB/G	<i>paricalcitol</i> and <i>calcitriol</i>	Add ST, Add QL, Remove SPB
ZEMPLAR INJ	NPS	NC		Remove SPB

UPPERCASE = brand-name drug; lower case *italics* = generic drug

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

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.

Abbreviation Key

Refer to your plan documents for a complete description of benefits, exclusions and limitations of coverage

*	Some plans may not cover this drug. Alternatives are available.
Expect Gen Expect Generic	Expect generic drugs to become available in the near future. When this happens, we may cover the brand-name drug at a higher copayment, add the brand-name drug to the precertification, quantity limit or step-therapy lists, or add the brand-name drug to the Formulary Exclusions list.
FE Formulary Exclusion	These drugs are not covered under your pharmacy benefit plan due to a formulary exclusion. You can still get these drugs but will need to pay the full cost of the drug.
HCR - Health Care Reform	There is no copay for these drugs.
LGC - Lowest generic copay	Lowest generic copay only applies if your plan has the Value Drug Program.
Medical	These drugs are not covered under your Pharmacy benefit but may be covered under your Medical benefit.
NC Not-Covered	These drugs are not covered under your pharmacy benefit plan due to benefit exclusion. You can still get these drugs but will need to pay the full cost of the drug.
NPB/G - Non-preferred brand or non-preferred generic drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred brand-name or non-preferred generic drug.
NPS Non-preferred specialty drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred drug on the Aetna Specialty Drug List.
NPL National Precertification List	Prior authorization (PA) is required for all plans. Your doctor must contact us to request approval for coverage.
PA Prior authorization or precertification	Prior authorization only applies if your plan includes precertification. This means that we have to approve some drugs before we cover them. If this is required, your doctor must contact us to request approval of coverage.
PB Preferred brand-name drug	These are brand-name drugs that are covered at your 2 nd Tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
PS Preferred specialty drugs	You may pay lower out-of-pocket costs when you use preferred drugs on the Aetna Specialty Drug List.
PG Preferred generic	These are generic drugs that are covered at your 1 st tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
QL Quantity limits	Quantity limits only applies if your plan includes quantity limits. Quantity limits help ensure that you get a safe amount of your drug. If you go past the quantity limit, your doctor must contact us to request approval of coverage.
Select OTC Select over-the-counter	Select OTC (over-the-counter) drugs are covered under your prescription plan with a prescription.
SPB Specialty pharmacy coverage	You may pay higher out of pocket costs and may be required to get these products at an Aetna Specialty Pharmacy network provider, like Aetna Specialty Pharmacy. Specialty products are limited to a 30 day supply.
ST Step therapy	Step therapy only applies if your plan includes step-therapy. This means that you must try one or more prerequisite drug(s) before we cover a step-therapy drug.

**Aetna Commercial Self-Insured and
Fully-Insured Non-Standard Plans
April 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 4/1/2017	Formulary Alternative(s)	Notes
ADDERALL	NPB/G	NPB/G		Remove PA
ADDERALL XR	NPB/G	NPB/G		Remove PA
ADRENALIN INJ	NPB/G	NC	EPIPEN, <i>epinephrine autoinjector</i>	Remove PA, Add QL
ADYPHREN	NPB/G	NPB/G	EPIPEN, <i>epinephrine autoinjector</i>	Add QL
ADYPHREN II	NPB/G	NPB/G	EPIPEN, <i>epinephrine autoinjector</i>	Add QL
ALA-QUIN	NC	NC		Move to Benefit Exclusion
ALCORTIN A	NC	NC		Move to Benefit Exclusion
ALOQUIN	NC	NC		Move to Benefit Exclusion
ASCENSIA AUTODISC	NPB/G	NPB/G		Add QL
BACTROBAN TOPICAL OINT, CRM	NPB/G	NPB/G		Add QL
BAYER BREEZE TEST DISC	NPB/G	NPB/G		Add QL
BENSAL HP	NC	NC		Move to Benefit Exclusion
BIVIGAM	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
CARIMUNE NF	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
CENTANY	NPB/G	NPB/G		Add QL
CIFEREX	NPB/G	NC		
COLCRYS	NPB/G	NPB/G	<i>colchicine</i> , MITIGARE	Add ST
CUVITRU	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
DEXEDRINE CAP	NPB/G	NPB/G		Remove PA
<i>dexedrine tab</i>	PG	PG		Remove PA
<i>dextroamphetamine</i>	PG	PG		Remove PA
<i>diclofenac gel</i>	PG	PG		Change QL
<i>doxepin hcl cream</i>	PG	PG		Add QL
DURACHOL	NPB/G	NC		

UPPERCASE = brand-name drug; lower case *italics* = generic drug

**Aetna Commercial Self-Insured and
Fully-Insured Non-Standard Plans
April 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 4/1/2017	Formulary Alternative(s)	Notes
DUTOPROL	NPB/G	NPB/G	<i>metoprolol/hctz, metoprolol er tabs, hctz</i>	Add ST, Add QL
<i>econazole</i>	PG	PG		Add QL
<i>epinephrine inj 0.15mg</i>	PG	PG		Add QL
<i>epinephrine inj 0.3mg</i>	PG	PG		Add QL
EPIPEN 2-PAK	PB	PB		Add QL
EPIPEN-JR	PB	PB		Add QL
EPISNAP	NPB/G	NPB/G	EPIPEN, <i>epinephrine autoinjector</i>	Add QL
FERIVA TAB 21/7	NPB/G	NC		
FLEBOGAMMA	NPS	PS		
FOCALIN	NPB/G	NPB/G		Remove PA
FOCALIN XR	NPB/G	NPB/G		Remove PA
GAMMAGARD	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
GAMMAGARD SD	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
GAMMAKED	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
GAMMAPLEX	NPS	PS		
GAMUNEX-C	NPS	PS		
HIZENTRA	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
HYLAFEM	NC	NC		Move to Benefit Exclusion
HYQVIA	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
METADATE CD	NPB/G	NPB/G		Remove PA
METHYLIN CHEW	NPB/G	NPB/G		Remove PA
METHYLIN SOLN	NPB/G	NPB/G		Remove PA
METOPROLOL/HCTZ SR	NPB/G	NPB/G	<i>metoprolol/hctz, metoprolol er tabs, hctz</i>	Add ST, Add QL

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**Aetna Commercial Self-Insured and
Fully-Insured Non-Standard Plans
April 1, 2017 Updates**



Drug Name	Current Tier	Tier as of 4/1/2017	Formulary Alternative(s)	Notes
MORCIN	NC	NC		Move to Benefit Exclusion
<i>mupirocin oint, crm</i>	PG	PG		Add QL
OCTAGAM	NPS	PS		
ORTHO D	NPB/G	NC		
PRIVIGEN	NPS	NPS	FLEBOGAMMA, GAMMAPLEX, GAMUNEX-C, OCTAGAM	Add ST
PRUDOXIN	NPB/G	NPB/G		Add QL
REVESTA	NPB/G	NC		
RITALIN	NPB/G	NPB/G		Remove PA
RITALIN LA	NPB/G	NPB/G		Remove PA
RYNODERM	NPB/G	NC		
THALAMUS	NC	NC		Move to Benefit Exclusion
TRAUMEEL	NC	NC		Move to Benefit Exclusion
TREXIMET	NPB/G	NPB/G	<i>sumatriptan and naproxen</i>	Add QL
UTOPIC	NPB/G	NC		
VANATOL LQ	NPB/G	NPB/G	<i>acetaminophen/ butalbital/caffeine tab</i>	Add ST, Add QL
VIBERZI	PB	PB		Remove PA
VOLTAREN GEL	PB	PB		Change QL
ZAVARA	NPB/G	NC		
ZENZEDI 2.5MG, 7.5MG, 15MG, 20MG, 30MG	NPB/G	NPB/G		Remove PA
<i>zenzedi 5mg, 10mg</i>	PG	PG		Remove PA
ZOLATE	NPB/G	NC		
ZONALON	NPB/G	NPB/G		Add QL

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

A copayment is a flat fee. Coinsurance is a percentage of the rate that Aetna negotiates with the plan sponsor for covered prescriptions except as required by law to be otherwise. Some drugs on the Aetna Pharmacy Plan and Specialty Drug List are subject to manufacturer rebates. Coinsurance is calculated before any rebates are subtracted. That means it may be possible for your cost of a preferred drug to be higher than your cost of a non-preferred drug.

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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 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, precertification approval is known as "preservice utilization review." It is not "verification" as defined by Texas law.

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 precertification 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 precertification 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, precertification, 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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Abbreviation Key

Refer to your plan documents for a complete description of benefits, exclusions and limitations of coverage

*	Some plans may not cover this drug. Alternatives are available.
Expect Gen Expect Generic	Expect generic drugs to become available in the near future. When this happens, we may cover the brand-name drug at a higher copayment, add the brand-name drug to the precertification, quantity limit or step-therapy lists, or add the brand-name drug to the Formulary Exclusions list.
HCR Health Care Reform	There is no copay for these drugs.
LGC Lowest generic copay	Lowest generic copay only applies if your plan has the Value Drug Program.
Medical	These drugs are not covered under your Pharmacy benefit but may be covered under your Medical benefit.
NC Not-Covered	These drugs are not covered under your pharmacy benefit plan. You can still get these drugs but will need to pay the full cost of the drug.
NPB/G Non-preferred brand or non-preferred generic drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred brand-name or non-preferred generic drug.
NPS Non-preferred specialty drug	These drugs aren't preferred. You may pay higher out-of-pocket costs when using a non-preferred drug on the Aetna Specialty Drug List.
NPL National Precertification List	Prior authorization (PA) is required for all plans. Your doctor must contact us to request approval for coverage.
PA Prior authorization or precertification	Prior authorization only applies if your plan includes precertification. This means that we have to approve some drugs before we cover them. If this is required, your doctor must contact us to request approval of coverage.
PB Preferred brand-name drug	These are brand-name drugs that are covered at your 2 nd Tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
PS Preferred specialty drugs	You may pay lower out-of-pocket costs when you use preferred drugs on the Aetna Specialty Drug List.
PG Preferred generic	These are generic drugs that are covered at your 1 st tier copay. You may pay lower out-of-pocket costs when you use preferred drugs, but this may not always be the case.
QL Quantity limits	Quantity limits only applies if your plan includes quantity limits. Quantity limits help ensure that you get a safe amount of your drug. If you go past the quantity limit, your doctor must contact us to request approval of coverage.
Select OTC Select over-the-counter	Select OTC (over-the-counter) drugs are covered under your prescription plan with a prescription.
SPB Specialty pharmacy coverage	You may pay higher out of pocket costs and may be required to get these products at an Aetna Specialty Pharmacy network provider, like Aetna Specialty Pharmacy. Specialty products are limited to a 30 day supply.
ST Step therapy	Step therapy only applies if your plan includes step-therapy. This means that you must try one or more prerequisite drug(s) before we cover a step-therapy drug.

Aetna Self-Insured Commercial Plans
January 1, 2017 Updates



Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
ADRENALIN	NPB/G	NPB/G		Remove PA
AKYNZEO	NPB/G	NPB/G	<i>oral ondansetron tab</i>	
ALINIA	NPB/G	NPB/G		Expect Gen
<i>alosetron</i>	PG	PG	<i>diphenoxylate/atropine, loperamide</i>	Add ST
ALOXI	NC	NC		Remove NPL
ALTOPREV	NPB/G	NPB/G	<i>atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin</i>	Remove ST
ALUVEA	NC	NC		
ANALPRAM SNGL	NC	NC		
ANALPRAM-HC	NC	NC		
ANASPAZ	NC	NC		
ANZEMET inj	NC	NC		Remove NPL
APIDRA	NPB/G	NPB/G	HUMULIN products, HUMALOG products	Add ST
ARNUITY ELPT	NPB/G	NPB/G		Remove PA, Remove ST
ARRANON	NC	NC		Expect Gen
ATACAND	NPB/G	NPB/G	<i>candesartan, eprosartan, irbesartan, losartan, valsartan, telmisartan</i>	Remove ST
ATACAND HCT 16-12.5mg	NPB/G	NPB/G	<i>candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz</i>	Remove ST
ATACAND HCT 32-12.5mg and 32-25mg	NPB/G	NPB/G	<i>candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz</i>	Remove ST, Add QL
AVALIDE	NPB/G	NPB/G	<i>candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz</i>	Remove ST
AVAPRO	NPB/G	NPB/G	<i>candesartan, eprosartan, irbesartan, losartan, valsartan, telmisartan</i>	Remove ST

UPPERCASE = brand-name drug; lower case *italics* = generic drug

Aetna Self-Insured Commercial Plans
January 1, 2017 Updates



Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
AZILECT	PB	PB		Expect Gen
<i>azuphen mb</i>	NC	NC		
BONIVA inj	NPS	NPS		Remove NPL
CARBAGLU	NPS	NPS		Expect Gen
<i>ciclodan</i>	PG	PG		Remove PA
<i>ciclopirox</i>	PG	PG		Remove PA
CLARINEX	NPB/G	NPB/G		Remove PA, Remove ST
CLIMARA PRO	NPB/G	NPB/G		Expect Gen
COLCRYS	PB	NPB/G	<i>colchicine</i> , MITIGARE	Add ST
COPAXONE 40mg	PS	PS		Expect Gen
COVERA-HS	NPB/G	NPB/G		Expect Gen
COZAAR	NPB/G	NPB/G	<i>candesartan</i> , <i>eprosartan</i> , <i>irbesartan</i> , <i>losartan</i> , <i>valsartan</i> , <i>telmisartan</i>	Remove ST
<i>desloratadine 2.5mg ODT</i>	PG	PG		Remove PA, Remove ST
<i>desloratadine 5mg ODT</i>	PG	PG		Remove PA
<i>diclofenac gel</i>	PG	PG		Add QL
<i>diclotral</i>	PG	NC	<i>diclofenac tabs</i> , <i>capsaicin crm (otc)</i>	
DIOVAN	NPB/G	NPB/G	<i>candesartan</i> , <i>eprosartan</i> , <i>irbesartan</i> , <i>losartan</i> , <i>valsartan</i> , <i>telmisartan</i>	Remove ST
DIOVAN HCT	NPB/G	NPB/G	<i>candesartan/hctz</i> , <i>eprosartan/hctz</i> , <i>irbesartan/hctz</i> , <i>losartan/hctz</i> , <i>telmisartan/hctz</i> , <i>valsartan/hctz</i>	Remove ST
DONNATAL	NC	NC		
<i>doxycycline cap 75mg</i>	PG	PG	generic MONODOX 50mg, 100mg; generic VIBRAMYCIN 50mg, 100mg	Add QL
DRYSOL	NC	NC		
DUEXIS	NPB/G	NPB/G		Add ST
EMEND	PB	NPB/G	<i>oral ondansetron tab</i>	
EMLA	NPB/G	NPB/G		Add QL
EPIDUO	PB	PB		Expect Gen
EPIDUO FORTE	PB	PB		Expect Gen
EPIPEN 2-PAK	PB	PB		Expect Gen

UPPERCASE = brand-name drug; lower case *italics* = generic drug

Aetna Self-Insured Commercial Plans
January 1, 2017 Updates



Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
EPIPEN-JR	PB	PB		Expect Gen
EPZICOM	NPB/G	NPB/G		Expect Gen
EVZIO	PB	NPB/G	NARCAN NASAL SPRAY	Add PA, Add ST
EXFORGE	PB	NPB/G	<i>amlodipine, candesartan, eprosartan, irbesartan, losartan, valsartan, telmisartan</i>	
EXFORGE HCT	PB	NPB/G	<i>amlodipine, candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz</i>	
EYLEA	NPS	NPS		Add NPL
GIAZO	NPB/G	NPB/G		Expect Gen
GLUCOSE TEST STRIPS (any brand except LIFESCAN and ABBOTT products)	NPB/G	NPB/G	LIFESCAN products (such as ONETOUGH), ABBOTT products (such as FREESTYLE)	Add ST
<i>grafco silver</i>	NC	NC		
HARVONI	PS	NPS	ZEPATIER	Add ST
<i>hc pramoxine</i>	NC	NC		
<i>hemmorex-hc</i>	NC	NC		
HUMULIN	NPB/G	PB		
HUMULIN N HUMULIN R	NPB/G	PB		
HYDRO 35	NC	NC		
<i>hyolev mb</i>	NC	NC		
<i>hyosyne</i>	NC	NC		
<i>hypercare</i>	NC	NC		
HYZAAR	NPB/G	NPB/G	<i>candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz</i>	Remove ST
<i>ibandronate inj</i>	PS	PS		Remove NPL
<i>indiomib mb</i>	NC	NC		
JEVTANA	NC	NC		Remove NPL
JUBLIA	NPB/G	NPB/G	<i>terbinafine, itraconazole, griseofulvin</i>	Remove PA

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Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
KERALAC	NC	NC		
KERYDIN	NPB/G	NPB/G	<i>terbinafine, itraconazole, griseofulvin</i>	Remove PA
LESCOL LESCOL XL	NPB/G	NPB/G	<i>atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin</i>	Remove ST
LEVBIID	NC	NC		
<i>levocetirizine solution</i>	PG	PG		Remove PA
LEVSIN	NC	NC		
LEVSIN/SL	NC	NC		
LEXIVA	PB	PB		Expect Gen
<i>lidocaine oint</i>	PG	PG		Add QL
<i>lidocaine pad</i>	PG	PG		Add QL
<i>lidocaine-prilocaine cream</i>	PG	PG		Add QL
LIDODERM	NPB/G	NPB/G		Add QL
<i>lidopril</i>	PG	PG		Add QL
LIPITOR	NPB/G	NPB/G	<i>atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin</i>	Remove ST
LOTEMAX	PB	PB		Expect Gen
LUCENTIS	NPS	NPS		Add NPL
LUPRON DEPO-PED	PS	PS	<i>leuprolide</i>	Add PA
MACUGEN	NPS	NPS		Add NPL
MICARDIS	NPB/G	NPB/G	<i>candesartan, eprosartan, irbesartan, losartan, valsartan, telmisartan</i>	Remove ST
MICARDIS HCT	NPB/G	NPB/G	<i>candesartan/hctz, eprosartan/hctz, irbesartan/hctz, losartan/hctz, telmisartan/hctz, valsartan/hctz</i>	Remove ST
MINASTRIN 24	NPB/G	NPB/G		Expect Gen
MIRENA	NPB/G	NPB/G		Expect Gen
MITIGARE	NPB/G	PB		Remove PA, Remove ST

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Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
<i>mondoxylene nl</i>	PG	PG	generic MONODOX 50mg, 100mg; generic VIBRAMYCIN 50mg, 100mg	Add QL
MONODOX	NPB/G	NPB/G	generic MONODOX 50mg, 100mg; generic VIBRAMYCIN 50mg, 100mg	Add QL
NARCAN	NPB/G	PB		
NASONEX	PB	NPB/G	<i>flunisolide, mometasone</i> , FLONASE OTC, NASACORT 24HR	Add ST
NOVOLOG NOVOLOG MIX	PB	NPB/G	HUMULIN products, HUMALOG products	Add ST
<i>nulev</i>	NC	NC		
OMNARIS	NPB/G	NPB/G	<i>flunisolide, mometasone</i>	Add ST
<i>oscimin</i>	NC	NC		
<i>oscimin sr</i>	NC	NC		
OTEZLA	NPS	PS		Remove ST
<i>pamidronate</i>	PS	PS		Remove NPL
PATADAY	PB	PB		Expect Gen
PENLAC	NPB/G	NPB/G	<i>terbinafine, itraconazole</i> , <i>griseofulvin</i>	Remove PA
<i>phenohydro</i>	NC	NC		
PREVIDENT	NC	NC		
PREVIDENT 5000	NC	NC		
PRISTIQ	NPB/G	NPB/G	<i>citalopram, fluoxetine</i> , <i>duloxetine, venlafaxine</i> , <i>amitriptyline</i> , <i>mirtazapine, trazodone</i>	Expect Gen
PROCORT CREAM	NPB/G	NC		
PROTOPIC	PB	PB	<i>fluticasone propionate</i> , <i>betamethasone</i> <i>dipropionate/augmented</i> , <i>triamcinolone acetonide</i>	Add ST
RECLAST	NPS	NPS		Remove NPL
RELPAK	NPB/G	NPB/G		Expect Gen
REVATIO SUS	NPS	NPS		Expect Gen

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Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
REYATAZ	PB	PB		Expect Gen
RILUTEK	NPB/G	NPB/G		Remove ST
<i>salicylic</i>	NC	NC		
SALIVAMAX	NC	NC		
SANDOSTATIN	NPS	NPS		Expect Gen
SAVAYSA	NPB/G	NPB/G		Remove ST
SOLARAZE	NPB/G	NPB/G		Add QL
SOMAVERT	NPS	NPS		Expect Gen
SOVALDI	PS	NPS	ZEPATIER	Add ST
STRATTERA	PB	PB		Expect Gen
STRIVERDI	NPB/G	NPB/G	SEREVENT	Add QL
SUBOXONE	NPB/G	NPB/G		Expect Gen
<i>sulfacetamide sodium with sulfur</i>	PG	NC	EPIDUO	
<i>sulfacetamide sodium with sulfur liquid wash</i>	PG	NC		
SUMADAN WASH	NPB/G	NC	EPIDUO	
SUMAXIN WASH LIQUID 9-4%	NPB/G	NC		
SUSTIVA	PB	PB		Expect Gen
<i>symax-sl</i>	NC	NC		
<i>symax-sr</i>	NC	NC		
<i>tacrolimus</i>	PG	PG	<i>fluticasone propionate, betamethasone dipropionate/augmented, triamcinolone acetonide</i>	Add ST
TAMIFLU	NPB/G	NPB/G		Expect Gen
TANZEUM	NPB/G	NPB/G		Remove ST
TAZORAC	NPB/G	PB		
TIKOSYN	NPB/G	NPB/G		Expect Gen
TRACLEER	PS	PS		Expect Gen
TRESIBA FLEX	NPB/G	PB		Remove ST
TROKENDI XR	NPB/G	NPB/G		Expect Gen
TWYNSTA	NPB/G	NPB/G		Remove ST
URAMAXIN	NC	NC		
URAMAXIN GT	NC	NC		
<i>uramit mb</i>	NC	NC		
<i>ure-k</i>	NC	NC		
<i>urolet mb</i>	NC	NC		
UTOPIC CREAM 41%	NPB/G	NC		
VELCADE	NC	NC		Expect Gen
VERAMYST	NPB/G	NPB/G	<i>flunisolide, mometasone</i>	Add ST
VIBERZI	NPB/G	PB		Remove ST

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Drug Name	Current Tier	Tier as of 1/1/2017	Formulary Alternative(s)	Notes
VIMOVO	PB	NPB/G		
VIREAD	PB	PB		Expect Gen
VISUDYNE	NPS	NPS		Expect Gen
VIVITROL	NPS	NPB/G		Remove SPB
VYTORIN	NPB/G	NPB/G	<i>atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin, ZETIA</i>	Expect Gen
VYTORIN TAB 10-80MG	NPB/G	NPB/G		Expect Gen
<i>x-viate</i>	NC	NC		
<i>zencia liquid 9-4%</i>	PG	NC		
ZEPATIER	NPS	PS		Remove ST
ZIANA	NPB/G	PB		
ZIOPTAN	NPB/G	NPB/G		Remove ST
<i>zoledronic acid inj</i>	PS	PS		Remove NPL
ZOMETA	NPS	NPS		Remove NPL

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

A copayment is a flat fee. Coinsurance is a percentage of the rate that Aetna negotiates with the plan sponsor for covered prescriptions except as required by law to be otherwise. Some drugs on the Aetna Pharmacy Plan and Specialty Drug List are subject to manufacturer rebates. Coinsurance is calculated before any rebates are subtracted. That means it may be possible for your cost of a preferred drug to be higher than your cost of a non-preferred drug.

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 Aetna plans, refer to **www.aetna.com**.

In accordance with state law, commercial fully insured 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, precertification approval is known as "preservice utilization review." It is not "verification" as defined by Texas law.

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 precertification 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 precertification 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, precertification, 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 about Aetna plans, refer to **www.aetna.com**.

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 bááh ílínígóó naaltsoos bee atah níłjigo nanitinígíí bee néého'dółzinígíí béésh bee hane'í bikáá' áají' 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 ያለከፍያ ለማግኘት፣ በመታወቂያዎች ላይ ያለውን ቁጥር ይደውሉ። (Amharic)

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

Անվճար լեզվական ծառայություններին 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 မပေးရဲဘဲ ဘာသာစကားဝန်ဆောင်မှုများ ရရှိနိုင်ရန်၊ သင့် ID ကတ်ပေါ်တွင်ရှိသော ဖုန်းနံပါတ်အား 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 lengguãhi ni dibåtde para hãgu, ågang i numiru gi iyo-mu kard aidentifikasion. (Chamorro)

[illegible]

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

Tajaajjiiloota 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 કોઈ 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)

လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢၤအတၢ်ဖဲးတၢ်မၤစတၢ်လၢတအိၣ်ဒီးအပ္ပၤလၢနကဘၣ်ဟ့ၣ်အိၣ်ဘၣ်န့ၣ်.ကိးဘၣ်လိတဖီခိၣ်ဂံၢ်လၢအိၣ်လၢနတၢ်ဂီၤခိၣ် (ID)
အခးလိၣ်တကၢ် (Karen)

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

M dyi wudu-dù kà kò dò bě dyi móuń nì pídýi ní, níí, dǎ nòbà nìà nì ID káàò kǝ. (Kru-Bassa)

بۆ دەسپێر اگەشتن بە خزمەتگوزاری زمان بەی تێچوون بۆ تۆ، پەيوەندی بکە بە ژمارەى سەر ئای دی (ID) کارتی خۆت.
(Kurdish)

ເພື່ອຂໍ້ໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ,
ໃຫ້ໂທຫາເບີໂທທິບອກໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານ. (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, kirllok 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)

Tě kɔɔr yīn wěēr de thokic ke cīn wěu kɔr keek tēnɔŋ yīn. Ke cɔl kɔc ye kɔc kuɔny nē nomba de abac tǝ
nē ID kard du kǝ. (Nilotic-Dinka)

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

Um Schprooch Services zu griegie 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)

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).

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