2027 Alternative Covered Drugs

WELLCARE BY BUCKEYE HEALTH PLAN HAS YOU COVERED FOR YOUR PRESCRIPTION DRUG NEEDS.

We strive to cover the most common drugs across all disease states. Below are some common drugs not covered by the plan, along with alternative drugs that are covered. If you are currently on a drug that is not covered, please check our plan's *formulary* (drug list) to see which alternative drugs are covered. Talk to your provider to see if the formulary alternatives listed below would work for you.

Generics, authorized generics, and biosimilars (medicines similar to make-up and function as biologic medicines from living systems) listed in the table below with the ** symbol have the same active ingredients as the drug not covered on the formulary. If you have an active prescription for a drug not covered, talk to your provider or pharmacist about getting the drug listed with ** without a new prescription.

DRUG(S) NOT COVERED ON THE FORMULARY	DRUG(S) COVERED ON THE FORMULARY	FORMULARY RESTRICTIONS
BASAGLAR KWIKPEN (insulin glargine) SEMGLEE (insulin glargine-YFGN)** TRESIBA	INSULIN GLARGINE-YFGN**	None
	LANTUS**	None
	INSULIN GLARGINE U-300	None
TOUJEO U-300 (insulin glargine)**	INSULIN GLARGINE U-300**	None
	INSULIN GLARGINE-YFGN	None
	LANTUS	None
NOVOLOG (insulin aspart)** FIASP (insulin aspart) HUMALOG	KIRSTY (insulin aspart-xjhz)**	None
	MERILOG (insulin aspart-szjj)	None
INVOKAMET INVOKAMET XR	dapagliflozin-metformin ER	QL
	SYNJARDY	QL
	SYNJARDY XR	QL
INVOKANA	dapagliflozin	QL
	JARDIANCE	QL

UPPERCASE TEXT = Brand name drug **lowercase text = Generic drug**
****Therapeutically equivalent** **PA = Prior authorization** **QL = Quantity limit**

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DRUG(S) NOT COVERED ON THE FORMULARY	DRUG(S) COVERED ON THE FORMULARY	FORMULARY RESTRICTIONS
ADVAIR DISKUS** wixela inhub**	fluticasone-salmeterol diskus**	QL
	breyna hfa	QL
	BREO ELLIPTA	QL
	ADVAIR HFA	QL
	FLUTICASONE-VILANTEROL	QL
VASCEPA** omega-3 ethyl esters	icosapent ethyl**	None
REPATHA	PRALUENT	PA
AJOVY	AIMOVIG	PA, QL
	EMGALITY 120mg/ml	PA, QL
QULIPTA UBRELVY ZAVZPRET	NURTEC	PA, QL
GEMTESA	mirabegron tab	QL
PROLIA (denosumab)**	CONEXXENCE (denosumab-bnht)**	QL
	STOBOCLO (denosumab-bmwo)**	QL
FORTEO	teriparatide (NDC 47781-0652-89)	PA, QL
	BONSITY	PA, QL
JASCAYD	pirfenidone 267 mg and 801 mg tab	PA, QL
	nintedanib	PA, QL
ACTEMRA (tocilizumab)**	AVTOZMA SC (tocilizumab-anoh)**	PA, QL
	TYENNE SC (tocilizumab-aazg)**	PA, QL
	ADALIMUMAB-adbm (NDC 82009-)	PA, QL
	ADALIMUMAB-aaty	PA, QL
	USTEKINUMAB-ttwe SC	PA, QL
	STEQEYMA SC	PA, QL
	tofacitinib	PA, QL
	COSENTYX SC	PA, QL
	SKYRIZI	PA, QL
	RINVOQ	PA, QL
	TREMFYA SC	PA, QL
	ZYMFENTRA	PA, QL
	ENTYVIO SC	PA, QL
	VELSIPITY	PA, QL

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DRUG(S) NOT COVERED ON THE FORMULARY	DRUG(S) COVERED ON THE FORMULARY	FORMULARY RESTRICTIONS
CYLTEZO (adalimumab-adbm)** YUFLYMA (adalimumab-aaty)** HUMIRA (adalimumab)**	ADALIMUMAB-adbm (NDC 82009-)**	PA, QL
	ADALIMUMAB-aaty**	PA, QL
	AVTOZMA SC (tocilizumab-anoh)	PA, QL
	TYENNE SC (tocilizumab-aazg)	PA, QL
	USTEKINUMAB-ttwe SC	PA, QL
	STEQEYMA SC	PA, QL
	tofacitinib	PA, QL
	COSENTYX SC	PA, QL
	SKYRIZI	PA, QL
	RINVOQ	PA, QL
	TREMFYA SC	PA, QL
	ZYMFENTRA	PA, QL
	ENTYVIO SC	PA, QL
	VELSIPITY	PA, QL
STELARA (ustekinumab)** USTEKINUMAB**	USTEKINUMAB-ttwe SC**	PA, QL
	STEQEYMA SC**	PA, QL
	ADALIMUMAB-adbm (NDC 82009-)	PA, QL
	ADALIMUMAB-aaty	PA, QL
	AVTOZMA SC (tocilizumab-anoh)	PA, QL
	TYENNE SC (tocilizumab-aazg)	PA, QL
	tofacitinib	PA, QL
	COSENTYX SC	PA, QL
	SKYRIZI	PA, QL
	RINVOQ	PA, QL
	TREMFYA SC	PA, QL
	ZYMFENTRA	PA, QL
	ENTYVIO SC	PA, QL
	VELSIPITY	PA, QL

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Note: Alternative drugs are suggestions and may not be right for every illness. This information is correct as of October 1, 2026, but it can change. Please check the drug list for details on which drugs are covered. The drug list can change from time to time during the year.