



January 1, 2020

Changes to your prescription drug coverage

There will be changes to the **Aetna Premier Plan** drug list that start on **January 1, 2020**. 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?

You or your prescriber can request a medical exception to the changes in this letter. If you would like to ask for a medical exception, speak directly with your prescriber or you can call us at the toll-free number on your Member ID card.

We'll contact you and your prescriber with our decision. If your exception is approved, you only need to pay your plan copay or cost-share. 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 information we have at the time this letter was sent.

UPPER CASE = brand-name medication

lower case = generic medication

* Changes apply if your plan includes this feature.

Prescription Drug	Change(s)
ABILIFY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization required*; You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*

Prescription Drug	Change(s)
ABSORICA	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
ACCU-CHEK AVIVA PLUS	Preferred brand drug; Step therapy has been removed
ACCU-CHEK COMPACT PLUS	Preferred brand drug; Step therapy has been removed
ACCU-CHEK GUIDE	Preferred brand drug; Step therapy has been removed
ACCU-CHEK SMARTVIEW STRIPS	Preferred brand drug; Step therapy has been removed
ACTEMRA IV	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
ACTEMRA SQ	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You can fill up to 4 syringes/ 28 days*
ACTEMRA SQ PEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
acyclovir	Preferred generic drug
ADDERALL	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
ADDERALL XR	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
ADLYXIN	You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*
ADVAIR DISKUS	Preferred brand drug; Step therapy has been removed

Prescription Drug	Change(s)
ADZENYS ER	Preauthorization has been removed; You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
ADZENYS XR-ODT	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
AFREZZA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN, NOVOLOG*
alendronate sodium	Preferred generic drug
allopurinol	Preferred generic drug
ALVESCO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try QVAR, FLOVENT, ARNUITY, PULMICORT FLEXHALER*
AMITIZA	Preferred brand drug; Step therapy has been removed
amitriptyline	Preferred generic drug
amlodipine besylate/benazepril	If your plan has the Value Drug Program, you will now pay the lowest generic copay
amlodipine besylate/valsartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
amlodipine/atorvastatin	If your plan has the Value Drug Program, you will now pay the lowest generic copay
amlodipine/olmesartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
amlodipine/valsartan/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
amoxicillin	Preferred generic drug
APTIVUS	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered

Prescription Drug	Change(s)
ARNUITY ELLIPTA	Preferred brand drug
ASMANEX HFA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try QVAR, FLOVENT, ARNUITY, PULMICORT FLEXHALER*
ASMANEX TWISTHALER	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try QVAR, FLOVENT, ARNUITY, PULMICORT FLEXHALER*
ASPIRIN LOW DOSE	If drug is covered by your plan, you will now pay a copay for this drug
atorvastatin	If your plan has the Value Drug Program, you will now pay the lowest generic copay
ATRIPLA	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
AVONEX	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BETASERON, COPAXONE, MAYZENT*
AVONEX PEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BETASERON, COPAXONE, MAYZENT*
baclofen	Preferred generic drug
BALCOLTRA	No copay required
BASAGLAR KWIKPEN	Preferred brand drug
benazepril/ hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
BENLYSTA	Step therapy has been removed
benztropine	Preferred generic drug

Prescription Drug	Change(s)
BEVESPI AEROSPHERE	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
BIDIL	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
BINOSTO	You must first try alendronate, ibandronate*
BISACODYL brand and generic	If drug is covered by your plan, you will now pay a copay for this drug
BIVIGAM	Step therapy has been removed
BLOOD GLUCOSE TEST STRIPS brand and generic (except ACCU-CHEK)	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try ACCU-CHEK*
BOSULIF	Preferred specialty drug; Step therapy has been removed
BRAVELLE	Non-preferred specialty drug; You must first try GONAL-F*
BUFFERIN LOW DOSE	If drug is covered by your plan, you will now pay a copay for this drug
buspirone	Preferred generic drug
BYDUREON BCISE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*
BYDUREON PEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*
BYETTA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*

Prescription Drug	Change(s)
candesartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
candesartan/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
captopril	If your plan has the Value Drug Program, you will now pay the lowest generic copay
CARIMUNE NANOFILTERED	Step therapy has been removed
cephalexin	Preferred generic drug
CHANTIX	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
CHANTIX CONTINUING MONTH PAK	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
CIMZIA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
CIPRODEX	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
ciprofloxacin	Preferred generic drug
COLYTE-FLAVOR PACKS	If drug is covered by your plan, you will now pay a copay for this drug
COSENTYX	Preferred specialty drug; Step therapy has been removed; You can fill up to 2 syringes/ 28 days*
COTEMPLA XR-ODT	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
cyclobenzaprine	Preferred generic drug
CYSTARAN	When a generic drug is available, the brand-name drug may be covered at a higher copay, require drug coverage reviews, or not be covered

Prescription Drug	Change(s)
DALIRESP	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
DAYTRANA	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
DELZICOL	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
DENA VIR	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
DEPO-SUBQ PROVERA 104	No copay required
DESONATE	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
DESVENLAFAXINE ER	You must first try fluoxetine, citalopram, duloxetine, venlafaxine, mirtazapine, bupropion*
DEXEDRINE	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
DEXILANT	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
diclofenac sodium dr	Preferred generic drug
dicyclomine	Preferred generic drug
DILANTIN 100MG	Non-preferred brand drug; You must first try phenytoin*; You can fill up to 6/ day*
DILANTIN 30MG	Non-preferred brand drug; You must first try phenytoin*; You can fill up to 20/ day*
DILANTIN INFATABS	Non-preferred brand drug; You must first try phenytoin*; You can fill up to 12/ day*

Prescription Drug	Change(s)
DILANTIN SUSP	Non-preferred brand drug; You must first try phenytoin*; You can fill up to 3 bottles/ month*
DISALCID	Not covered under pharmacy benefit
DITROPAN XL	You must first try trospium/ er, tolterodine/ er, oxybutynin/ xl, solifenacin, MYRBETRIQ, TOVIAZ*
DUEXIS	Step therapy has been removed
DULERA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try ADVAIR, BREO ELLIPTA, SYMBICORT*; 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
DUREZOL	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
DYANAVAL XR	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
DYRENIUM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
EMEND	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
EMGALITY 100 MG	You must first try sumatriptan, zolmitriptan*
ENBREL	Step therapy has been removed
ENBREL MINI	Step therapy has been removed
ENTYVIO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
estradiol	Preferred generic drug

Prescription Drug	Change(s)
EVEKEO	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
EVEKEO ODT	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
EXELDERM	You must first try ketoconazole, econazole*
EXTAVIA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BETASERON, COPAXONE, MAYZENT*
famotidine	Preferred generic drug
FANAPT	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization required*; You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*
FANAPT TITRATION PACK	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization required*; You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*
FAZACLO	You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*
FERRIPROX	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
FIASP	Preferred brand drug; Step therapy has been removed
FIASP FLEXTOUCH	Preferred brand drug; Step therapy has been removed
FIRAZYR	Preferred specialty drug
FLUORIDE brand and generic	If drug is covered by your plan, you will now pay a copay for this drug

Prescription Drug	Change(s)
fluticasone propionate/salmeterol diskus	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try ADVAIR, ANORO ELLIPTA, BREO ELLIPTA, BEVESPI, SYMBICORT*
FOCALIN XR	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
folic acid	If drug is covered by your plan, you will now pay a copay for this drug
FOLLISTIM AQ	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try GONAL-F*
FORTEO	Preferred specialty drug; Step therapy has been removed; You can fill up to 1 pen/ month*
fosinopril sodium	If your plan has the Value Drug Program, you will now pay the lowest generic copay
fosinopril/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
FYCOMPA	Preferred brand drug
GAMMAGARD	Step therapy has been removed
GAMMAKED	Step therapy has been removed
gavilyte-c	If drug is covered by your plan, you will now pay a copay for this drug
gavilyte-g	If drug is covered by your plan, you will now pay a copay for this drug
gavilyte-n/ flavor pack	If drug is covered by your plan, you will now pay a copay for this drug
GELNIQUE	You must first try trospium/ er, tolterodine/ er, oxybutynin/ xl, solifenacin, MYRBETRIQ, TOVIAZ*
GENOTROPIN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HUMATROPE*

Prescription Drug	Change(s)
GEODON	You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*
GLEEVEC	You must first try imatinib, BOSULIF, SPRYCEL*
glipizide er	If your plan has the Value Drug Program, you will now pay the lowest generic copay
glipizide xl	If your plan has the Value Drug Program, you will now pay the lowest generic copay
glipizide/metformin	If your plan has the Value Drug Program, you will now pay the lowest generic copay
glyburide	If your plan has the Value Drug Program, you will now pay the lowest generic copay
gnp clearlax	If drug is covered by your plan, you will now pay a copay for this drug
GOLYTELY	If drug is covered by your plan, you will now pay a copay for this drug
HALOG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
healthylax	If drug is covered by your plan, you will now pay a copay for this drug
HUMALOG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*
HUMALOG JUNIOR KWIKPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*
HUMALOG KWIKPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*

Prescription Drug	Change(s)
HUMALOG MIX 50/50	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*
HUMALOG MIX 50/50 KWIKPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*
HUMALOG MIX 75/25	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*
HUMALOG MIX 75/25 KWIKPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLOG*
HUMATROPE	Preferred specialty drug; Step therapy has been removed
HUMIRA	Preferred specialty drug; Step therapy has been removed; You can fill up to 2 syringes/ 28 days*
HUMIRA PEDIATRIC CROHNS DISEASE	Preferred specialty drug; Step therapy has been removed; You can fill up to 6 syringes/ 28 days*
HUMIRA PEN INJ	Preferred specialty drug; Step therapy has been removed; You can fill up to 6 pens/ 28 days*
HUMIRA PEN KIT	Preferred specialty drug; Step therapy has been removed
HUMULIN 70/30	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
HUMULIN 70/30 KWIKPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
HUMULIN N	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*

Prescription Drug	Change(s)
HUMULIN N KWIKPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
HUMULIN R	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
ibuprofen	Preferred generic drug
ILUMYA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
IMVEXXY	Step therapy has been removed
INFLECTRA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
insulin lispro	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
insulin lispro kwikpen	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
INTUNIV	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
INVOKAMET	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, XIGDUO XR, SYNJARDY/ XR*
INVOKAMET XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, XIGDUO XR, SYNJARDY/ XR*

Prescription Drug	Change(s)
INVOKANA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JARDIANCE, FARXIGA*
irbesartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
irbesartan/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
JADENU	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
JENTADUETO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JANUMET/ XR*
JENTADUETO XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JANUMET/ XR*
JUBLIA	Preferred brand drug
JUXTAPID	You must first try atorvastatin, simvastatin, rosuvastatin AND ezetimibe AND REPATHA*; 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
KALETRA	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
KAPVAY	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
KARBINAL ER	You must first try carbinoxamine*
KAZANO	You must first try metformin/ xr, JANUMET/ XR*

Prescription Drug	Change(s)
KEPPRA 1000MG	You can fill up to 3/ day*
KEPPRA 250MG	You can fill up to 12/ day*
KEPPRA 500MG	You can fill up to 6/ day*
KEPPRA 750MG	You can fill up to 4/ day*
KEPPRA SOL	You can fill up to 2 bottles/ month*
KEVZARA	Preferred specialty drug
KHEDEZLA	You must first try fluoxetine, citalopram, duloxetine, venlafaxine, mirtazapine, bupropion*
KINERET	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 syringe/ day*
KOMBIGLYZE XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JANUMET/ XR*
KRYSTEXXA	You must first try allopurinol, febuxostat, probenecid*
KYNAMRO	You must first try atorvastatin, simvastatin, rosuvastatin AND ezetimibe AND REPATHA*
lactulose	Preferred generic drug
LAMICTAL	You must first try lamotrigine*
LAMICTAL CHEWABLE DISPERSIBLE	You must first try lamotrigine*
LAMICTAL ODT	You must first try lamotrigine*
LAMICTAL STARTER	You must first try lamotrigine*
LAMICTAL XR	You must first try lamotrigine*
LANTUS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BASAGLAR, LEVEMIR, TRESIBA*

Prescription Drug	Change(s)
LANTUS SOLOSTAR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BASAGLAR, LEVEMIR, TRESIBA*
LATUDA	Step therapy has been removed
levothyroxine	Preferred generic drug
LO LOESTRIN FE	No copay required
loratadine	Preferred generic drug
LUZU	You must first try ketoconazole, econazole*
MAGNESIUM CITRATE brand and generic	If drug is covered by your plan, you will now pay a copay for this drug
MAKENA	Preferred specialty drug
MAKENA SQ	Preferred specialty drug; Step therapy has been removed
MAVENCLAD	Non-preferred specialty drug; Step therapy has been removed
MAVYRET	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HARVONI, EPCLUSA, VOSEVI*
MAYZENT	Preferred specialty drug; Step therapy has been removed
medroxyprogesterone acetate	Preferred generic drug
meloxicam	Preferred generic drug
MENOPUR	You must first try GONAL-F*
metoclopramide	Preferred generic drug
MOTEGRITY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try LINZESS, AMITIZA*

Prescription Drug	Change(s)
MYDAYIS	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
naproxen	Preferred generic drug
naproxen dr	Preferred generic drug
NATAZIA	No copay required
nateglinide	If your plan has the Value Drug Program, you will now pay the lowest generic copay
NESINA	You must first try metformin/ xr, JANUVIA*
NEXIUM	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
NORDITROPIN FLEXPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HUMATROPE*
nortriptyline	Preferred generic drug
NOVOLIN 70/30	Preferred brand drug; Step therapy has been removed
NOVOLIN 70/30 FLEXPEN	Preferred brand drug; Step therapy has been removed
NOVOLIN N	Preferred brand drug; Step therapy has been removed
NOVOLIN R	Preferred brand drug; Step therapy has been removed
NOVOLOG	Preferred brand drug; Step therapy has been removed
NOVOLOG FLEXPEN	Preferred brand drug; Step therapy has been removed
NOVOLOG MIX 70/30	Preferred brand drug; Step therapy has been removed

Prescription Drug	Change(s)
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	Preferred brand drug; Step therapy has been removed
NOVOLOG PENFILL	Preferred brand drug; Step therapy has been removed
NULYTELY/FLAVOR PACKS	If drug is covered by your plan, you will now pay a copay for this drug
NUTROPIN AQ	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HUMATROPE*
NUVARING	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
NYMALIZE	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
olmesartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
olmesartan/amlodipine/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
olmesartan/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
OLUMIANT	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
OMNITROPE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HUMATROPE*
ONFI	You must first try clobazam*
ONGLYZA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JANUVIA*

Prescription Drug	Change(s)
pioglitazone	If your plan has the Value Drug Program, you will now pay the lowest generic copay
pioglitazone/metformin	If your plan has the Value Drug Program, you will now pay the lowest generic copay
PLEGRIDY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BETASERON, COPAXONE, MAYZENT*
POLY-PREP	If drug is covered by your plan, you will now pay a copay for this drug
POLYETHYLENE GLYCOL brand and generic	If drug is covered by your plan, you will now pay a copay for this drug
POMALYST	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
potassium chloride er	Preferred generic drug
PRADAXA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try warfarin, XARELTO, ELIQUIS*
PRALUENT	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try REPATHA*
pravastatin	If your plan has the Value Drug Program, you will now pay the lowest generic copay
prednisone	Preferred generic drug
PRIVIGEN	Step therapy has been removed
PROAIR HFA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try albuterol*

Prescription Drug	Change(s)
PROAIR RESPICLICK	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try albuterol*
PROCENTRA	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
PULMICORT FLEXHALER	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
qc natura-lax	If drug is covered by your plan, you will now pay a copay for this drug
QUILLICHEW ER	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
QUILLIVANT XR	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
quinapril	If your plan has the Value Drug Program, you will now pay the lowest generic copay
quinapril/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
ramipril	If your plan has the Value Drug Program, you will now pay the lowest generic copay
ranitidine	Preferred generic drug
RELION 70/30	You must first try NOVOLIN*
RELION 70/30 FLEXPEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NOVOLIN*
RELION N	You must first try NOVOLIN*
RELION R	You must first try NOVOLIN*
REMICADE	Step therapy has been removed
RENFLEXIS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay

Prescription Drug	Change(s)
repaglinide	If your plan has the Value Drug Program, you will now pay the lowest generic copay
REPATHA	Step therapy has been removed
RINVOQ	Preferred specialty drug; You can fill up to 1/ day*
ROCKLATAN	Step therapy has been removed
rosuvastatin	If your plan has the Value Drug Program, you will now pay the lowest generic copay
SABRIL	You must first try vigabatrin*
SAIZEN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HUMATROPE*
salsalate	Not covered under pharmacy benefit
SAPHRIS	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
SAVAYSA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try warfarin, XARELTO, ELIQUIS*
SAXENDA	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed; Quantity limits have been removed
SEEBRI NEOHALER	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try SPIRIVA, INCRUSE ELLIPTA*
SEGLUROMET	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, XIGDUO XR, SYNJARDY/ XR*

Prescription Drug	Change(s)
SEROQUEL XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; Preauthorization required*; You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*
SILIQ	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
SIMBRINZA	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
SIMPONI	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
SIMPONI ARIA	Step therapy has been removed
SKYRIZI	Preferred specialty drug; Step therapy has been removed
sm clearlax	If drug is covered by your plan, you will now pay a copay for this drug
SODIUM PHOSPHATES - ENEMA brand and generic	If drug is covered by your plan, you will now pay a copay for this drug
SOLIQUA 100/33	You must first try metformin/ xr, BASAGLAR, LEVEMIR, TRESIBA, VICTOZA, OZEMPIC, TRULICITY*
SOVALDI	Non-preferred specialty drug; You must first try HARVONI, EPCLUSA, VOSEVI*
SPRYCEL	Preferred specialty drug; Step therapy has been removed
STEGLATRO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JARDIANCE, FARXIGA*

Prescription Drug	Change(s)
STEGLUJAN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
STELARA	Step therapy has been removed
STELARA IV	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
SUBOXONE	You must first try buprenorphine/naloxone*
sulfamethoxazole/trimethoprim	Preferred generic drug
SUNOSI	Non-preferred brand drug
sw clearlax	If drug is covered by your plan, you will now pay a copay for this drug
SYNDROS	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
SYNRIBO	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
TACLONEX	You must first try triamcinolone acetonide, hydrocortisone valerate, betamethasone dipropionate*
TALTZ	Preferred specialty drug; Step therapy has been removed
tamsulosin	Preferred generic drug
TASIGNA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try imatinib, BOSULIF, SPRYCEL*
TAYTULLA	No copay required
TAZORAC	Preferred brand drug

Prescription Drug	Change(s)
telmisartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
telmisartan/amlodipine	If your plan has the Value Drug Program, you will now pay the lowest generic copay
telmisartan/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
THALOMID	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
TOUJEO MAX SOLOSTAR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BASAGLAR, LEVEMIR, TRESIBA*
TOUJEO SOLOSTAR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BASAGLAR, LEVEMIR, TRESIBA*
TOVIAZ	Preferred brand drug; Step therapy has been removed
TRADJENTA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metformin/ xr, JANUVIA*
trandolapril	If your plan has the Value Drug Program, you will now pay the lowest generic copay
TRAVATAN Z	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
trazodone	Preferred generic drug
TREMFYA	Step therapy has been removed
triamcinolone topical	Preferred generic drug

Prescription Drug	Change(s)
trihexyphenidyl	Preferred generic drug
trilyte	If drug is covered by your plan, you will now pay a copay for this drug
TRINTELLIX	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
TROKENDI XR	Preferred brand drug
TRULANCE	Non-preferred brand drug
TRUVADA	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
TUDORZA PRESSAIR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try SPIRIVA, INCRUSE ELLIPTA*
TYMLOS	Step therapy has been removed
ULESFIA	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
UTIBRON NEOHALER	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try ADVAIR, ANORO ELLIPTA, BREO ELLIPTA, BEVESPI, SYMBICORT*
valsartan	If your plan has the Value Drug Program, you will now pay the lowest generic copay
valsartan/hctz	If your plan has the Value Drug Program, you will now pay the lowest generic copay
VASCEPA	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
VESICARE	Preferred brand drug; Step therapy has been removed

Prescription Drug	Change(s)
VIEKIRA PAK	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HARVONI, EPCLUSA, VOSEVI*
VIIBRYD	Preferred brand drug; Step therapy has been removed
VIMOVO	Step therapy has been removed
VIMPAT	Preferred brand drug
VIOKACE	Preferred brand drug; Step therapy has been removed
VRAYLAR	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed; Quantity limits have been removed
VRAYLAR CAP 1.5-3MG	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
VYTORIN	You must first try ezetimibe/simvastatin 10/ 80mg, simvastatin 80mg*
VYZULTA	You must first try latanoprost, TRAVATAN Z*
wixela inhub	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try ADVAIR, ANORO ELLIPTA, BREO ELLIPTA, BEVESPI, SYMBICORT*
XELJANZ	Step therapy has been removed
XELJANZ XR	Step therapy has been removed
XELPROS	You must first try latanoprost, TRAVATAN Z*
XULTOPHY 100/3.6	You must first try metformin/ xr, BASAGLAR, LEVEMIR, TRESIBA, VICTOZA, OZEMPIC, TRULICITY*
YONSA	Step therapy has been removed
ZEMBRACE SYMTOUCH	You must first try naratriptan, rizatriptan, sumatriptan, zolmitriptan*

Prescription Drug	Change(s)
ZEPATIER	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HARVONI, EPCLUSA, VOSEVI*
ZOMACTON	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try HUMATROPE*
ZONEGRAN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try zonisamide*
ZORTRESS	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
ZUBSOLV	Preferred brand drug; Step therapy has been removed

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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 or its affiliate(s) may receive rebates from drug manufacturers. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. Information is subject to change. The drugs on the Pharmacy Drug Guide (formulary), Formulary Exclusions, Precertification, Quantity Limit and Step Therapy Lists are subject to change. In certain states, including Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Minnesota, North Dakota and Texas, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of stage-four advanced, metastatic cancer.

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 removed from the Pharmacy Drug Guide (formulary) or added to the Precertification, Quantity Limits or Step-Therapy Lists during the plan year will continue to have those medications covered at the same benefit level until their plan's renewal date. Due to system constraints, drugs that are added to the Pharmacy Drug Guide (formulary) or moved to a lower tier during the plan year will also continue to be covered at the same benefit level until the 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 members (except Federal Employee Health Benefit Plan members) who obtained approval from an Aetna plan for coverage of medications that are later added to the Precertification or Step Therapy Lists or removed from the Pharmacy Drug Guide will continue to have those medications covered, for as long as the plan's prescriber 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 preferred provider organization (PPO) members (except Federal Employee Health Benefit Plan members) who are receiving coverage under the current policy for medications that are later added to the Precertification or Step Therapy Lists will continue to have those medications covered for as long as the plan's prescriber continues prescribing them, provided the prescriber states in writing that 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.

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. Aetna is part of the CVS Health family of companies.

Policy forms issued in Oklahoma include: AL COC00010, HC COC00010.

Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 05, HO HGrpPol 04, AL SG GrpPOLAmend 2019 01, HI SG GrpAgAmend 2019 01.