



January 1, 2020

## Changes to your prescription drug coverage

There will be changes to the **Aetna Value Plus 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*

<b>Prescription Drug</b>	<b>Change(s)</b>
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
acyclovir	Preferred generic drug
ACZONE	You must first try adapalene/ benzoyl peroxide gel, erythromycin gel, dapsone gel*
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
ADVAIR HFA	Preferred brand drug
ADZENYS ER	Preauthorization has been removed; You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*

Prescription Drug	Change(s)
ADZENYS XR-ODT	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*
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*
AIMOVIG	Preferred brand drug
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

Prescription Drug	Change(s)
APTIOM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try carbamazepine*
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
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

<b>Prescription Drug</b>	<b>Change(s)</b>
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
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	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*
BUFFERIN LOW DOSE	If drug is covered by your plan, you will now pay a copay for this drug
bupirone	Preferred generic drug
BYDUREON BCISE	You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*
BYDUREON PEN	You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*
BYETTA	You must first try metformin/ xr, TRULICITY, VICTOZA, OZEMPIC*

Prescription Drug	Change(s)
BYSTOLIC	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try metoprolol, atenolol, nadolol*
calcipotriene/betamethasone dipropionate	You must first try triamcinolone acetonide, hydrocortisone valerate, betamethasone dipropionate*
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
CLEOCIN-T	You must first try adapalene/ benzoyl peroxide gel, erythromycin gel, dapsons gel*

<b>Prescription Drug</b>	<b>Change(s)</b>
CLINDAGEL	You must first try adapalene/ benzoyl peroxide gel, erythromycin gel, dapson gel*
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	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*
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
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
DENAVIR	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*

Prescription Drug	Change(s)
DEXEDRINE	You must first try 3 of generic stimulants, VYVANSE, MYDAYIS*
DEXILANT	Preferred brand drug; Step therapy has been removed; 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	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try phenytoin*; You can fill up to 6/ day*
DILANTIN 30MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try phenytoin*; You can fill up to 20/ day*
DILANTIN INFATABS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try phenytoin*; You can fill up to 12/ day*
DILANTIN SUSP	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; 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*
DOVONEX	You must first try triamcinolone acetonide, hydrocortisone valerate, betamethasone dipropionate*
DUAC	You must first try adapalene/ benzoyl peroxide gel, erythromycin gel, dapsone gel*



Prescription Drug	Change(s)
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
DYANAVEL 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
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*

Prescription Drug	Change(s)
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*; You can fill up to 8 tabs/ month*
FAZACLO	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; 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	Non-preferred specialty drug
FLOVENT DISKUS	Preferred brand drug
FLOVENT HFA	Preferred brand 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	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try trospium/ er, tolterodine/ er, oxybutynin/ xl, solifenacin, MYRBETRIQ, TOVIAZ*

Prescription Drug	Change(s)
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*
GEODON	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; 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*

Prescription Drug	Change(s)
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*
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
HUMIRA PEN	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*
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*

Prescription Drug	Change(s)
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*
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*

Prescription Drug	Change(s)
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	You must first try metformin/ xr, JANUMET/ XR*
JENTADUETO XR	You must first try metformin/ xr, JANUMET/ XR*
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	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*
KARBINAL ER	You must first try carbinoxamine*
KAZANO	You must first try metformin/ xr, JANUMET/ XR*
KEPPRA 1000MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try levetiracetam*; You can fill up to 3/ day*
KEPPRA 250MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try levetiracetam*; You can fill up to 12/ day*

<b>Prescription Drug</b>	<b>Change(s)</b>
KEPPRA 500MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try levetiracetam*; You can fill up to 6/ day*
KEPPRA 750MG	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try levetiracetam*; You can fill up to 4/ day*
KEPPRA SOL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try levetiracetam*; You can fill up to 2 bottles/ month*
KEPPRA XR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try levetiracetam xr*
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
KOMBIGLYZE XR	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*



<b>Prescription Drug</b>	<b>Change(s)</b>
LAMICTAL XR	You must first try lamotrigine*
LANTUS	You must first try BASAGLAR, LEVEMIR, TRESIBA*
LANTUS SOLOSTAR	You must first try BASAGLAR, LEVEMIR, TRESIBA*
LATUDA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try aripirazole, olanzapine, risperidone, quetiapine, ziprasidone, VRAYLAR*
levothyroxine	Preferred generic drug
LO LOESTRIN FE	No copay required
loratadine	Preferred generic drug
LUMIGAN	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try latanoprost, TRAVATAN Z*
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

<b>Prescription Drug</b>	<b>Change(s)</b>
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*
MYDAYIS	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
MYRBETRIQ	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

<b>Prescription Drug</b>	<b>Change(s)</b>
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
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	Preferred brand drug; Step therapy has been removed
NOVOLOG PENFILL	Preferred brand drug; Step therapy has been removed
NUCYNTA ER	You must first try For chronic pain: HYSINGLA, OXYCONTIN, EMBEDA; For Diabetic Peripheral Neuropathy: duloxetine, pregabalin*
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



<b>Prescription Drug</b>	<b>Change(s)</b>
peg-3350/electrolytes	If drug is covered by your plan, you will now pay a copay for this drug
peg-3350/nacl/na bicarbonate/kcl	If drug is covered by your plan, you will now pay a copay for this drug
penicillin	Preferred generic drug
perindopril	If your plan has the Value Drug Program, you will now pay the lowest generic copay
PICATO	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
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*

<b>Prescription Drug</b>	<b>Change(s)</b>
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*
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

<b>Prescription Drug</b>	<b>Change(s)</b>
RELEXXII	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*
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
repaglinide	If your plan has the Value Drug Program, you will now pay the lowest generic copay
REPATHA	Step therapy has been removed
RESTASIS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try XIIDRA*
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

Prescription Drug	Change(s)
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*
SAVELLA	You must first try duloxetine, pregabalin*
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	You must first try metformin/ xr, XIGDUO XR, SYNJARDY/ XR*
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



<b>Prescription Drug</b>	<b>Change(s)</b>
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	You must first try metformin/ xr, JARDIANCE, FARXIGA*
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
STIOLTO RESPIMAT	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*
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

<b>Prescription Drug</b>	<b>Change(s)</b>
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; Step therapy has been removed
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	You must first try BASAGLAR, LEVEMIR, TRESIBA*
TOUJEO SOLOSTAR	You must first try BASAGLAR, LEVEMIR, TRESIBA*
TOVIAZ	Preferred brand drug; Step therapy has been removed
trandolapril	If your plan has the Value Drug Program, you will now pay the lowest generic copay

<b>Prescription Drug</b>	<b>Change(s)</b>
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
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; Step therapy has been removed
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

Prescription Drug	Change(s)
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	You must first try trospium/ er, tolterodine/ er, oxybutynin/ xl, solifenacin, MYRBETRIQ, TOVIAZ*
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
VIIBRYD STARTER PACK	Preferred brand drug
VIMPAT	Preferred brand drug
VIOKACE	Preferred brand drug; Step therapy has been removed
VRAYLAR	Preferred brand drug; Step therapy has been removed
VRAYLAR CAP 1.5-3MG	Preferred brand drug; Step therapy has been removed; You can fill up to 2/ day*
VYTORIN	You must first try ezetimibe/simvastatin 10/ 80mg, simvastatin 80mg*
VYZULTA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; 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*

<b>Prescription Drug</b>	<b>Change(s)</b>
XELJANZ	Step therapy has been removed
XELJANZ XR	Step therapy has been removed
XELPROS	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; 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*
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*
ZIOPTAN	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed
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

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

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

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

Aetna 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.