Updates to your prescription benefits

Effective January 1, 2025

Traditional 3-Tier PDL update summary

Within the Prescription Drug List (PDL), prescription drugs are grouped by tier. The tier indicates the amount you pay when you fill a prescription. Please reference the chart below as you review the following updates to the PDL.

$	$$	$$$
Tier 1	**Tier 2**	**Tier 3**
Lowest-cost medications	Mid-range cost	Highest-cost

Prescription drugs with new benefit coverage

The following drugs were previously not covered under most benefit plans and are now eligible for coverage.

Therapeutic use	Medication name	Tier placement
Inflammatory conditions	Amjevita for Nuvaila[1]	**Tier 2**
Inflammatory conditions	Taltz[1]	**Tier 2**

Prescription drugs moving to a lower tier

The following drugs are moving to a lower tier, making them a lower cost.

Therapeutic use	Medication name	Tier placement
Inflammatory conditions	Entyvio[1]	**Tier 3 to Tier 2**
Inflammatory conditions	Omvoh[1]	**Tier 3 to Tier 2**
Inflammatory conditions	Sotyktu[1]	**Tier 3 to Tier 2**

continued

Prescription drugs moving to a higher tier

The following medications are moving to a higher tier. Medications may move from a lower tier to a higher tier when they are more costly and have available lower-cost options.

Therapeutic use	Medication name	Tier placement	Alternative treatment option(s)
Anemia	Epogen[2]	**Tier 2 to Tier 3**	Procrit
Anemia	Procrit[2]	**Tier 2 to Tier 3**	Procrit
Blood disorders	Mulpleta[1]	**Tier 2 to Tier 3**	Discuss alternative treatment options with your provider
Elevated phosphate levels	Velphoro[1]	**Tier 2 to Tier 3**	calcium acetate (generic PhosLo), sevelamer carbonate tablet (generic Renvela)

Prescription drugs excluded from benefit coverage[3,4]

We evaluate prescription drugs based on their total value, including how a drug works and how much it costs. When several drugs work in the same way, we may choose to exclude the higher-cost option. Effective January 1, 2025, the drugs listed below may be excluded from coverage or you may need to get a prior authorization. Sign into your online account to check which drugs your plan covers and if there are any actions you need to take.

Therapeutic use	Medication name	Alternative treatment option(s)
Acne	Cabtreo[5]	OTC Differin gel plus clindamycin 1.2%/benzoyl peroxide 5% (generic Duac) or adapalene 0.1%/ benzoyl peroxide 2.5% (generic Epiduo) plus clindamycin 1% gel (generic Clindagel)
Blood disorders	Promacta tablet[1]	Alvaiz[1]
Cushing's disease	Korlym (brand only)[1]	mifepristone (generic Korlym)
Diabetes	Sitagliptin (Zituvio authorized generic)[1,5]	saxagliptin (generic Onglyza), Alogliptin (Nesina authorized generic), Tradjenta
Diabetes	Zituvio[1,5]	saxagliptin (generic Onglyza), Alogliptin (Nesina authorized generic), Tradjenta
Dry eye disease	Vevye ophthalmic solution[1,5]	Restasis single dose vial[1], Xiidra[1]
Elevated phosphate levels	sevelamer hydrochloride tablet (generic Renagel)	sevelamer carbonate tablet (generic Renvela)
Growth hormone	Nutropin AQ NuSpin[1]	Norditropin Flexpro[1], Omnitrope[1]
Infections	Tetracycline tablet[5]	tetracycline capsule (generic Achromycin V)

Therapeutic use	Medication name	Alternative treatment option(s)
Inflammatory conditions	Adalimumab-adbm (unbranded Cyltezo)[1]	Adalimumab-adaz (unbranded Hyrimoz)[1], Amjevita for Nuvaila[1], Humira[1]
Inflammatory conditions	Amjevita 20 mg/0.2 mL, 40 mg/0.4 mL, 80 mg/0.8 mL (manufactured by Amgen)[1]	Adalimumab-adaz (unbranded Hyrimoz)[1], Amjevita for Nuvaila[1], Humira[1]
Inflammatory conditions	Cosentyx[1]	adalimumab [Adalimumab-adaz (unbranded Hyrimoz)[1], Amjevita for Nuvaila[1], Humira[1]], Cimzia[1], Enbrel[1], Rinvoq[1], Simponi[1], Skyrizi[1], Sotyktu[1], Stelara[1], Taltz[1] , Tremfya[1], Xeljanz[1]
Inflammatory conditions	Eohilia oral suspension[1,5]	budesonide nebulized solution (generic Pulmicort Respules)
Inflammatory conditions	Hadlima[1]	Adalimumab-adaz (unbranded Hyrimoz)[1], Amjevita for Nuvaila[1], Humira[1]
Inflammatory conditions	Zymfentra[1,5]	adalimumab [Adalimumab-adaz (unbranded Hyrimoz)[1], Amjevita for Nuvaila[1], Humira[1]], Cimzia[1], Entyvio[1], Infliximab IV (medical benefit)[1], Omvoh[1], Rinvoq[1], Simponi[1], Stelara[1], Skyrizi [1], Xeljanz[1]
Oral steroid	Agamree oral suspension[1,5]	prednisone
Pain	tramadol 25 mg tablet[5]	1/2 of tramadol (generic Ultram) 50 mg tablet
Pain and inflammation	Coxanto[5]	ibuprofen, naproxen, oxaprozin tablet, Over-the-counter NSAIDs
Pain and inflammation	Oxaprozin (Coxanto authorized generic)[5]	ibuprofen, naproxen, oxaprozin tablet, Over-the-counter NSAIDs
Vitamin	Davimet/Fluoride[5]	generic pediatric multivitamins with fluoride

[1] Step therapy or prior authorization may be required prior to coverage.

[2] Medication is typically excluded from coverage.

[3] Exclusion includes brand, generic and authorized generic products unless otherwise noted.

[4] For benefits that do not exclude, step therapy or prior authorization may be required.

[5] Newly released medication which was excluded from coverage at the time of launch and will continue to be excluded from our pharmacy benefit.

Traditional 3-Tier PDL clinical programs update summary

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective January 1, 2025.

QL Revised Quantity Limits

Quantity Limits establish the maximum quantity of a drug that is covered per copay or in a specified time frame. The drugs below will now be part of the Quantity Limits program.

Therapeutic use	Medication name	New quantity limit
Neuropathic pain	Gralise 450 mg[6]	62 Tablets per month
Neuropathic pain	Gralise 600 mg[6]	62 Tablets per month

MN New Medical Necessity

Medical Necessity is a type of Prior Authorization that evaluates the clinical appropriateness of a medication, such as condition being treated, type of medication, frequency of use, and duration of therapy. The following medications will now require Medical Necessity for coverage.

Therapeutic use	Medication name
Blood disorders	Mulpleta
Blood disorders	Promacta packet

PA New Prior Authorization

Prior Authorization – Notification requires additional clinical information to verify members benefit coverage.

Therapeutic use	Medication name
Cancer	Rozlytrek
Endocrine disorders	Demser

ST Revised Step Therapy

The following medications have revised Step Therapy requirements for coverage.

Therapeutic use	Medication name
Inflammatory conditions	Cosentyx

ST New Step Therapy

The below medications are part of the Step Therapy program and have revised requirements. You must try one or more other medications before the medication below may be covered.

Therapeutic use	Medication name	Step 1 medication
Allergies	Xhance[6]	Chronic Rhinosinusitis with Nasal Polyps requires both Prescription fluticasone nasal spray (generic Flonase) and Prescription mometasone nasal spray (generic Nasonex) OR Chronic Rhinosinusitis without Nasal Polyps requires three of the following: budesonide nasal spray (Rhinocort Allergy Spray), fluticasone nasal spray (generic Flonase, Flonase Allergy or Flonase Sensimist), flunisolide nasal spray (generic Nasalide), mometasone nasal spray (generic Nasonex or Nasonex 24H Allergy), triamcinolone nasal spray (Nasacort Allergy 24HR) or Zetonna
Elevated phosphate levels	Velphoro	One of the following: calcium acetate (eg. PhosLo) or sevelamer carbonate (generic Renvela)

ST Removed Step Therapy

The following medications no longer have Step Therapy requirements for coverage.

Therapeutic use	Medication name
Inflammatory conditions	Sotyktu
Inflammatory conditions	Taltz

[6] Medication is typically excluded from benefit coverage.

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P.O. Box 30608
Salt Lake City, UT 84130

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Phone: Toll free **1-800-368-1019, 1-800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

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알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

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