July 2023

There are upcoming changes to your plan's drug coverage — and we want to be sure you're ready

Starting **July 1, 2023** you'll see changes to the drugs your **Advanced Control Plan-Aetna** covers. It's important that you review the changes in the chart enclosed. Talk to your doctor about how these changes might impact you.

Find out how to keep your costs low

If the status of your current drug is changing, you may pay more for refilling them on or after **July 1, 2023**. So, we want to make sure you understand your options and what to do next.

What to do if your drugs are changing

Talk to your doctor to find out if changing to a preferred drug is right for you. If they agree, have them send a new prescription to your pharmacy so it's ready for you to fill **July 1, 2023**.

Your doctor may decide it's best for you to stay on your current drug. If so, they can ask for medical exception. Or you can call us at the number on your member ID card to request one. If approved, you'll still pay your plan copay or cost-share, after you meet your plan's deductible or out-of-pocket requirements.

Need more support? We're here to help.

- Visit the website listed on your member ID card to view your current plan details.
- Call us at the number on your member ID card.

{Enclosure}

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Changes beginning July 1, 2023

On or after this date, log in to your member website. Here, you can search for and estimate the cost of your drug(s). You can also find options that may cost you less. Keep in mind, these costs will depend on several things, like where you are with your deductible.

The changes listed in this chart are based on your plan information as of the date of this letter.

UPPER CASE = brand-name drug **lower case** = generic drug

Drug name	Change(s)
ANDRODERM	Moving to non-preferred brand tier
ARALAST NP	Drug list addition (preferred specialty); Preauthorization required
ARANESP ALBUMIN FREE	Drug list addition (preferred specialty); Preauthorization required
AUBAGIO	Non-formulary; not covered. Covered options include: dimethyl fumarate delayed-rel, fingolimod, glatiramer, teriflunomide, Avonex, Betaseron, Copaxone, Glatopa, Kesimpta, Mayzent, Rebif, Tysabri, Vumerity, Zeposia
BANZEL	Non-formulary; not covered. Covered options include: clobazam, felbamate, lamotrigine tabs and chew tabs, rufinamide, topiramate, topiramate ER (except sprinkles), Trokendi XR
BARACLUDE	Moving to non-preferred specialty tier
BETHKIS	Non-formulary; not covered. Covered options include: tobramycin inhalation solution
bimatoprost	Drug list addition (preferred)
BRAND MULTIVITAMINS	Non-formulary; not covered
DIACOMIT	Non-formulary; not covered
DILAUDID LIQ 1MG / ML	Quantity limits apply. Covered up to 480 mL every 25 days
DILAUDID TAB 4MG	Quantity limits apply. Covered up to 120 tabs every 25 days
doxepin hcl cre 5% (NDC* 00093960995 only)	Non-formulary drug (Other NDCs covered)
DYANAVEL XR	Non-formulary; not covered. Covered options include: amphetamine/dextroamphetamine mixed salts ext-rel, dexmethylphenidate ext-rel, dextroamphetamine ext-rel, methylphenidate ext-rel (except generic Relexxi and Concerta), Azstarys, Vyvanse
EPOGEN	Drug list addition (preferred specialty); Preauthorization required
FINTEPLA	Non-formulary; not covered. Covered options include: clobazam, felbamate, lamotrigine (tabs and chew tabs), rufinamide, topiramate, topiramate ER (except sprinkles), Trokendi XR
FIRMAGON	Non-formulary; not covered. Covered options include: leuprolide, Eligard
FLOVENT HFA	Non-formulary; not covered. Covered options include: Pulmicort Flexhaler (for all members), Qvar (for members 5 years of age and under only)

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Drug name	Change(s)
FLUTICASONE PROPIONATE HF	Non-formulary; not covered. Covered options include: Pulmicort Flexhaler (for all members), Qvar (for members 5 years of age and under only)
hydromorphon liq 1mg / ml	Quantity limits apply. Covered up to 480 mL every 25 days
hydromorphon tab 4mg	Quantity limits apply. Covered up to 120 tabs every 25 days
JORNAY PM	Non-formulary; not covered. Covered options include: amphetamine/dextroamphetamine mixed salts ext-rel, dexmethylphenidate ext-rel, dextroamphetamine ext-rel, methylphenidate ext-rel (except generic Relexxi and Concerta), Azstarys, Vyvanse
JYNARQUE	Non-formulary; not covered
KITABIS PAK	Non-formulary; not covered. Covered options include: tobramycin inhalation solution
LATUDA	Non-formulary; not covered. Covered options include: lurasidone, aripiprazole, asenapine, clozapine, olanzapine, quetiapine, quetiapine ext-rel, risperidone, ziprasidone, Vraylar
LOKELMA	Non-formulary; not covered. Covered options include: Veltassa
LOVAZA	Non-formulary; not covered. Covered options include: omega-3 acid ethyl esters, Vascepa
methadone con 10mg / ml (NDC* 00054355344 only)	Quantity limits apply. Covered up to 45 mL every 25 days
methadone sol 10mg / 5ml	Quantity limits apply. Covered up to 225 mL every 25 days
methadone tab 10mg	Quantity limits apply. Covered up to 30 tabs every 25 days
MYDAYIS	Non-formulary; not covered. Covered options include: amphetamine/dextroamphetamine mixed salts ext-rel, dexmethylphenidate ext-rel, dextroamphetamine ext-rel, methylphenidate ext-rel (except generic Relexxi and Concerta), Azstarys, Vyvanse
NP THYROID TAB 120MG (NDC* 42192032801 only)	Moving to non-preferred brand tier
NP THYROID TAB 15MG (NDC* 42192032701 only)	Moving to non-preferred brand tier
NP THYROID TAB 30MG (NDC*42192032901 only)	Moving to non-preferred brand tier
NP THYROID TAB 60MG (NDC* 42192033001 only)	Moving to non-preferred brand tier
NP THYROID TAB 90MG (NDC* 42192033101 only)	Moving to non-preferred brand tier
OPZELURA	Preauthorization required
PHOSLYRA	Moving to non-preferred brand tier
PRALUENT	Non-formulary; not covered. Covered options include: Repatha
PROCRIT	Drug list addition (preferred specialty); Preauthorization required
PROLASTIN-C	Drug list addition (preferred specialty); Preauthorization required

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Drug name	Change(s)
RENVELA	Non-formulary; not covered. Covered options include: calcium acetate, sevelamer carbonate, Auryxia, Velphoro
REPATHA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 3 injections every 28 days
REPATHA PUSHTRONEX SYSTEM	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 injection every 28 days
REPATHA SURECLICK	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 3 injections every 28 days
RHOPRESSA	Non-formulary; not covered. Covered options include: bimatoprost, latanoprost, tafluprost, travoprost, Zioptan
ROCKLATAN	Non-formulary; not covered. Covered options include: bimatoprost, latanoprost, tafluprost, travoprost, Zioptan
SAMSCA	Non-formulary; not covered
TOBI	Non-formulary; not covered. Covered options include: tobramycin inhalation solution
VEMLIDY	Non-formulary; not covered. Covered options include: adefovir dipivoxil, entecavir, lamivudine, tenofovir disoproxil fumarate
VIMPAT	Non-formulary; not covered. Covered options include: lacosamide, carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, felbamate, gabapentin, lamotrigine, lamotrigine ext-rel, lamotrigine tabs and chew tabs, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, pregabalin, primidone, tiagabine, topiramate, topiramate ER (except sprinkles), valproic acid, zonisamide, Aptiom, Fycompa, Oxtellar XR, Trokendi XR, Xcopri
ZEMAIRA	Drug list addition (preferred specialty); Preauthorization required

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* Drug products are identified by unique numerical product identifiers, called National Drug Codes (NDC), which identify the manufacturer, strength, dosage form, formulation and package size.

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Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. To check coverage and copay information for a specific medicine, log into your member website. For questions, please call the toll-free number on the back of your member ID card.

Information is subject to change. In accordance with state law, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in Louisiana, New York, Texas, and in most circumstances Connecticut, until the plans' renewal date.

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Policy forms issued in Oklahoma include: AL OK HCOC, HC OK HCOC.
Policy forms issued in Missouri include: AL HGrpPol 07, AL SG HGrpPol-1A 01, HI HGrpAg 05, HI GrpAgAmend-2022 01, HO HGrpPol 04, HO GrpPolAmend-2022 01, HI SG HGrpAg-1A 01. AL IVL HPOL-1A-2023-EPO-HIX 02, AL IVL SOB 1A EPO HIX 02R2, AL IVL HPOL-1A-2023-EPO 02, AL IVL SOB 1A EPO 02R1.

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