Advantage 4-Tier PDL
Update Summary

Updates to your prescription benefits

Effective Jan. 1, 2020

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Tier 1
Lowest-cost medications

$$
Tiers 2 and 3
Mid-range cost

$$$
Tier 4
Highest-cost

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 to the right as you review the following updates to the PDL.

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
COPD	Yupelri	4
Eye Inflammation	Lotemax SM	3
Infections	Nuzyra	4
	Xepi	3
Malaria	Arakoda	4
Parkinson's Disease	Inbrija	3

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
Eye Inflammation	Lotemax ointment	4 ▸ 3
Hereditary Polyneuropathy	Tegsedi	4 ▸ 2
Infertility[1]	Follistim AQ	4 ▸ 2
	ganirelix acetate (Merck/Organon)	3 ▸ 2
	pregnyl	2 ▸ 1
Inflammatory Conditions	Olumiant	4 ▸ 2
	Orencia	4 ▸ 3
	Rinvoq	4 ▸ 2
	Xeljanz, Xeljanx XR	3 ▸ 2
Severe Allergic Reactions	Symjepi	3 ▸ 2

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Prescription drugs moving to a higher tier

The following drugs are moving to a higher tier. Drugs 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)
Eye Inflammation	FML	2 ▸ 3	prednisolone (generic Pred Forte)
	FML Forte		
	Pred Mild		
Infertility[1]	Cetrotide	2 ▸ 4	ganirelix acetate (Merck/Organon)
	chorionic gonadotropin	1 ▸ 4	pregnyl, Novarel
	ganirelix acetate (Ferring)	3 ▸ 4	ganirelix acetate (Merck/Organon)
	Gonal-F	2 ▸ 4	Follistim AQ
	Gonal-F RFF		
	Ovidrel	3 ▸ 4	pregnyl, Novarel

Prescription drugs excluded from benefit coverage

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 Jan. 1, 2020, 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	Altreno	OTC Differin gel, tretinoin cream (generic Retin-A)
	Minolira	minocycline immediate-release capsules (generic Minocin)
	Seysara	doxycycline hyclate (generic Vibramycin), doxycycline monohydrate 50 mg and 100 mg (generic Monodox), minocycline immediate-release capsules (generic Minocin)
ADHD	Dexedrine (Brand Only)	dextroamphetamine extended-release (generic Dexedrine)
Allergies	dexchlorpheniramine maleate (generic Ryclora)	OTC chlorpheniramine (generic Chlor-Trimeton)
	Ryclora	
Anemia	Epogen	Retacrit
	Procrit	
Angina	Ranexa (Brand Only)	ranolazine (generic Ranexa)
Asthma	Albuterol HFA [Ventolin HFA authorized generic (Prasco)] Inhaler	Ventolin HFA
	Pulmicort inhalation suspension (Brand Only)	budesonide inhalation suspension (generic Pulmicort)
Blood Clots	Lovenox (Brand Only)	enoxaparin (generic Lovenox)
Constipation	lactulose (generic Kristalose)	lactulose oral solution
COPD	Lonhala Magnair	Incruse Ellipta, Spiriva Handihaler/Resipmat, Yupelri
	Tudorza Pressair	Incruse Ellipta, Spiriva Handihaler/Resipmat
Cough and Cold	Hydrocodone/Guaifenesin 2.5 mg/200 mg/5 mL Solution	guaifenesin/codeine solution (Cheratussin AC)
Diabetes	Levemir	Basaglar, Tresiba

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Therapeutic Use	Medication Name	Alternative Treatment Option(s)
Glaucoma	Xalatan (Brand Only)	latanoprost (generic Xalatan)
High Blood Pressure	Norvasc (Brand Only)	amlodipine (generic Norvasc)
Hormone Replacement	Minivelle (Brand Only)	estradiol patch (generic Minivelle), Vivelle-Dot
	Prometrium (Brand Only)	progesterone (generic Prometrium)
Infections	Tolsura	itraconazole capsule (generic Sporanox)
Inflammatory Conditions	Ilumya	Cimzia, Cosentyx, Humira, Skyrizi, Stelara, Tremfya
	Plaquenil (Brand Only)	hydroxychloroquine (generic Plaquenil)
	Siliq	Cimzia, Cosentyx, Humira, Skyrizi, Stelara, Tremfya
	Taltz	
Iron Overload	Exjade (Brand Only)	desferasirox (generic Exjade)
Mental Health	Abilify MyCite	aripiprazole (generic Abilify)
Neuropathic Pain	ZTLido	lidocaine patch (generic Lidoderm)
Neutropenia	Fulphila	Neulasta
	Nivestym	Zarxio
	Udenyca	Neulasta
Parkinson's Disease	Osmolex ER	amantadine immediate-release
Pulmonary Hypertension	Letairis (Brand Only)	ambrisentan (generic Letairis)
Rosacea	Oracea	doxycycline hyclate 50 mg, 100 mg (generic Morgidox, Vibramycin), doxycycline hyclate 20 mg (generic Periostat), doxycycline monohydrate 50 mg and 100 mg (generic Monodox)
Seizures	Klonopin (Brand Only)	clonazepam (generic Klonopin)
	Sympazan	clobazam (generic Onfi), clonazepam (generic Klonopin), lamotrigine (generic Lamictal), topiramate (generic Topamax)
Skin Conditions	Bryhali	fluocinonide 0.05% gel/solution (generic Lidex), desoximetasone 0.05% gel (generic Topicort)
	Cordran 0.025% cream	hydrocortisone valerate 0.2% cream (generic Westcort cream), prednicarbate 0.1% cream (generic Dermatop cream), fluticasone propionate cream 0.05% (generic Cutivate cream)
	diflorasone diacetate 0.05% ointment (generic Psorcon)	clobetasol 0.05% ointment (generic Temovate), halobetasol 0.05% ointment (generic Ultravate)
	Halobetasol 0.05% (Lexette) foam	betamethasone 0.05% augmented gel (generic Diprolene), clobetasol propionate 0.05% gel/solution (generic Temovate)
	Lexette	
	Ultravate 0.05% lotion	
Testosterone Replacement	Xyosted	testosterone injection, Testim
Thyroid Replacement	Cytomel (Brand Only)	liothyronine (generic Cytomel)

[1] Coverage is determined by the consumer's prescription drug benefit plan. Please consult plan documents regarding benefit coverage and cost-share. Infertility coverage is determined by the consumer's prescription drug benefit plan. For those who qualify, all infertility medications are required to be either fully excluded or fully covered. Prior authorization (sometimes referred to as precertification) may be required for Oxford plans.

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Updates to your prescription benefits

Effective Jan. 1, 2020

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective Jan. 1, 2020.

N Prior Authorization – Notification

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

Therapeutic Use	Medication Name
Electrolyte Imbalance	Samsca Tablet

MN 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
Infertility[1]	Cetrotide

ST Step Therapy[2]

The below medications will be added to the Step Therapy program. You must try one or more other medications before the medication below may be covered.

Therapeutic Use	Medication Name	Step 1 Medication
Infertility[1]	Gonal-F	Follistim AQ
	Gonal-F RFF	
	Gonal-F RFF Rediject	
	Cetrotide	ganirelix acetate (Merck/ Organon)

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SL Supply Limits

Supply 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 Supply Limits program.

Therapeutic Use	Medication Name	New Supply Limit	Revised Supply Limit
Anemia	Retacrit - 2,000 units/1 ml vials	12 mL (12 vials) per month	
	Retacrit - 3,000 units/1 ml vials		
	Retacrit - 4,000 units/1 ml vials		
	Retacrit - 10,000 units/1 ml vials	8 mL (8 vials) per month	
	Retacrit - 40,000 units/1 ml vials	4 mL (4 vials) per month	
Cancer	Bosulif 400 mg tablets	31 tablets per month	
	Imbruvica 70 mg capsules	31 capsules per month	
	Imbruvica 140 mg capsules		31 capsules per month
	Imbruvica 140 mg tablets; 280 mg tablets; 420 mg tablets; 560 mg tablets	31 tablets per month	
	Rubraca 250 mg tablets	124 tablets per month	
	Sprycel 80 mg tablets		31 tablets per month
	Tasigna 50 mg capsules	124 capsules per month	
Cystic Fibrosis	Kalydeco 25 mg oral granules	62 packets per month	
Diabetes	Ozempic 2 mg/1.5 ml (0.5 mg injection) pen		1 pen per month
Electrolyte Imbalance	Samsca 15 mg tablets		90 tablets per year
	Samsca 30 mg tablets		60 tablets per year
Infertility[1]	Cetrotide 0.25 mg solution for injection	14 cartons per 21 days	
	ganirelix acetate 250 mg prefilled syringe	14 syringes per 21 days	
Inflammatory Conditions	Actemra ACTpen 162 mg/0.9 mL autoinjector	4 autoinjectors per month	
Severe Allergic Reactions	Symjepi 0.15 mg prefilled syringe	2 pens per copay	
	Symjepi 0.3 mg prefilled syringe		
Skin Conditions	Triderm (triamcinolone) 0.5% cream	15 grams per copay	

[1] Coverage is determined by the consumer's prescription drug benefit plan. Please consult plan documents regarding benefit coverage and cost-share. Prior authorization (sometimes referred to as precertification) may be required for Oxford plans.

[2] Referred to as First Start in New Jersey.

For additional information:

Visit the member website listed on your health plan ID card to look up the price of drugs covered by your plan, find lower-cost options and more.

Call the toll-free phone number on your ID card to speak with a Customer Service representative.

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Online: UHC_Civil_Rights@uhc.com

Mail: Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130

You must send the complaint within 60 days of your experience. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your ID card, TTY **711**, Monday through Friday, 8 a.m. to 8 p.m., or at the times listed in your health plan documents.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

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

We provide free services to help you communicate with us, including letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free phone number listed on your ID card, TTY **711**, Monday through Friday, 8 a.m. to 8 p.m., or at the times listed in your health plan documents.

Multi-language interpreter services

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

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

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dę́ę́' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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