

CareFirst Abridged Exchange Formulary

2025

PLEASE READ: This document contains information about the drugs we cover in this plan. This formulary is for:

- Individuals or families purchasing their own plan, and
- Members of an employer group with less than 51 employees purchasing a plan

This abridged drug list is a list of drugs used to treat common conditions only. It does not include all drugs covered by your benefit plan. For a complete and updated list, visit carefirst.com/rx, click on *Drug Search* and select the *Exchange Formulary* to view the full list of covered drugs. Note that the abridged formulary listed below is not an all-inclusive list and is subject to change.

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit carefirst.com/rx.

Introduction

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals, known as the Pharmacy and Therapeutics Committee. This committee makes sure the drugs on the formulary are safe and clinically effective.

Within the formulary, prescription drugs are divided into tiers as described below. Depending on your plan, prescription drugs fall into one of five drug tiers which determines the price you pay.

Using Your Formulary

The first column of the formulary lists drugs by name. If the drugs are shown in lowercase italics, they are *generic drugs*. If the drugs are bold and capitalized, they are **BRAND-NAME DRUGS**.

You may search the formulary for a drug by pressing “CTRL” and “F” at the same time to prompt a search.

The second column indicates the drug tier for a covered drug.

The third column indicates any prescription guidelines a drug requires such as prior authorization (PA), step therapy (ST) or quantity limits (QL).

- **Prior Authorization** from CareFirst is required before you fill prescriptions for certain

drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CareFirst, your drugs may not be covered.

- **Step Therapy** requires that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your doctor will need to provide information to CareFirst about your experience with these alternatives prior to dispensing a more expensive drug.
- **Quantity Limits** have been placed on the use of selected drugs for quality or safety reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time. For example, quantity limits apply to specialty drugs. Specialty drugs are medications that may be used to treat complex and/or rare health conditions and require special handling, administration or monitoring. Specialty drugs are typically covered for a one-month supply.

Members can view specific cost-share (copay or coinsurance) information and prescription guidelines by logging in to *My Account* at carefirst.com/myaccount and clicking on *Tools* and *Drug Pricing Tool* or by reviewing their annual summary of benefits.

Tier 0: \$0 Drugs	<ul style="list-style-type: none"> ■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share.
Tier 1: Generic Drugs \$	<ul style="list-style-type: none"> ■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs \$\$	<ul style="list-style-type: none"> ■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-preferred Brand Drugs \$\$\$	<ul style="list-style-type: none"> ■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.
Tier 4: Preferred Specialty Drugs \$\$\$\$	<ul style="list-style-type: none"> ■ Preferred specialty drugs are medications that may be used to treat complex and/or rare health conditions. These drugs may have a lower cost-share than non-preferred specialty drugs.
Tier 5: Non-Preferred Specialty Drugs \$\$\$\$	<ul style="list-style-type: none"> ■ Non-preferred specialty drugs often have a specialty drug option where your cost-share will be lower.

CareFirst Exchange Formulary - 5-Tier Effective 02/01/2025

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
GOUT		
<i>allopurinol</i>	Tier 1	
<i>colchicine</i>	Tier 1	
<i>colchicine w/ probenecid</i>	Tier 1	
<i>probenecid</i>	Tier 1	
NSAIDS		
<i>diclofenac potassium</i>	Tier 1	
<i>diclofenac sodium</i>	Tier 1	
<i>etodolac</i>	Tier 1	
<i>flurbiprofen</i>	Tier 1	
<i>ibuprofen</i>	Tier 1	
<i>meclofenamate sodium</i>	Tier 1	
<i>mefenamic acid</i>	Tier 1	
<i>naproxen</i>	Tier 1	
<i>piroxicam</i>	Tier 1	
NSAIDS, COMBINATIONS		
<i>diclofenac w/ misoprostol</i>	Tier 1	
OPIOID ANALGESICS		
<i>fentanyl</i>	Tier 1	ST, PA; High Strength Requires PA
<i>hydromorphone hcl</i>	Tier 1	ST, PA; High Strength Requires PA
<i>morphine sulfate</i>	Tier 1	ST, PA; High Strength Requires PA
<i>morphine sulfate beads</i>	Tier 1	ST, PA; High Strength Requires PA
<i>oxymorphone hcl</i>	Tier 1	ST, PA; High Strength Requires PA
<i>tramadol hcl</i>	Tier 1	ST, PA; High Strength Requires PA
XTAMPZA ER	Tier 2	ST, PA; High Strength Requires Prior Auth

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OPIOID PARTIAL AGONISTS		
BELBUCA	Tier 2	ST, PA; High Strength Requires Prior Auth
<i>buprenorphine</i>	Tier 1	ST, PA; High Strength Requires Prior Auth
ANTI-INFECTIVES		
ANTHELMINTICS		
<i>ivermectin</i>	Tier 1	
<i>praziquantel</i>	Tier 1	QL (24 tabs every 365 days)
ANTI-BACTERIALS - MISCELLANEOUS		
<i>fosfomycin tromethamine</i>	Tier 1	
<i>neomycin sulfate</i>	Tier 1	
<i>tinidazole</i>	Tier 1	
ANTIFUNGALS		
<i>fluconazole</i>	Tier 1	
<i>griseofulvin microsize</i>	Tier 1	
<i>itraconazole</i>	Tier 1	PA
<i>nystatin</i>	Tier 1	
ANTIMALARIALS		
<i>atovaquone-proguanil hcl</i>	Tier 1	
<i>chloroquine phosphate</i>	Tier 1	
<i>mefloquine hcl</i>	Tier 1	
<i>primaquine phosphate</i>	Tier 1	
<i>quinine sulfate</i>	Tier 1	
ANTIRETROVIRAL AGENTS		
<i>abacavir sulfate soln</i>	Tier 1	QL (900 mL every 30 days)
<i>abacavir sulfate tabs</i>	Tier 1	QL (60 tabs every 30 days)
<i>atazanavir sulfate 150mg, 300mg</i>	Tier 1	QL (30 caps every 30 days)
<i>atazanavir sulfate 200mg</i>	Tier 1	QL (60 caps every 30 days)
<i>efavirenz</i>	Tier 1	QL (90 caps every 30 days)
<i>emtricitabine</i>	Tier 1	QL (30 caps every 30 days)

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Drug Name	Drug Tier	Requirements/Limits
<i>fosamprenavir calcium</i>	Tier 1	QL (120 tabs every 30 days)
ISENTRESS CHEW	Tier 2	QL (180 tabs every 30 days)
ISENTRESS PACK	Tier 2	QL (60 packets every 30 days)
ISENTRESS TABS	Tier 2	QL (120 tabs every 30 days)
ISENTRESS HD	Tier 2	QL (60 tabs every 30 days)
<i>lamivudine 150mg</i>	Tier 1	QL (60 tabs every 30 days)
<i>lamivudine 300mg</i>	Tier 1	QL (30 tabs every 30 days)
<i>nevirapine susp</i>	Tier 1	QL (1200 mL every 30 days)
<i>nevirapine tabs</i>	Tier 1	QL (60 tabs every 30 days)
NORVIR	Tier 2	QL (360 packets every 30 days)
PREZISTA SUSP	Tier 2	QL (400 ml every 30 days)
PREZISTA TABS 75MG	Tier 2	QL (300 tabs every 30 days)
PREZISTA TABS 150MG	Tier 2	QL (180 tabs every 30 days)
REYATAZ	Tier 2	QL (180 packets every 30 days)
<i>tenofovir disoproxil fumarate</i>	Tier 1	QL (30 tabs every 30 days)
TIVICAY	Tier 2	QL (60 tabs every 30 days)
TIVICAY PD	Tier 2	QL (360 tabs every 30 days)
<i>zidovudine caps</i>	Tier 1	QL (180 caps every 30 days)
<i>zidovudine tabs</i>	Tier 1	QL (60 tabs every 30 days)
ANTIRETROVIRAL COMBINATION AGENTS		
<i>abacavir sulfate-lamivudine</i>	Tier 1	QL (30 tabs every 30 days)
BIKTARVY	Tier 2	QL (30 tabs every 30 days)
CIMDUO	Tier 2	QL (30 tabs every 30 days)

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Drug Name	Drug Tier	Requirements/Limits
DESCOVY	Tier 0	PA, QL (30 tabs every 30 days); \$0 copay when medically necessary for pre-exposure prophylaxis; copay applies for treatment
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	Tier 1	QL (30 tabs every 30 days)
<i>emtricitabine-tenofovir disoproxil fumarate</i>	Tier 0	QL (30 tabs every 30 days); \$0 copay when medically necessary for pre-exposure prophylaxis; copay applies for treatment
<i>emtricitabine-tenofovir disoproxil fumarate</i>	Tier 1	QL (30 tabs every 30 days)
GENVOYA	Tier 2	QL (30 tabs every 30 days)
<i>lamivudine-zidovudine</i>	Tier 1	QL (60 tabs every 30 days)
ODEFSEY	Tier 2	QL (30 tabs every 30 days)
ANTITUBERCULAR AGENTS		
<i>cycloserine</i>	Tier 1	
<i>ethambutol hcl</i>	Tier 1	
<i>isoniazid</i>	Tier 1	
<i>rifabutin</i>	Tier 1	
ANTIVIRALS		
<i>acyclovir</i>	Tier 1	
<i>famciclovir</i>	Tier 1	
<i>oseltamivir phosphate caps 30mg</i>	Tier 1	QL (40 caps every 90 days)
<i>oseltamivir phosphate caps 45mg, 75mg</i>	Tier 1	QL (20 caps every 90 days)
<i>oseltamivir phosphate susr</i>	Tier 1	QL (360 mL every 90 days)
RELENZA DISKHALER	Tier 2	QL (2 inhalers every 90 days)
<i>rimantadine hydrochloride</i>	Tier 1	
<i>valacyclovir hcl</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
CEPHALOSPORINS		
<i>cefaclor</i>	Tier 1	
<i>cefadroxil</i>	Tier 1	
<i>cefdinir</i>	Tier 1	
<i>cefixime</i>	Tier 1	
<i>cefpodoxime proxetil</i>	Tier 1	
<i>cefprozil</i>	Tier 1	
<i>cefuroxime axetil</i>	Tier 1	
<i>cephalexin</i>	Tier 1	
ERYTHROMYCINS/MACROLIDES		
<i>azithromycin</i>	Tier 1	
<i>clarithromycin</i>	Tier 1	
DIFICID	Tier 2	PA
<i>ery-tab</i>	Tier 1	
<i>erythrocin stearate</i>	Tier 1	
<i>erythromycin base</i>	Tier 1	
<i>erythromycin ethylsuccinate</i>	Tier 1	
FLUOROQUINOLONES		
<i>ciprofloxacin hcl</i>	Tier 1	
<i>levofloxacin</i>	Tier 1	
<i>moxifloxacin hcl</i>	Tier 1	
<i>ofloxacin</i>	Tier 1	
HEPATITIS C		
EPCLUSA	Tier 4	PA, QL (28 tabs every 28 days)
HARVONI PACK	Tier 4	PA, QL (28 pellets every 28 days)
HARVONI TABS	Tier 4	PA, QL (28 tabs every 28 days)
VOSEVI	Tier 4	PA, QL (28 tabs every 28 days)
MISCELLANEOUS		
<i>atovaquone</i>	Tier 1	
<i>clindamycin hcl</i>	Tier 1	
<i>clindamycin palmitate hydrochloride</i>	Tier 1	
<i>linezolid</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
<i>methenamine hippurate</i>	Tier 1	
<i>metronidazole</i>	Tier 1	
<i>nitrofurantoin macrocrystal</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>nitrofurantoin monohyd macro</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>pentamidine isethionate</i>	M	M
<i>sulfamethoxazole-trimethoprim</i>	Tier 1	
<i>vancomycin hcl</i>	Tier 1	QL (80 caps every 10 days)
PENICILLINS		
<i>amoxicillin</i>	Tier 1	
<i>amoxicillin & pot clavulanate</i>	Tier 1	
<i>ampicillin</i>	Tier 1	
<i>dicloxacillin sodium</i>	Tier 1	
<i>penicillin v potassium</i>	Tier 1	
TETRACYCLINES		
<i>avidoxy</i>	Tier 1	
<i>demeclocycline hcl</i>	Tier 1	
<i>doxycycline (monohydrate)</i>	Tier 1	
<i>doxycycline hyclate</i>	Tier 1	
<i>minocycline hcl</i>	Tier 1	
ANTINEOPLASTIC AGENTS		
ALKYLATING AGENTS		
<i>carmustine</i>	M	M
ANTIMETABOLITES		
<i>mercaptopurine</i>	Tier 0	
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate</i>	Tier 0	PA, QL (120 tabs every 30 days)
<i>anastrozole</i>	Tier 0	\$0 copay for women ages 35 and older for the primary prevention of breast cancer
<i>bicalutamide</i>	Tier 0	

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Drug Name	Drug Tier	Requirements/Limits
<i>exemestane</i>	Tier 0	\$0 copay for women ages 35 and older for the primary prevention of breast cancer
<i>letrozole</i>	Tier 0	
<i>megestrol acetate</i>	Tier 0	
<i>nilutamide</i>	Tier 0	
NUBEQA	Tier 0	PA, QL (120 tabs every 30 days)
<i>tamoxifen citrate</i>	Tier 0	\$0 copay for women ages 35 and older for the primary prevention of breast cancer
<i>toremifene citrate</i>	Tier 0	
KINASE INHIBITORS		
ALECENSA	Tier 0	PA, QL (240 caps every 30 days)
<i>imatinib mesylate</i>	Tier 0	PA, QL (60 tabs every 30 days)
KISQALI 200MG	Tier 0	PA, QL (21 tabs every 28 days); 200 mg dose
KISQALI 200MG	Tier 0	PA, QL (42 tabs every 28 days); 400 mg dose
KISQALI 200MG	Tier 0	PA, QL (63 tabs every 28 days); 600 mg dose
MISCELLANEOUS		
<i>arsenic trioxide</i>	M	M
<i>hydroxyurea</i>	Tier 0	
LYNPARZA	Tier 0	PA, QL (120 tabs every 30 days)
ODOMZO	Tier 0	PA, QL (30 caps every 30 days)
<i>tretinoin (chemotherapy)</i>	Tier 0	
MITOTIC INHIBITORS		
<i>docetaxel</i>	M	M

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Drug Name	Drug Tier	Requirements/Limits
PROTECTIVE AGENTS		
<i>leucovorin calcium</i>	Tier 0	
TOPOISOMERASE INHIBITORS		
<i>etoposide</i>	Tier 0	
<i>irinotecan hcl</i>	M	M
CARDIOVASCULAR		
ACE INHIBITOR COMBINATIONS		
<i>amlodipine besylate-benazepril hcl</i>	Tier 1	
<i>benazepril & hydrochlorothiazide</i>	Tier 1	
<i>enalapril maleate & hydrochlorothiazide</i>	Tier 1	
<i>fosinopril sodium & hydrochlorothiazide</i>	Tier 1	
<i>trandolapril-verapamil hcl</i>	Tier 1	
ACE INHIBITORS		
<i>benazepril hcl</i>	Tier 1	
<i>captopril</i>	Tier 1	
<i>enalapril maleate</i>	Tier 1	
<i>fosinopril sodium</i>	Tier 1	
<i>lisinopril</i>	Tier 1	
<i>moexipril hcl</i>	Tier 1	
<i>ramipril</i>	Tier 1	
<i>trandolapril</i>	Tier 1	
ALDOSTERONE RECEPTOR ANTAGONISTS		
<i>eplerenone</i>	Tier 1	
ALPHA BLOCKERS		
<i>prazosin hcl</i>	Tier 1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS		
<i>amlodipine besylate-olmesartan medoxomil</i>	Tier 1	
<i>amlodipine besylate-valsartan</i>	Tier 1	
<i>candesartan cilexetil-hydrochlorothiazide</i>	Tier 1	
<i>irbesartan-hydrochlorothiazide</i>	Tier 1	
<i>losartan potassium & hydrochlorothiazide</i>	Tier 1	
<i>olmesartan medoxomil-amlodipine-hydrochlorothiazide</i>	Tier 1	
<i>telmisartan-amlodipine</i>	Tier 1	
<i>valsartan-hydrochlorothiazide</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
<i>candesartan cilexetil</i>	Tier 1	
<i>irbesartan</i>	Tier 1	
<i>olmesartan medoxomil</i>	Tier 1	
<i>telmisartan</i>	Tier 1	
<i>valsartan</i>	Tier 1	
ANTIARRHYTHMICS		
<i>amiodarone hcl</i>	Tier 1	
<i>disopyramide phosphate</i>	Tier 1	
<i>dofetilide</i>	Tier 1	PA
<i>flecainide acetate</i>	Tier 1	
NORPACE CR	Tier 2	
<i>pacerone</i>	Tier 1	
<i>propafenone hcl</i>	Tier 1	
<i>sotalol hcl</i>	Tier 1	
<i>sotalol hcl (afib/afl)</i>	Tier 1	
ANTILIPEMICS, BILE ACID RESINS		
<i>colestipol hcl</i>	Tier 1	
<i>prevalite</i>	Tier 1	
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR		
<i>ezetimibe</i>	Tier 1	
ANTILIPEMICS, FIBRATES		
<i>fenofibrate</i>	Tier 1	
<i>fenofibrate micronized</i>	Tier 1	
<i>gemfibrozil</i>	Tier 1	
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium</i>	Tier 1	\$0 copay for members age 40 through 75
<i>fluvastatin sodium</i>	Tier 1	\$0 copay for members age 40 through 75
<i>lovastatin</i>	Tier 1	\$0 copay for members age 40 through 75
<i>pravastatin sodium</i>	Tier 1	\$0 copay for members age 40 through 75
<i>simvastatin</i>	Tier 1	\$0 copay for members age 40 through 75

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Drug Name	Drug Tier	Requirements/Limits
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS		
<i>ezetimibe-simvastatin</i>	Tier 1	
ANTILIPEMICS, OMEGA-3 FATTY ACIDS		
<i>omega-3-acid ethyl esters</i>	Tier 1	
BETA-BLOCKER/DIURETIC COMBINATIONS		
<i>atenolol & chlorthalidone</i>	Tier 1	
<i>bisoprolol & hydrochlorothiazide</i>	Tier 1	
<i>metoprolol & hydrochlorothiazide</i>	Tier 1	
BETA-BLOCKERS		
<i>atenolol</i>	Tier 1	
<i>betaxolol hcl</i>	Tier 1	
<i>bisoprolol fumarate</i>	Tier 1	
<i>carvedilol</i>	Tier 1	
<i>carvedilol phosphate</i>	Tier 1	
<i>metoprolol succinate</i>	Tier 1	
<i>metoprolol tartrate</i>	Tier 1	
<i>nadolol</i>	Tier 1	
<i>pindolol</i>	Tier 1	
<i>propranolol hcl</i>	Tier 1	
<i>timolol maleate</i>	Tier 1	
CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS		
<i>amlodipine besylate-atorvastatin calcium</i>	Tier 1	
CALCIUM CHANNEL BLOCKERS		
<i>amlodipine besylate</i>	Tier 1	
<i>cartia xt</i>	Tier 1	
<i>dilt-xr</i>	Tier 1	
<i>diltiazem hcl</i>	Tier 1	
<i>diltiazem hcl coated beads</i>	Tier 1	
<i>diltiazem hcl extended release beads</i>	Tier 1	
<i>felodipine</i>	Tier 1	
<i>isradipine</i>	Tier 1	
<i>matzim la</i>	Tier 1	
<i>nifedipine</i>	Tier 1	
<i>nisoldipine</i>	Tier 1	
<i>verapamil hcl</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
DIGITALIS GLYCOSIDES		
<i>digoxin</i>	Tier 1	
DIRECT RENIN INHIBITORS/COMBINATIONS		
<i>aliskiren fumarate</i>	Tier 1	
DIURETICS		
<i>acetazolamide</i>	Tier 1	
<i>amiloride hcl</i>	Tier 1	
<i>bumetanide</i>	Tier 1	
<i>chlorthalidone</i>	Tier 1	
<i>furosemide</i>	Tier 1	
<i>hydrochlorothiazide</i>	Tier 1	
<i>indapamide</i>	Tier 1	
<i>mannitol</i>	Tier 1	
<i>metolazone</i>	Tier 1	
<i>osmitrol viaflex</i>	Tier 1	
<i>spironolactone & hydrochlorothiazide</i>	Tier 1	
<i>toremide</i>	Tier 1	
<i>triamterene</i>	Tier 1	
HEART FAILURE		
ENTRESTO	Tier 2	
MISCELLANEOUS		
<i>clonidine</i>	Tier 1	
<i>clonidine hcl</i>	Tier 1	
<i>guanfacine hcl</i>	Tier 1	
<i>hydralazine hcl</i>	Tier 1	
<i>midodrine hcl</i>	Tier 1	
<i>minoxidil</i>	Tier 1	
<i>ranolazine</i>	Tier 1	ST; PA**
NITRATES		
<i>isosorbide dinitrate</i>	Tier 1	
<i>isosorbide mononitrate</i>	Tier 1	
NITRO-DUR	Tier 2	
<i>nitroglycerin</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CENTRAL NERVOUS SYSTEM		
ALCOHOL DETERRENTS		
<i>acamprosate calcium</i>	Tier 1	PA
ANTIANKXIETY		
<i>buspirone hcl</i>	Tier 1	
<i>fluvoxamine maleate</i>	Tier 1	
<i>meprobamate</i>	Tier 1	
ANTIDEMENTIA		
<i>donepezil hydrochloride</i>	Tier 1	
<i>galantamine hydrobromide</i>	Tier 1	
ANTIDEPRESSANTS		
<i>amitriptyline hcl</i>	Tier 1	PA; High strength requires PA for members age 65 and older
<i>bupropion hcl</i>	Tier 1	
<i>citalopram hydrobromide</i>	Tier 1	
<i>duloxetine hcl</i>	Tier 1	
<i>escitalopram oxalate</i>	Tier 1	
<i>fluoxetine hcl caps; cpdr</i>	Tier 1	
<i>fluoxetine hcl tabs</i>	Tier 1	(generic Sarafem not covered)
<i>imipramine pamoate</i>	Tier 1	PA; High strength requires PA for members age 65 and older
<i>mirtazapine</i>	Tier 1	
<i>nefazodone hcl</i>	Tier 1	
<i>nortriptyline hcl</i>	Tier 1	PA; High strength requires PA for members age 65 and older
<i>paroxetine hcl</i>	Tier 1	
<i>sertraline hcl</i>	Tier 1	
<i>tranylcypromine sulfate</i>	Tier 1	
<i>trazodone hcl</i>	Tier 1	
<i>venlafaxine hcl</i>	Tier 1	
ANTIPARKINSONIAN AGENTS		
<i>amantadine hcl</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>benztropine mesylate</i>	Tier 1	
<i>bromocriptine mesylate</i>	Tier 1	
<i>carbidopa-levodopa</i>	Tier 1	
<i>carbidopa-levodopa-entacapone</i>	Tier 1	
<i>pramipexole dihydrochloride</i>	Tier 1	
<i>rasagiline mesylate</i>	Tier 1	
<i>ropinirole hydrochloride</i>	Tier 1	
<i>selegiline hcl</i>	Tier 1	
<i>trihexyphenidyl hcl</i>	Tier 1	

ANTIPSYCHOTICS

<i>aripiprazole</i>	Tier 1	
ARISTADA	Tier 2	
ARISTADA INITIO	Tier 2	
<i>chlorpromazine hcl</i>	Tier 1	
<i>clozapine</i>	Tier 1	
<i>fluphenazine hcl</i>	Tier 1	
<i>haloperidol</i>	Tier 1	
<i>haloperidol lactate</i>	Tier 1	
<i>loxapine succinate</i>	Tier 1	
<i>olanzapine</i>	Tier 1	
<i>perphenazine</i>	Tier 1	
<i>quetiapine fumarate</i>	Tier 1	
<i>risperidone</i>	Tier 1	
<i>thioridazine hcl</i>	Tier 1	
<i>trifluoperazine hcl</i>	Tier 1	
<i>ziprasidone hcl</i>	Tier 1	

ANTISEIZURE AGENTS

<i>carbamazepine</i>	Tier 1	
<i>clonazepam</i>	Tier 1	
<i>divalproex sodium</i>	Tier 1	
<i>epitol</i>	Tier 1	
<i>ethosuximide</i>	Tier 1	
<i>felbamate</i>	Tier 1	
<i>lamotrigine</i>	Tier 1	
<i>levetiracetam</i>	Tier 1	
<i>oxcarbazepine</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>phenobarbital</i>	Tier 1	
<i>phenytoin sodium extended</i>	Tier 1	
<i>pregabalin</i>	Tier 1	ST; PA**
<i>primidone</i>	Tier 1	
<i>tiagabine hcl</i>	Tier 1	
<i>topiramate</i>	Tier 1	
<i>valproate sodium</i>	Tier 1	
<i>valproic acid</i>	Tier 1	
<i>vigabatrin</i>	Tier 4	PA, QL (180 packets every 30 days)
<i>zonisamide</i>	Tier 1	
ATTENTION DEFICIT HYPERACTIVITY DISORDER		
<i>atomoxetine hcl</i>	Tier 1	
<i>guanfacine hcl (adhd)</i>	Tier 1	
HYPNOTICS		
<i>BELSOMRA</i>	Tier 2	ST; PA**
<i>cvs sleep-aid nighttime</i>	Tier 1	OTC
MOOD STABILIZERS		
<i>lithium carbonate</i>	Tier 1	
MULTIPLE SCLEROSIS AGENTS		
<i>BETASERON</i>	Tier 4	PA, QL (14 injections every 28 days)
<i>dimethyl fumarate cdpk</i>	Tier 4	PA, QL (1 kit every 30 days)
<i>dimethyl fumarate cpdr 120mg</i>	Tier 4	PA, QL (14 caps every 28 days)
<i>dimethyl fumarate cpdr 240mg</i>	Tier 4	PA, QL (60 caps every 30 days)
<i>glatiramer acetate</i>	Tier 2	PA, QL (12 syringes every 28 days)
<i>glatopa</i>	Tier 2	PA, QL (30 injections every 30 days)
MUSCULOSKELETAL THERAPY AGENTS		
<i>baclofen</i>	Tier 1	
<i>chlorzoxazone</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy 14

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>cyclobenzaprine hcl</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>dantrolene sodium</i>	Tier 1	
<i>methocarbamol</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>tizanidine hcl</i>	Tier 1	
MYASTHENIA GRAVIS		
<i>pyridostigmine bromide</i>	Tier 1	
OPIOID ANTAGONIST		
<i>naltrexone hcl</i>	Tier 0	\$0 copay
PSYCHOTHERAPEUTIC-MISC		
<i>pimozide</i>	Tier 1	
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deterrent)</i>	Tier 0	\$0 limited to 2 treatment cycles/year
ENDOCRINE AND METABOLIC		
ANDROGENS		
<i>testosterone</i>	Tier 1	PA
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose</i>	Tier 1	
ANTIDIABETICS, BIGUANIDE		
<i>metformin hcl</i>	Tier 1	
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
<i>glipizide-metformin hcl</i>	Tier 1	
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
SOLIQUA 100/33	Tier 2	ST; PA**
XULTOPHY 100/3.6	Tier 2	ST; PA**
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN	Tier 2	
FIASP	Tier 2	
FIASP FLEXTOUCH	Tier 2	
FIASP PENFILL	Tier 2	
HUMULIN R U-500 (CONCENTR	Tier 2	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
HUMULIN R U-500 KWIKPEN	Tier 2	
NOVOLIN 70/30	Tier 2	OTC; RELION not covered
NOVOLIN 70/30 FLEXPEN	Tier 2	OTC; RELION not covered
NOVOLIN N	Tier 2	OTC; RELION not covered
NOVOLIN N FLEXPEN	Tier 2	OTC; RELION not covered
NOVOLIN R	Tier 2	OTC; RELION not covered
NOVOLIN R FLEXPEN	Tier 2	OTC; RELION not covered
NOVOLOG MIX 70/30	Tier 2	
NOVOLOG MIX 70/30 PREFILL	Tier 2	
TRESIBA	Tier 2	
TRESIBA FLEXTOUCH	Tier 2	
ANTIDIABETICS, INSULIN SENSITIZER		
<i>pioglitazone hcl</i>	Tier 1	
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
<i>pioglitazone hcl-metformin hcl</i>	Tier 1	
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
<i>pioglitazone hcl-glimepiride</i>	Tier 1	
ANTIDIABETICS, MEGLITINIDE		
<i>nateglinide</i>	Tier 1	
<i>repaglinide</i>	Tier 1	
ANTIDIABETICS, SULFONYLUREA		
<i>glimepiride</i>	Tier 1	
<i>glipizide</i>	Tier 1	
CONTRACEPTIVES		
<i>altavera</i>	Tier 0	
<i>alyacen 1/35</i>	Tier 0	
<i>alyacen 7/7/7</i>	Tier 0	
ANNOVERA	Tier 0	QL (1 every 300 days)
<i>apri</i>	Tier 0	
<i>aranelle</i>	Tier 0	
<i>ashlyna</i>	Tier 0	
<i>aviane</i>	Tier 0	
<i>camila</i>	Tier 0	
<i>cryselle-28</i>	Tier 0	
<i>dasetta 1/35</i>	Tier 0	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dasetta 7/7/7</i>	Tier 0	
<i>delyla</i>	Tier 0	
<i>drospirenone-ethinyl estradiol-levomefolate calcium</i>	Tier 0	
<i>elinest</i>	Tier 0	
<i>enpresse-28</i>	Tier 0	
<i>enskyce</i>	Tier 0	
<i>errin</i>	Tier 0	
<i>ethynodiol diacet & eth estrad</i>	Tier 0	
<i>etonogestrel-ethinyl estradiol</i>	Tier 0	QL (13 every 300 days)
<i>falmina</i>	Tier 0	
<i>gemmily</i>	Tier 0	
<i>heather</i>	Tier 0	
<i>introvale</i>	Tier 0	
<i>jolessa</i>	Tier 0	
<i>junel 1.5/30</i>	Tier 0	
<i>junel 1/20</i>	Tier 0	
<i>junel fe 1.5/30</i>	Tier 0	
<i>junel fe 1/20</i>	Tier 0	
<i>junel fe 24</i>	Tier 0	
<i>kariva</i>	Tier 0	
<i>kelnor 1/35</i>	Tier 0	
<i>kurvelo</i>	Tier 0	
<i>larin 1.5/30</i>	Tier 0	
<i>leena</i>	Tier 0	
<i>lessina</i>	Tier 0	
<i>levonest</i>	Tier 0	
<i>levonorgestrel & eth estradiol</i>	Tier 0	
<i>levonorgestrel-ethinyl estradiol (91-day)</i>	Tier 0	
<i>levora 0.15/30-28</i>	Tier 0	
LO LOESTRIN FE	Tier 0	
<i>loryna</i>	Tier 0	
<i>low-ogestrel</i>	Tier 0	
<i>lutra</i>	Tier 0	
<i>marlissa</i>	Tier 0	
<i>mono-lynyah</i>	Tier 0	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
NATAZIA	Tier 0	
<i>nikki</i>	Tier 0	
<i>norethindrone & ethinyl estradiol-fe</i>	Tier 0	
<i>norethindrone (contraceptive)</i>	Tier 0	
<i>norethindrone acet & eth estra</i>	Tier 0	
<i>norgestimate-ethinyl estradiol</i>	Tier 0	
<i>norgestimate-ethinyl estradiol (triphasic)</i>	Tier 0	
<i>nortrel 0.5/35 (28)</i>	Tier 0	
<i>nortrel 1/35</i>	Tier 0	
<i>nortrel 7/7/7</i>	Tier 0	
<i>ocella</i>	Tier 0	
<i>portia-28</i>	Tier 0	
<i>reclipsen</i>	Tier 0	
<i>rivelsa</i>	Tier 0	
SLYND	Tier 0	
<i>sprintec 28</i>	Tier 0	
<i>sronyx</i>	Tier 0	
<i>syeda</i>	Tier 0	
<i>take action</i>	Tier 0	OTC
<i>tri-linyah</i>	Tier 0	
<i>tri-sprintec</i>	Tier 0	
<i>trivora-28</i>	Tier 0	
TWIRLA	Tier 0	
<i>velivet</i>	Tier 0	
<i>viorele</i>	Tier 0	
<i>wera</i>	Tier 0	
<i>xulane</i>	Tier 0	

DIABETIC SUPPLIES

ACCU-CHEK AVIVA PLUS	M	OTC; M
ACCU-CHEK GUIDE	M	OTC; M
ACCU-CHEK GUIDE ME	M	OTC; M
BD VEO INSULIN SYRINGE UL	Tier 0	OTC
CAREFINE PEN NEEDLES 32GX	Tier 0	OTC
DEXCOM G5 MOBILE RECEIVER	Tier 0	PA
DEXCOM G5 MOBILE TRANSMIT	Tier 0	PA
DEXCOM G5 RECEIVER KIT	Tier 0	PA

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
DEXCOM G6 RECEIVER	Tier 0	PA
DEXCOM G6 TRANSMITTER	Tier 0	PA
NOVOFINE PEN NEEDLE 32G X	Tier 0	OTC
OMNIPOD CLASSIC PDM START	Tier 0	PA, QL (10 kits every 30 days)
OMNIPOD CLASSIC PODS (GEN	Tier 0	PA, QL (10 boxes every 30 days)
OMNIPOD DASH PODS (GEN 4)	Tier 0	PA, QL (10 boxes every 30 days)
V-GO 20	Tier 0	PA, QL (30 pumps per 25 days)
V-GO 30	Tier 0	PA, QL (30 pumps per 25 days)
V-GO 40	Tier 0	PA, QL (30 pumps per 25 days)
ENDOMETRIOSIS		
<i>danazol</i>	Tier 1	
ORILISSA	Tier 2	
FERTILITY REGULATORS		
GANIRELIX ACETATE	Tier 4	PA
GLUCOCORTICOIDS		
<i>dexamethasone</i>	Tier 1	
DEXAMETHASONE INTENSOL	Tier 2	
<i>fludrocortisone acetate</i>	Tier 1	
<i>hydrocortisone</i>	Tier 1	
MEDROL	Tier 2	
<i>methylprednisolone</i>	Tier 1	
<i>prednisolone sodium phosphate</i>	Tier 1	
<i>prednisone</i>	Tier 1	
PREDNISONONE INTENSOL	Tier 2	
GLUCOSE ELEVATING AGENTS		
<i>glucagon (rdna)</i>	Tier 1	
MENOPAUSAL SYMPTOM AGENTS		
CLIMARA PRO	Tier 2	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
<i>estradiol</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>estradiol & norethindrone acetate</i>	Tier 1	
<i>estradiol vaginal</i>	Tier 1	
<i>jinteli</i>	Tier 1	
<i>mimvey</i>	Tier 1	
<i>norethindrone acetate-ethinyl estradiol</i>	Tier 1	
<i>yuvafem</i>	Tier 1	
MISCELLANEOUS		
<i>cabergoline</i>	Tier 1	
<i>raloxifene hcl</i>	Tier 1	\$0 copay for women ages 35 and older for the primary prevention of breast cancer
PHOSPHATE BINDER AGENTS		
<i>calcium acetate (phosphate binder)</i>	Tier 1	
<i>sevelamer carbonate</i>	Tier 1	
PROGESTINS		
CRINONE	Tier 2	
<i>medroxyprogesterone acetate</i>	Tier 1	
<i>norethindrone acetate</i>	Tier 1	
THYROID AGENTS		
<i>levothyroxine sodium</i>	Tier 1	
<i>levoxyl</i>	Tier 1	
<i>liothyronine sodium</i>	Tier 1	
<i>propylthiouracil</i>	Tier 1	
SYNTHROID	Tier 2	
<i>unithroid</i>	Tier 1	
VASOPRESSINS		
<i>desmopressin acetate</i>	Tier 1	
<i>desmopressin acetate spray refrigerated</i>	Tier 1	
VITAMIN D ANALOGS		
<i>calcitriol</i>	Tier 1	
<i>doxercalciferol</i>	Tier 1	
<i>paricalcitol</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy 20

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
GASTROINTESTINAL		
ANTICHOLINERGICS		
<i>dicyclomine hcl</i>	Tier 1	
<i>glycopyrrolate</i>	Tier 1	
<i>methscopolamine bromide</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
ANTIDIARRHEALS		
<i>diphenoxylate w/ atropine</i>	Tier 1	
<i>loperamide hcl</i>	Tier 1	
ANTIEMETICS		
<i>aprepitant</i>	Tier 1	QL (3 caps every 180 days)
<i>compro</i>	Tier 1	
<i>meclizine hcl</i>	Tier 1	
<i>metoclopramide hcl</i>	Tier 1	
<i>prochlorperazine</i>	Tier 1	
<i>promethazine hcl soln; tabs</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>promethazine hcl supp</i>	Tier 1	
<i>promethegan</i>	Tier 1	
<i>scopolamine</i>	Tier 1	
<i>trimethobenzamide hcl</i>	Tier 1	
VARUBI	Tier 2	
H2-RECEPTOR ANTAGONISTS		
<i>cimetidine</i>	Tier 1	
<i>famotidine</i>	Tier 1	
<i>nizatidine</i>	Tier 1	
INFLAMMATORY BOWEL DISEASE		
<i>balsalazide disodium</i>	Tier 1	
<i>hydrocortisone (intrarectal)</i>	Tier 1	
<i>mesalamine</i>	Tier 1	
<i>mesalamine w/ cleanser</i>	Tier 1	
<i>sulfasalazine</i>	Tier 1	
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS	Tier 2	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
<i>lubiprostone</i>	Tier 1	
LAXATIVES		
<i>enulose</i>	Tier 1	
<i>gavilyte-c</i>	Tier 1	
<i>gavilyte-g</i>	Tier 1	
<i>generlac</i>	Tier 1	
<i>lactulose</i>	Tier 1	
<i>peg 3350-kcl-sod bicarb-sod chloride-sod sulfate</i>	Tier 1	
<i>peg 3350-potassium chloride-sod bicarbonate-sod chloride</i>	Tier 1	
<i>polyethylene glycol 3350</i>	Tier 1	OTC
MISCELLANEOUS		
<i>cromolyn sodium (mastocytosis)</i>	Tier 1	
<i>sucralfate</i>	Tier 1	
<i>ursodiol</i>	Tier 1	
PANCREATIC ENZYMES		
CREON	Tier 2	PA
VIOKACE	Tier 2	PA
ZENPEP	Tier 2	PA
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium</i>	Tier 1	QL (90 caps every 365 days)
<i>lansoprazole</i>	Tier 1	QL (90 caps every 365 days)
<i>omeprazole</i>	Tier 1	QL (90 caps every 365 days)
<i>pantoprazole sodium</i>	Tier 1	QL (90 tabs every 365 days)
GENITOURINARY		
BENIGN PROSTATIC HYPERPLASIA		
<i>alfuzosin hcl</i>	Tier 1	
<i>dutasteride</i>	Tier 1	
<i>dutasteride-tamsulosin hcl</i>	Tier 1	
<i>finasteride</i>	Tier 1	
<i>tamsulosin hcl</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS		
<i>potassium citrate (alkalinizer)</i>	Tier 1	
URINARY ANTISPASMODICS		
<i>oxybutynin chloride</i>	Tier 1	
<i>tolterodine tartrate</i>	Tier 1	
<i>trospium chloride</i>	Tier 1	
VAGINAL ANTI-INFECTIVES		
<i>clindamycin phosphate vaginal</i>	Tier 1	
<i>metronidazole vaginal</i>	Tier 1	
<i>miconazole 3</i>	Tier 1	
<i>terconazole vaginal</i>	Tier 1	
HEMATOLOGIC		
ANTICOAGULANTS		
ELIQUIS	Tier 2	
ELIQUIS STARTER PACK	Tier 2	
<i>enoxaparin sodium</i>	Tier 1	
<i>fondaparinux sodium</i>	Tier 1	
<i>jantoven</i>	Tier 1	
<i>warfarin sodium</i>	Tier 1	
XARELTO	Tier 2	
XARELTO STARTER PACK	Tier 2	
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ARANESP ALBUMIN FREE	Tier 4	PA
RETACRIT	Tier 4	PA
MISCELLANEOUS		
<i>anagrelide hcl</i>	Tier 1	
<i>pentoxifylline</i>	Tier 1	
<i>tranexamic acid</i>	Tier 1	
PLATELET AGGREGATION INHIBITORS		
<i>aspirin-dipyridamole</i>	Tier 1	
<i>clopidogrel bisulfate</i>	Tier 1	
<i>dipyridamole</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>prasugrel hcl</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
IMMUNOLOGIC AGENTS		
<i>AUTOIMMUNE AGENTS (SELF-ADMINISTERED)</i>		
ENBREL	Tier 4	PA, QL (4 syringes every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENBREL MINI	Tier 4	PA, QL (4 cartridges every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
ENBREL SURECLICK	Tier 4	PA, QL (4 syringes every 28 days); Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis
OTEZLA TABS	Tier 4	PA, QL (60 tabs every 30 days); Preferred agent for Psoriasis and Psoriatic Arthritis
OTEZLA TBPk	Tier 4	PA, QL (55 tabs every 28 days); Preferred agent for Psoriasis and Psoriatic Arthritis
TALTZ	Tier 4	PA, QL (1 injection every 28 days); Preferred agent for Psoriasis
<i>DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)</i>		
<i>leflunomide</i>	Tier 1	
<i>methotrexate sodium</i>	Tier 0	\$0 copay based on your plan/benefit
<i>IMMUNOSUPPRESSANTS</i>		
<i>cyclosporine</i>	Tier 1	
<i>cyclosporine modified (for microemulsion)</i>	Tier 1	
<i>everolimus (immunosuppressant)</i>	Tier 1	
<i>gengraf</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy 24

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Drug Name	Drug Tier	Requirements/Limits
<i>mycophenolate mofetil</i>	Tier 1	
<i>mycophenolate sodium</i>	Tier 1	
<i>sirolimus</i>	Tier 1	
<i>tacrolimus</i>	Tier 1	

NUTRITIONAL/SUPPLEMENTS

ELECTROLYTES

<i>potassium chloride</i>	Tier 1	
<i>sodium fluoride chew 1mg</i>	Tier 1	
<i>sodium fluoride chew .25mg, .5mg</i>	Tier 0	\$0 applies for ages 5 and under, otherwise not covered
<i>sodium fluoride soln</i>	Tier 0	\$0 applies for ages 5 and under, otherwise not covered
<i>sodium fluoride tabs 1mg</i>	Tier 1	
<i>sodium fluoride tabs .5mg</i>	Tier 0	\$0 applies for ages 5 and under, otherwise not covered

VITAMINS

<i>cholecalciferol</i>	Tier 1	OTC
<i>folic acid</i>	Tier 1	
<i>multi-vitamin/fluoride dr</i>	Tier 1	
<i>multi-vitamin/fluoride/ir</i>	Tier 1	
<i>pyridoxine hcl</i>	Tier 1	OTC
<i>tri-vite/fluoride</i>	Tier 1	

OPHTHALMIC

ANTI-INFECTIVE/ANTI-INFLAMMATORY

<i>neomycin-polymy-dexameth</i>	Tier 1	
<i>neomycin-polymyxin-hc (ophth)</i>	Tier 1	
<i>sulfacetamide sod-prednisolone</i>	Tier 1	
TOBRADEX	Tier 2	
TOBRADEX ST	Tier 2	
<i>tobramycin-dexamethasone</i>	Tier 1	

ANTI-INFECTIVES

AZASITE	Tier 2	
<i>bacitracin (ophthalmic)</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
<i>bacitracin-polymyxin b (ophth)</i>	Tier 1	
<i>erythromycin (ophth)</i>	Tier 1	
<i>moxifloxacin hcl (ophth)</i>	Tier 1	
<i>neomycin-polymyxin-gramicidin</i>	Tier 1	
<i>polycin</i>	Tier 1	
<i>sulfacetamide sodium (ophth)</i>	Tier 1	
<i>trifluridine</i>	Tier 1	
ANTI-INFLAMMATORIES		
<i>dexamethasone sodium phosphate (ophth)</i>	Tier 1	
<i>diclofenac sodium (ophth)</i>	Tier 1	
<i>flurbiprofen sodium</i>	Tier 1	
ILEVRO	Tier 2	
<i>ketorolac tromethamine (ophth)</i>	Tier 1	
<i>loteprednol etabonate</i>	Tier 1	
<i>prednisolone acetate (ophth)</i>	Tier 1	
PREDNISOLONE SODIUM PHOSP	Tier 2	
ANTIALLERGICS		
<i>azelastine hcl (ophth)</i>	Tier 1	
<i>epinastine hcl (ophth)</i>	Tier 1	
<i>olopatadine hcl</i>	Tier 1	
ANTIGLAUCOMA BETA-BLOCKERS		
<i>carteolol hcl (ophth)</i>	Tier 1	
<i>levobunolol hcl</i>	Tier 1	
<i>timolol maleate (ophth)</i>	Tier 1	
ANTIGLAUCOMA COMBINATION AGENTS		
<i>dorzolamide hcl-timolol maleate</i>	Tier 1	
CARBONIC ANHYDRASE INHIBITORS		
<i>brinzolamide</i>	Tier 1	
MISCELLANEOUS		
<i>pilocarpine hcl</i>	Tier 1	
<i>proparacaine hcl</i>	Tier 1	
<i>tropicamide</i>	Tier 1	
PROSTAGLANDINS		
<i>latanoprost</i>	Tier 1	
LUMIGAN	Tier 2	ST; PA**

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy

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Drug Name	Drug Tier	Requirements/Limits
<i>travoprost</i>	Tier 1	
SYMPATHOMIMETICS		
<i>brimonidine tartrate</i>	Tier 1	
RESPIRATORY		
ALPHA-1 ANTITRYPSIN DEFICIENCY AGENTS		
PROLASTIN-C	M	M
ANTICHOLINERGICS		
<i>ipratropium bromide (nasal)</i>	Tier 1	
ANTI-HISTAMINES		
<i>carbinoxamine maleate</i>	Tier 1	
<i>clemastine fumarate</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>cyproheptadine hcl</i>	Tier 1	
<i>desloratadine</i>	Tier 1	
<i>diphenhydramine hcl</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>hydroxyzine hcl</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>hydroxyzine pamoate</i>	Tier 1	PA; High Risk Medications require PA for members age 70 and older
<i>levocetirizine dihydrochloride</i>	Tier 1	
BETA AGONISTS		
<i>albuterol sulfate</i>	Tier 1	
<i>terbutaline sulfate</i>	Tier 1	
COLD/COUGH		
<i>benzonatate</i>	Tier 1	
<i>pseudoephed-bromphen-dm</i>	Tier 1	
LEUKOTRIENE RECEPTOR ANTAGONISTS		
<i>montelukast sodium</i>	Tier 1	
<i>zafirlukast</i>	Tier 1	
MISCELLANEOUS		
<i>acetylcysteine</i>	Tier 1	

M - Covered Under the Medical Benefit Only **OTC** - Over the counter **PA** - Prior Authorization **PA**** - PA Applies if Step is Not Met **QL** - Quantity Limits **ST** - Step Therapy 27

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Drug Name	Drug Tier	Requirements/Limits
<i>sodium chloride (inhalant)</i>	Tier 1	
SEVERE ASTHMA AGENTS		
XOLAIR SOLR	Tier 4	PA, QL (8 vials every 28 days)
XOLAIR SOSY 75MG/0.5ML	Tier 4	PA, QL (2 syringes every 28 days)
XOLAIR SOSY 150MG/ML	Tier 4	PA, QL (8 syringes every 28 days)
XANTHINES		
<i>theophylline</i>	Tier 1	
TOPICAL		
DERMATOLOGY, ACNE		
<i>adapalene-benzoyl peroxide</i>	Tier 1	
<i>clindamycin phosphate (topical)</i>	Tier 1	
<i>ery</i>	Tier 1	
<i>isotretinoin</i>	Tier 1	PA
<i>sulfacetamide sodium (acne)</i>	Tier 1	
<i>tretinoin</i>	Tier 1	PA; PA applies for members age 35 and older
<i>tretinoin microsphere</i>	Tier 1	PA; PA applies for members age 35 and older
DERMATOLOGY, ACTINIC KERATOSIS		
<i>fluorouracil (topical)</i>	Tier 1	
DERMATOLOGY, ANTIBIOTICS		
<i>silver sulfadiazine</i>	Tier 1	
<i>ssd</i>	Tier 1	
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin</i>	Tier 1	
<i>methoxsalen rapid</i>	Tier 1	
<i>tazarotene</i>	Tier 1	PA
TAZORAC	Tier 2	PA
DERMATOLOGY, ANTISEBORRHEICS		
<i>selenium sulfide</i>	Tier 1	
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>lactic acid (ammonium lactate)</i>	Tier 1	

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Drug Name	Drug Tier	Requirements/Limits
<i>podofilox</i>	Tier 1	
DERMATOLOGY, ROSACEA		
<i>azelaic acid</i>	Tier 1	
FINACEA	Tier 2	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl</i>	Tier 1	
<i>chlorhexidine gluconate (mouth-throat)</i>	Tier 1	
<i>lidocaine hcl (mouth-throat)</i>	Tier 1	
<i>nystatin (mouth-throat)</i>	Tier 1	
<i>oralone dental paste</i>	Tier 1	
<i>periogard</i>	Tier 1	
<i>pilocarpine hcl (oral)</i>	Tier 1	
<i>triamcinolone acetonide (mouth)</i>	Tier 1	
OTIC		
<i>acetic acid (otic)</i>	Tier 1	
<i>ciprofloxacin hcl (otic)</i>	Tier 1	
<i>ciprofloxacin-dexamethasone</i>	Tier 1	
<i>fluocinolone acetonide (otic)</i>	Tier 1	
<i>hydrocortisone w/acetic acid</i>	Tier 1	
<i>neomycin-polymyxin-hc (otic)</i>	Tier 1	
<i>ofloxacin (otic)</i>	Tier 1	

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<i>duloxetine hcl</i>	12	<i>etonogestrel-ethinyl estradiol</i>	17
<i>dutasteride</i>	22	<i>etoposide</i>	8
<i>dutasteride-tamsulosin hcl</i>	22	<i>everolimus (immunosuppressant)</i>	24
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Washington, D.C. 20201
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Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ (Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ አገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtètíléko: Àkíyèsí yìí ní iwífún nípa isẹ adójútòfò rẹ. Ó le ní àwọn déèti pátó o sì le ní láti gbé igbésé ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèé. Àwọn omọ-egbé gbòdò pe nóm̀bà fòdùn tò wà lèyìn kààdì idánimò wòn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò tí tí a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ a ó sì sọ ọ pò mò ògbufò kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsòò-wùdù (Bassa) Tò Dùù Cáo! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúá-tiǐn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ kè dε wa ḿ m̄ kè nyuεε nyu hwè b́é wé b́éa kè zi. Ǿ m̀ò nì kpé b́é m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ ḿεε dyé dé nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàò dεín nyε. Nyò t̀òò séín m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ fò tee b́é wa kέε m̄ gbo ćé b́é m̄ kè nòbà m̀ò 0 kέε dyi pàd̀àn hwè. Ǿ j̀ú kè nyò d̀ò dyi m̄ gǎ j̀úǐn, po wuqu m̄ ḿ poε dyie, kè nyò d̀ò mu bó nìin b́é Ǿ kè nì wuquò mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للأخريين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahu ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아닌 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólóq doo íiyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowól t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náána'á' éí kójjí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį́ áádóo éí bikéé'dóo naasbaqas bił adidiilchil. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'í'ígíí yii diikił dóo ata' halne'é lá níká'ádoowól.