

## Your Prescription Benefit Updates

### Prior Authorization

Prior Authorization requires your doctor to provide more information to see if you can get coverage for your medication.

Therapeutic use	Medication name
<b>Dermatology: Topical Acne Agents (Age &gt;25 only)</b>	<b>TAZORAC CREAM</b> (tazarotene)  <b>TAZORAC GEL</b> (tazarotene)  <b>TAZAROTENE CREAM</b>  <b>FABIOR FOAM</b> (tazarotene)
<b>Anti-infectives: HIV</b>	<b>TRUVADA</b> <sup>1</sup> (emtricitabine-tenofovir)
<b>Central Nervous System: Migraine Agents</b>	<b>D.H.E. 45</b> (dihydroergotamine)  <b>MIGRANAL</b> (dihydroergotamine)
<b>Ophthalmology: Vascular Endothelial Growth Factor (VEGF) Inhibitors</b>	<b>BEOVU</b> (brolucizumab-dbll)  <b>EYLEA</b> (aflibercept)  <b>LUCENTIS</b> (ranibizumab)  <b>MACUGEN</b> (pegaptanib)

## Step Therapy

If you have Step Therapy, you must try a lower-cost medication (Step 1) before a higher-cost medication (Step 2 or 3) is covered.

Therapeutic use	Medication name	Step 1 Medications
<b>Central Nervous System: Antidepressants</b>	<b>FORFIVO XL<sup>1</sup></b> (bupropion ER)	<b>Bupropion ER</b>
<b>Central Nervous System: Atypical Antipsychotics</b>	<b>CAPLYTA</b> (lumateperone)  <b>FANAPT</b> (iloperidone)  <b>FANAPT PACK</b> (iloperidone)  <b>SECUADO<sup>1</sup></b> (asenapine)	<b>Any two of the following generics or preferred brands: quetiapine IR/ER, risperidone, aripiprazole, olanzapine, Saphris.</b>
<b>Central Nervous System: Migraine Agents</b>	<b>TREXIMET<sup>1</sup></b> (sumatriptan-naproxen)  <b>ZOMIG SPRAY</b> (zolmitriptan)  <b>TOSYMRA<sup>1</sup></b> (sumatriptan)	<b>Any two of the following generics: almotriptan, eletriptan, frovatriptan, naratriptan, rizatriptan, sumatriptan, sumatriptan nasal, zolmitriptan.</b>
<b>Dermatology: Topical Acne Agents (Age &lt;25 only)</b>	<b>ADAPALENE LOTION</b>  <b>ADAPALENE PAD</b>  <b>ADAPALENE SOLUTION</b>  <b>AKLIEF</b> (trifarotene)  <b>ALTRENO</b> (tretinoin)  <b>ATRALIN</b> (tretinoin)	<b>Both of the following: generic adapalene and topical tretinoin.</b>

Therapeutic use	Medication name	Step 1 Medications
<b>Dermatology: Topical Acne Agents (Age &lt;25 only)</b>	<b>DIFFERIN CREAM</b> (adapalene)  <b>DIFFERIN GEL</b> (adapalene)  <b>DIFFERIN LOTION</b> (adapalene)  <b>RETIN-A</b> (tretinoin)  <b>RETIN-A MICRO</b> (tretinoin)	<b>Both of the following: generic adapalene and topical tretinoin.</b>
	<b>FABIOR (tazarotene)</b>  <b>TAZORAC GEL (tazarotene)</b>	<b>Generic tazarotene and one of the following: generic adapalene or topical tretinoin.</b>
<b>Dermatology: Topical Rosacea Agents</b>	<b>FINACEA GEL</b> (azelaic acid)	<b>One of the following: generic azelaic acid, Soolantra or Finacea foam.</b>
	<b>METROGEL<sup>1</sup></b> (metronidazole gel)	<b>One of the following: generic metronidazole gel, Soolantra or Finacea foam.</b>
	<b>NORITATE<sup>1</sup></b> (metronidazole cream)	<b>One of the following: Soolantra or Finacea foam.</b>
<b>Diabetes: Test Strips/ Blood Glucose Meters</b>	<b>NON-PREFERRED TEST STRIPS/ BLOOD GLUCOSE METERS<sup>1</sup></b>	<b>Contour Next</b>
<b>Gastrointestinal: Bowel Prep Agents</b>	<b>MOVIPREP<sup>1</sup></b> (PEG-3350/kcl/nacl/na sulfate/na ascorbate-c)  <b>OSMOPREP<sup>1</sup></b> (sod phos mono-sod phos)  <b>PLENVU<sup>1</sup></b> (PEG-3350/kcl/nacl/na sulfate/na ascorbate-c)	<b>Any one of the following preferred brands: Clenpiq, Prepopik, or Suprep</b>

Therapeutic use	Medication name	Step 1 Medications
<b>Miscellaneous: Antigout Agents</b>	<b>COLCRYS<sup>1</sup></b> (colchicine)	<b>Generic colchicine tablets</b>
	<b>COLCHICINE CAPSULES<sup>1</sup></b>	
	<b>GLOPERBA<sup>1</sup></b> (colchicine)	
	<b>MITIGARE<sup>1</sup></b> (colchicine)	
<b>Miscellaneous: MeToo Products</b>	<b>CONSENSI<sup>1</sup></b> (amlodipine-celecoxib)	<b>Both of the following generics: amlodipine and celecoxib</b>
	<b>KATERZIA<sup>1</sup></b> (amlodipine)	<b>Generic amlodipine</b>
	<b>OZOBAX<sup>1</sup></b> (baclofen)	<b>Generic baclofen</b>
	<b>RAYOS<sup>1</sup></b> (prednisone)	<b>Two of the following oral generics: prednisone, prednisolone, methylprednisolone.</b>
	<b>RELAFEN DS<sup>1</sup></b> (nabumetone)	<b>Generic nabumetone</b>
<b>Obstetrics &amp; Gynecology: Hormone Replacement</b>	<b>ALORA</b> (estradiol patch)	<b>Generic estradiol patch</b>
	<b>MENOSTAR</b> (estradiol patch)	
	<b>MINIVELLE</b> (estradiol patch)	
	<b>INTRAROSA</b> (prasterone vaginal insert)	<b>Any two of the following: Premarin vaginal cream, Imvexxy vaginal insert, Osphena tablet.</b>
	<b>FEMRING</b> (estradiol vaginal ring)	<b>Any one of the following: Premarin vaginal cream, Imvexxy vaginal insert, Osphena tablet</b>
<b>Ophthalmology: Prostaglandins:</b>	<b>VYZULTA<sup>1</sup></b> (latanoprostene)	<b>All of the following: latanoprost, travoprost, and Lumigan.</b>
	<b>XELPROS</b> (latanoprost)	

Therapeutic use	Medication name	Step 1 Medications
<b>Respiratory: Long-Acting Bronchodilators</b>	<b>INCRUSE ELLIPTA<sup>1</sup></b> (umeclidinium)  <b>TUDORZA PRESSAIR<sup>1</sup></b> (aclidinium)  <b>SEEBRI NEOHALER<sup>1</sup></b> (glycopyrrolate)	<b>Spiriva</b>
<b>Respiratory: Short-Acting Bronchodilators</b>	<b>ALBUTEROL HFA<sup>1</sup></b> (manufactured by Prasco)  <b>PROAIR DIGIHALER<sup>1</sup></b> (albuterol)  <b>PROAIR HFA<sup>1</sup></b> (albuterol)  <b>PROAIR RESPICLICK<sup>1</sup></b> (albuterol)  <b>PROVENTIL HFA<sup>1</sup></b> (albuterol)  <b>VENTOLIN HFA<sup>1</sup></b> (albuterol)  <b>XOPENEX HFA<sup>1</sup></b> (levalbuterol)  <b>LEVALBUTEROL HFA<sup>1</sup></b>	<b>Generic albuterol HFA</b>

## Quantity Limits

Quantity Limits establish the maximum quantity of a drug that is covered per copay or in a specified timeframe.

Therapeutic use	Medication name	New or revised quantity limit
<b>Cardiology: Hemostatic Agents</b>	<b>BERINERT</b> (C1 esterase inhibitor)	<b>10 vials per 30 days</b>
	<b>FIRAZYR</b> (icatibant)	<b>6 syringes per 30 days</b>
	<b>KALBITOR</b> (ecallantide)	<b>6 vials per 30 days</b>
	<b>RUCONEST</b> (C1 esterase inhibitor)	<b>8 vials per 30 days</b>
<b>Immunology: Biologic Immunomodulators</b>	<b>STELARA</b> (ustekinumab)	<b>1 unit per 56 days</b>
<b>Obstetrics &amp; Gynecology: Ergot Alkaloids</b>	<b>METHERGINE</b> (methylergonovine)	<b>28 tablets per fill, limited to 2 fills per 365 days</b>
<b>Ophthalmology: Prostaglandins</b>	<b>RHOPRESSA</b> (netarsudil)	<b>1 bottle per 25 days</b>

<sup>1</sup> Medication is excluded on the Premium PDL.

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For the most current list of covered medications, or if you have questions:



Call the number on your member ID card.



Visit your plan's website on your member ID card to:

- Find a network retail pharmacy by ZIP code.
- Look up possible lower-cost medications.
- Compare medication pricing.



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Applies to the Premium Formulary