



April 1, 2020

Changes to your prescription drug coverage

There will be changes to the **Aetna Value Plus Plan** drug list that start on **April 1, 2020**. It's important that you review and understand the changes in the chart below. Talk to your health care provider about how these changes might impact you.

What if I need a prescription drug that requires a medical exception?

You or your prescriber can request a medical exception to the changes in this letter. If you would like to ask for a medical exception, speak directly with your prescriber or you can call us at the toll-free number on your Member ID card.

We'll contact you and your prescriber with our decision. If your exception is approved, you only need to pay your plan copay or cost-share. This amount is based on your pharmacy plan design.

How to find a preferred medicine that's right for you

You can visit the website that's on your member ID card and sign in to your account. Your doctor can also request a medical exception if your drug has been removed from the formulary. If you have any questions, you can call us at the toll-free number on your member ID card.

The changes made to the prescription drugs in this chart are based on the plan information we have at the time this letter was sent.

UPPER CASE = brand-name medication

lower case = generic medication

* Changes apply if your plan includes this feature.

Prescription Drug	Change(s)
ACCU-CHEK FASTCLIX LANCET DEVICE KIT	Preferred brand drug
ACCU-CHEK FASTCLIX LANCETS	Preferred brand drug
ACCU-CHEK MULTICLIX LANCET DEVICE KIT	Preferred brand drug
ACCU-CHEK MULTICLIX LANCETS	Preferred brand drug

Prescription Drug	Change(s)
ACCU-CHEK SAFE-T-PRO LANCETS	Preferred brand drug
ACCU-CHEK SAFE-T-PRO PLUS LANCETS	Preferred brand drug
ACCU-CHEK SOFT TOUCH LANCETS	Preferred brand drug
ACCU-CHEK SOFTCLIX LANCET DEVICE KIT	Preferred brand drug
ACCU-CHEK SOFTCLIX LANCETS	Preferred brand drug
acyclovir cream	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
ADDERALL XR	Non-preferred brand drug; Step therapy has been removed
amphetamine / dextroamphetamine cap er	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
BOSULIF	You can fill up to 3/ day*
capecitabine tab 150mg	You can fill up to 4/ day*
capecitabine tab 500mg	You can fill up to 10/ day*
COAGUCHEK LANCETS	Preferred brand drug
codeine sulfate	You can fill up to 6 tabs per day for 7 days
CONCERTA	Step therapy has been removed
CORLANOR	Preferred brand drug; Preauthorization has been removed; Step therapy has been removed; Quantity limits have been removed
CUTAQUIG	Step therapy has been removed
CUVITRU	Step therapy has been removed
cyclobenzaprine 7.5 mg	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
dexchlorpheniramine syrup	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
diclofenac gel 1%	You can fill up to 300gm/ month
DILAUDID	You can fill up to 6 tabs per day for 7 days
DOLOPHINE	You can fill up to 3/ day
EMFLAZA	You can fill up to 1/ day*
EMFLAZA SUSP	You can fill up to 52ml/ month*
ENLITE CONTINUOUS GLUCOSE MONITORING SYSTEM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try DEXCOM*
FARYDAK	You can fill up to 6/ 21 days*
FOSRENOL	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay

Prescription Drug	Change(s)
FREESTYLE LIBRE CONTINUOUS GLUCOSE MONITORING SYSTEM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try DEXCOM*
FULPHILA	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try NEULASTA, UDENYCA*; You can fill up to 2 inj/ month*
GUARDIAN CONNECT CONTINUOUS GLUCOSE MONITORING SYSTEM	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try DEXCOM*
hydromorphone 2 mg	You can fill up to 6 tabs per day for 7 days
HYQVIA	Step therapy has been removed
IMBRUVICA 140 MG CAP	You can fill up to 3/ day*
ketoprofen er	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
lanthanum carbonate	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
methadone 5 mg	You can fill up to 3/ day
methylphenidate hcl er	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
NEULASTA	Preferred specialty drug; Step therapy has been removed; You can fill up to 2 inj/ month*
NEULASTA ONPRO KIT	Preferred specialty drug; Step therapy has been removed; You can fill up to 2 inj/ month*
NICOMIDE	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay
PARADIGM REAL-TIME STARTER KIT	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try DEXCOM*
REVLIMID	You can fill up to 21/ month*
SOF-SENSOR	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try DEXCOM*
SPRYCEL	You can fill up to 1/ day*
TAKHZYRO	You must first try HAEGARDA*
VOLTAREN GEL 1%	You can fill up to 300gm/ month
XELODA TAB 150MG	You can fill up to 4/ day*
XELODA TAB 500MG	You can fill up to 10/ day*
ZONTIVITY	Not covered for plans with Formulary Exclusions. For plans without this program, you will pay the non-preferred copay; You must first try BRILINTA, anagralide, clopidogrel*

Prescription Drug	Change(s)
ZYTIGA	You can fill up to 2/ day*

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and their affiliates (Aetna).

Some health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Each insurer has sole financial responsibility for its own products.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Aetna or its affiliate(s) may receive rebates from drug manufacturers. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. Information is subject to change. The drugs on the Pharmacy Drug Guide (formulary), Formulary Exclusions, Precertification, Quantity Limit and Step Therapy Lists are subject to change. In certain states, including Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Minnesota, North Dakota and Texas, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of stage-four advanced, metastatic cancer.

In accordance with state law, commercial fully insured (including HMO) members in Louisiana and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for medications that are removed from the Pharmacy Drug Guide (formulary) or added to the Precertification, Quantity Limits or Step-Therapy Lists during the plan year will continue to have those medications covered at the same benefit level until their plan's renewal date. Due to system constraints, drugs that are added to the Pharmacy Drug Guide (formulary) or moved to a lower tier during the plan year will also continue to be covered at the same benefit level until the plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In accordance with state law, fully insured commercial California members (except Federal Employee Health Benefit Plan members) who obtained approval from an Aetna plan for coverage of medications that are later added to the Precertification or Step Therapy Lists or removed from the Pharmacy Drug Guide will continue to have those medications covered, for as long as the plan's prescriber continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.

In accordance with state law, fully insured Commercial Connecticut preferred provider organization (PPO) members (except Federal Employee Health Benefit Plan members) who are receiving coverage under the current policy for medications that are later added to the Precertification or Step Therapy Lists will continue to have those medications covered for as long as the plan's prescriber continues prescribing them, provided the prescriber states in writing that the drug is medically necessary and more medically beneficial than other covered drugs. Nothing in this section shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the enrollee, nor shall anything in this section be construed to prohibit generic drug substitutions.

This material is for information only. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Aetna is part of the CVS Health family of companies.

Policy forms issued in Oklahoma include: AL COC00010, HC COC00010.

Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 05, HO HGrpPol 04, AL SG GrpPOLAmend 2019 01, HI SG GrpAgAmend 2019 01.