



Updates to your prescription benefits

Effective upon renewal

Access PDL benefit summary

Dear Valued Customer:

We are pleased to announce our **Access Prescription Drug List (PDL)** pharmacy benefit updates. Our PDL Management Committee carefully reviews and evaluates prescription medications to place them in tiers corresponding to their overall health care value. By managing pharmacy benefits responsibly, we are able to provide integrated pharmacy benefit solutions for our customers and affordable medications for our members. If you have questions regarding the PDL and benefit plan updates listed below, please contact your broker or a UnitedHealthcare representative.

Below is a list of PDL updates effective upon your renewal.

Medication Name	Current Benefit Coverage	New Benefit Coverage
abiraterone 500mg (generic Zytiga)	EAL ¹	Excluded ²
Actonel (Brand only)	3/4	Excluded ²
Afinitor 2.5 mg, 5 mg, 7.5 mg tablet (Brand only)	3/4	Excluded ²
Albuterol Sulfate HFA [Ventolin HFA authorized generic (Prasco)]	3	Excluded ²
Aldactone (brand only)	3/4	Excluded ²
Alkindi Sprinkle	EAL ¹	Excluded ²
Altace (brand only)	3/4	Excluded ²
Amerge (brand only)	3/4	Excluded ²
Amicar (Brand only)	3/4	Excluded ²
Arazlo	EAL ¹	Excluded ²
Aricept 5 mg, 10 mg (brand only)	3	Excluded ²
Arixtra (brand only)	3/4	Excluded ²
Aromasin (Brand only)	3/4	Excluded ²
Arthrotec (brand only)	3	Excluded ²

Medication Name	Current Benefit Coverage	New Benefit Coverage
Atacand (Brand only)	3/4	Excluded ²
Atacand HCT (brand only)	3/4	Excluded ²
Avalide (brand only)	3/4	Excluded ²
Avapro (Brand only)	3/4	Excluded ²
Azeschew Prenatal/Postnatal	EAL ¹	Excluded ²
Berinert	2	3/4
Bethkis (Brand only)	3/4	Excluded ²
Bynfezia Pen	EAL ¹	Excluded ²
Bystolic	2	3/4
Carafate (Brand only)	3/4	Excluded ²
Catapres-TTS (brand only)	3/4	Excluded ²
Conjupri	EAL ¹	Excluded ²
Coreg (brand only)	3/4	Excluded ²
Cozaar (Brand only)	3/4	Excluded ²
Cuprimine (Brand only)	3/4	Excluded ²
cyclobenzaprine 7.5mg (generic Fexmid)	1	Excluded ²
DDAVP injection (brand only)	3/4	Excluded ²
DDAVP tablets (brand only)	3/4	Excluded ²
Desoxyn (brand only)	3/4	Excluded ²
diclofenac 1% gel (generic Voltaren)	1	Excluded ²
diclofenac sodium 1.5% topical solution (generic Pennsaid)	1	Excluded ²
Doral	3	Excluded ²
Elidel (Brand only)	3/4	Excluded ²
Esperoct	EAL ¹	Excluded ²
Estrace (brand only)	3/4	Excluded ²
Estrace vaginal cream (Brand only)	1	Excluded ²
Evoxac (brand only)	3/4	Excluded ²
Eysuvis	EAL ¹	Excluded ²
Fareston (Brand only)	3/4	Excluded ²
Fexmid 7.5mg (cyclobenzaprine)	3/4	Excluded ²
Flector 1.3% patch	3/4	Excluded ²
Forteo	3	Excluded ²
Frova (Brand only)	3/4	Excluded ²
Gastrocrom (brand only)	3/4	Excluded ²
Gimoti	EAL ¹	Excluded ²

Medication Name	Current Benefit Coverage	New Benefit Coverage
Halog 0.1% solution	EAL ¹	Excluded ²
Halog cream (Brand only)	3/4	Excluded ²
Hemady	EAL ¹	Excluded ²
Hepsera (brand only)	3/4	Excluded ²
Horizant	3/4	Excluded ²
Hyzaar (brand only)	3/4	Excluded ²
icosapent ethyl 1g capsule (generic Vascepa)	1	Excluded ²
Impeklo	EAL ¹	Excluded ²
Incruse Ellipta	2	Excluded ²
Inderal XL	3	Excluded ²
Ingrezza	3/4	Excluded ²
Innopran XL	3	Excluded ²
Inspra (brand only)	3/4	Excluded ²
Jadenu (Brand only)	3/4	Excluded ²
Jatenzo	EAL ¹	Excluded ²
Letairis (Brand only)	3/4	Excluded ²
Lexiva (brand only)	3/4	Excluded ²
Loestrin FE 1/20 (brand only)	3/4	Excluded ²
Lotemax 0.5% ophthalmic suspension (brand only)	3/4	Excluded ²
Lotrel (Brand only)	3/4	Excluded ²
Mestinon 60 mg tablet (Brand only)	3/4	Excluded ²
Mestinon Timespan (brand only)	2	Excluded ²
Mycapssa	EAL ¹	Excluded ²
Naprosyn oral suspension (brand only)	3/4	Excluded ²
Naprosyn tablets (brand only)	3/4	Excluded ²
Niacor	1	Excluded ²
Nityr	2	Excluded ²
Norco (Brand only)	3/4	Excluded ²
Nurtec ODT	EAL ¹	Excluded ²
Nyvepria	EAL ¹	Excluded ²
olopatadine 0.2% (generic Pataday)	1	Excluded ²
Ortikos	EAL ¹	Excluded ²
Otrexup	3/4	Excluded ²

Medication Name	Current Benefit Coverage	New Benefit Coverage
Pamelor (brand only)	3/4	Excluded ²
Pataday (olopatadine 0.2%) (brand only)	3/4	Excluded ²
Patanol (Brand only)	3/4	Excluded ²
Paxil (brand only)	3/4	Excluded ²
Paxil CR (Brand only)	3/4	Excluded ²
Pazeo	3/4	Excluded ²
Pennsaid 2% solution	3/4	Excluded ²
Phexxi	EAL ¹	Excluded ²
Praluent	2	Excluded ²
Pred Forte 1% (brand only)	3/4	Excluded ²
Prenara	EAL ¹	Excluded ²
Prenatrix	EAL ¹	Excluded ²
Prevacid Solutab (Brand only)	3/4	Excluded ²
Proair HFA (Brand only)	2	Excluded ²
Proair RespiClick	2	Excluded ²
Procardia XL (brand only)	3/4	Excluded ²
Proglycem (brand only)	3/4	Excluded ²
Proventil HFA (Brand only)	3	Excluded ²
Prudoxin (brand only)	3/4	Excluded ²
Qdolo	EAL ¹	Excluded ²
quazepam (generic Doral)	1	Excluded ²
RediTrex	EAL ¹	Excluded ²
Relafen (Brand only)	EAL ¹	Excluded ²
Revatio suspension (Brand only)	3/4	Excluded ²
Riomet (Brand only)	3/4	Excluded ²
Roxicodone (Brand only)	3/4	Excluded ²
Rozerem (brand only)	3/4	Excluded ²
Rythmol SR (brand only)	3/4	Excluded ²
Seasonique (Brand only)	3/4	Excluded ²
Semglee	EAL ¹	Excluded ²
Sensipar (Brand only)	3/4	Excluded ²
Soma 350 mg tablets (brand only)	3	Excluded ²
Soriatane (brand only)	3/4	Excluded ²
Sprix	3	3/4
Sustiva capsules (Brand only)	3/4	Excluded ²
Syprine (Brand only)	1	Excluded ²

Medication Name	Current Benefit Coverage	New Benefit Coverage
Talicia	EAL ¹	Excluded ²
Tarceva (Brand only)	3/4	Excluded ²
Tazorac 0.05% gel, cream	2	3/4
Tazorac 0.1% gel	2	3/4
Tecfidera	2	Excluded ²
Temodar capsules (Brand only)	3/4	Excluded ²
Transderm Scop (brand only)	3/4	Excluded ²
Travatan Z (Brand only)	3/4	Excluded ²
Trizivir (brand only)	3/4	Excluded ²
True Metrix Blood Glucose Meters	3	Excluded ²
True Metrix Blood Glucose Test Strips	3	Excluded ²
Truetrack Blood Glucose Meters	3	Excluded ²
Truetrack Blood Glucose Test Strips	3	Excluded ²
Truvada 200mg-300mg (Brand only)	3/4	Excluded ²
Twirla	EAL ¹	Excluded ²
Ultram (brand only)	3/4	Excluded ²
Uroxatral (Brand only)	3/4	Excluded ²
Valcyte oral solution (brand only)	3/4	Excluded ²
Varubi	2	Excluded ²
Vascepa 0.5g capsule	2	Excluded ²
Vascepa 1g capsule	2	Excluded ²
Ventolin HFA	2	Excluded ²
Voltaren 1% gel	1	Excluded ²
Xeloda (Brand only)	1	Excluded ²
Zcort 7-day	EAL ¹	Excluded ²
Zerviate 0.24%	EAL ¹	Excluded ²
Zocor (brand only)	3/4	Excluded ²
Zofran tablets (brand only)	3/4	Excluded ²
Zohydro ER (Brand only)	3/4	Excluded ²
Zomig tablets (Brand only)	3/4	Excluded ²
Zomig ZMT (brand only)	3/4	Excluded ²
Zonalon (Brand only)	3/4	Excluded ²
Zortress (Brand only)	3/4	Excluded ²
Zytiga 250mg (Brand only)	1	Excluded ²
Zytiga 500mg	1	Excluded ²

¹ The Exclude at Launch Program (EAL) enables us to immediately exclude upon launch a high-cost medication from benefit coverage, eliminating unnecessary costs for you and allowing appropriate clinical programs to be implemented which minimizes any disruption for your employees. For clients that do not participate in the Exclude at Launch Program, these medications will be placed on the highest tier.

² This medication is excluded for the majority of benefit plans. For customers not participating in exclusions, this medication may be covered in the highest tier.

Access PDL clinical programs benefit summary

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective upon renewal.

N Prior Authorization – Notification

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

Therapeutic Use	Medication Name
Cancer	Zolinza
Diabetes	Adlyxin
Diabetes	Bydureon/Bydureon BCise
Diabetes	Byetta
Diabetes	Ozempic
Diabetes	Rybelsus
Diabetes	Trulicity
Diabetes	Victoza
High cholesterol	Nexlizet
HIV	Fuzeon
Multiple sclerosis	Bafiertam
Multiple sclerosis	Gilenya
Parkinson's disease	Apokyn
Rosacea	Mirvaso
Rosacea	Rhofade
Seizures	Xcopri

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
Hereditary angioedema	Berinert
Hereditary angioedema	Firazyr
Hereditary angioedema	Ruconest
Parkinson's disease	Apokyn
Parkinson's disease	Tasmar (tolcapone)
Seizures	Fintepla
Skin conditions	Halucort

ST Step Therapy

The medications below 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
Bladder pain	Elmiron	amitriptyline
Dermatitis	Extina	Must try one of the following: (1) ciclopirox (generic ciclopirox gel, generic Loprox) (2) ketoconazole shampoo (generic Nizoral)
Diabetes	Invokamet ³	Synjardy/Synjardy XR
Diabetes	Invokamet XR ³	Synjardy/Synjardy XR
Diabetes	Invokana ³	Must try both of the following: (1) metformin (generic Glucophage, Glucophage XR) (2) Jardiance
Hemophilia	Esperoct ³	Must try three of the following: (1) Advate (2) Kogenate FS (3) Kovaltry (4) NovoEight (5) Nuwiq (6) Recombinate
Hereditary angioedema	Berinert	Ruconest
HIV	Descovy	Truvada
Migraines	Nurtec ODT ³	Must try Ubrelvy plus two of the following: almotriptan (Axert), eletriptan (Relpax), frovatriptan (Frova), naratriptan (Amerge), rizatriptan (Maxalt/Maxalt MLT), sumatriptan (Imitrex), zolmitriptan (Zomig)
Migraines	Ubrelvy	Must try two of the following: (1) almotriptan (Axert), (2) eletriptan (Relpax), (3) frovatriptan (Frova), (4) naratriptan (Amerge), (5) rizatriptan (Maxalt/Maxalt MLT), (6) sumatriptan (Imitrex), (7) zolmitriptan (Zomig)
Osteoporosis	Forteo ³	Must try both: (1) Tymlos (2) Teriparatide
Pain	levorphanol tartrate	Must try three of the following: (1) hydromorphone (generic Dilaudid) (2) morphine immediate-release (3) oxycodone (generic Roxicodone) (4) oxymorphone (generic Opana)
Sedative hypnotics	Dayvigo	Must try two of the following: (1) zolpidem (generic Ambien) (2) zaleplon (generic Sonata) (3) eszopiclone (generic Lunesta)
Skin conditions - infections	Veregen	Must try one of the following: (1) imiquimod (generic Aldara) (2) podofilox (generic Condylox)

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
ADHD	Dexedrine 5 mg	310 capsules per month	
ADHD	Dexedrine 10 mg	124 capsules per month	
ADHD	Dexedrine 15 mg	124 capsules per month	
Asthma	Nucala 100 mg/ml autoinjector/syringe	.04 ml per month	
Endocrine	Jynarque 15 mg Therapy Pack	56 tablets per month	
Endocrine	Jynarque 30/15 mg Therapy Pack	56 tablets per month	
Endocrine	tolvaptan 30 mg (generic Samsca) tablets	56 tablets per month	
Hereditary angioedema	Berinert 500 units injectable kit	10 boxes per month	
Hereditary angioedema	Firazyr 30 mg syringe	6 syringes per month	
Hereditary angioedema	Ruconest 2100 unit vials	8 vials per month	
HIV	Temixys 300-300 mg tablet	31 tablets per month	
Infections	Dificid 40 mg/mL	136 mL per 10 days	
Infections	gentamicin sulfate 0.1% cream and ointment	30 mg per copay	
Infections	gentamicin sulfate 0.3% solution	15 mL per copay	
Infections	Nyamyc 100000 unit/gm powder	12 gm per copay	
Infections	nystatin 100000 unit/gm cream and ointment	90 mg per copay	
Infections	Nystop 100000 unit/gm powder	120 mg per copay	
Inflammatory conditions	Dupixent 200 mg/1.4 mL pre-filled syringe		2 syringes per month
Inflammatory conditions	Dupixent 300 mg/2 mL pre-filled syringe		2 syringes per month
Inflammatory conditions	Enbrel 25 mg/0.5 mL	4.65 ml per month	
Inflammatory conditions/ rheumatoid arthritis	Olumiant 1 mg tablets	31 tablets per month	
Migraines	Aimovig 140 mg	1 syringe per month	
Migraines	Nurtec 75 mg ODT		8 tablets per 24 days
Migraines	Reyvow 100 mg tablet		8 tablets per 24 days
Migraines	Ubrelvy 50 mg tablet		8 tablets per 24 days
Migraines	Ubrelvy 100 mg tablet		8 tablets per 24 days
Multiple sclerosis	Gilenya 0.25 mg capsules	31 capsules per month	
Parkinson's disease	Apokyn 10 mg/mL	30 cartridges per month	
Pulmonary hypertension	Tracleer 32 mg tablets	124 tablets per month	
Weight Loss	Saxenda 18mg/3mL (6 mg/mL) ³	15 mL (5 pens)	

³ Typically excluded from coverage. For benefits that do not exclude, step therapy may be required.

Nondiscrimination notice and access to communication services

UnitedHealthcare® and its subsidiaries do not discriminate on the basis of race, color, national origin, age, disability or sex in their health programs or activities.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

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 LU'U 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 معرف 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. لطفاً با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, आपको भाषा सहायता सेवाएं, निःशुल्क 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 xovtooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

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

Díí BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániit'igo, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shq'oodí ninaaltsoos nit'izí bee nééhozinígíí bine'déé' t'áá jíík'ehgo béésh bee hane'í bik'á'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.

Learn more



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



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.

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