ENVISIONINSURANCE

January 1 – December 31, 2020

Evidence of Coverage:

Your Medicare Prescription Drug Coverage as a Member of EnvisionRxPlus Employer Group Retiree PDP Employer Group Retiree PDP

This booklet gives you the details about your Medicare prescription drug coverage from January 1 – December 31, 2020. It explains how to get coverage for the prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, **EnvisionRxPlus Employer Group Retiree PDP**, is offered by Envision Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Envision Insurance Company. When it says "plan" or "our plan," it means **EnvisionRxPlus Employer Group Retiree PDP**.)

This document is available for free in Spanish.

Please contact our Member Services number at 1-833-682-1186 for additional information. (TTY users should call 711.) Hours are 24 hours a day, 7 days a week.

This information is available in large print.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021.

The formulary and pharmacy network may change at any time. You will receive notice when necessary.

S7694_2020 EGWP EOC_C Kansas CE Reviewed 11/7/2019

OMB Approval 0938-1051 (Expires: December 31, 2021)

2020 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member **4**

Explains what it means to be in a Medicare prescription drug plan and how to use this booklet. Tells about materials we will send you, your plan premium, the Part D late enrollment penalty, your plan membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources **20**

Tells you how to get in touch with our plan (**EnvisionRxPlus Employer Group Retiree PDP**) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

Chapter 3. Using the plan's coverage for your Part D prescription drugs **33**

Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's *List of Covered Drugs (Formulary)* to find out which drugs are covered. Tells which kinds of drugs are *not* covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.

Chapter 4. What you pay for your Part D prescription drugs **57**

Tells about the 4 stages of drug coverage (*Deductible Stage (if applicable)*, *Initial Coverage Period*, *Coverage Gap Stage*, *Catastrophic Coverage Stage*) and how these stages affect what you pay for your drugs. Explains the 5 cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.

Chapter 5. Asking us to pay our share of the costs for covered drugs **74**

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered drugs.

Chapter 6. Your rights and responsibilities **81**

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints) **91**

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules and/or extra restrictions on your coverage.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 8. Ending your membership in the plan **117**

Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 9. Legal notices **127**

Includes notices about governing law and about non-discrimination.

Chapter 10. Definitions of important words **135**

Explains key terms used in this booklet.

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction 6
Section 1.1 You are enrolled in **EnvisionRxPlus Employer Group Retiree PDP**, which is a Medicare Prescription Drug Plan 6
Section 1.2 What is the *Evidence of Coverage* booklet about? 6
Section 1.3 Legal information about the *Evidence of Coverage* 6

SECTION 2 What makes you eligible to be a plan member? 7
Section 2.1 Your eligibility requirements 7
Section 2.2 What are Medicare Part A and Medicare Part B? 7
Section 2.3 Here is the plan service area for **EnvisionRxPlus Employer Group Retiree PDP** 7
Section 2.4 U.S. Citizen or Lawful Presence 8

SECTION 3 What other materials will you get from us? 8
Section 3.1 Your plan membership card – Use it to get all covered prescription drugs 8
Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network 9
Section 3.3 The plan's *List of Covered Drugs (Formulary)* 9
Section 3.4 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs 10

SECTION 4 Your monthly premium (if appicable) for EnvisionRxPlus Employer Group Retiree PDP 10
Section 4.1 How much is your plan premium (if applicable)? 10

SECTION 5 Do you have to pay the Part D "late enrollment penalty"? 12
Section 5.1 What is the Part D "late enrollment penalty"? 12
Section 5.2 How much is the Part D late enrollment penalty? 12
Section 5.3 In some situations, you can enroll late and not have to pay the penalty 13
Section 5.4 What can you do if you disagree about your Part D late enrollment penalty? 14

SECTION 6 Do you have to pay an extra Part D amount because of your income? 14
Section 6.1 Who pays an extra Part D amount because of income? 14
Section 6.2 How much is the extra Part D amount? 14
Section 6.3 What can you do if you disagree about paying an extra Part D amount? 15
Section 6.4 What happens if you do not pay the extra Part D amount? 15

SECTION 7 More information about your monthly premium (if applicable) 15
Section 7.1 There are several ways you can pay your plan premium (if applicable) 16
Section 7.2 Can we change your monthly plan premium (if applicable) during the year? 16

SECTION 8 Please keep your plan membership record up to date 16
Section 8.1 How to help make sure that we have accurate information about you 16

SECTION 9 We protect the privacy of your personal health information 17
Section 9.1 We make sure that your health information is protected 17

SECTION 10 How other insurance works with our plan 17
Section 10.1 Which plan pays first when you have other insurance? 17

SECTION 1 Introduction

Section 1.1 You are enrolled in EnvisionRxPlus Employer Group Retiree PDP, which is a Medicare Prescription Drug Plan

You have chosen to get your Medicare prescription drug coverage through our plan, **EnvisionRxPlus Employer Group Retiree PDP**.

There are different types of Medicare plans. **EnvisionRxPlus Employer Group Retiree PDP** is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a member of **EnvisionRxPlus Employer Group Retiree PDP**.

It's important for you to learn what the plan's rules are and what coverage is available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how **EnvisionRxPlus Employer Group Retiree PDP** covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in **EnvisionRxPlus Employer Group Retiree PDP** between January 1, 2020, and December 31, 2020.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of **EnvisionRxPlus Employer Group Retiree PDP** after December 31, 2020. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2020.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve **EnvisionRxPlus Employer Group Retiree PDP** each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have Medicare Part A or Medicare Part B (or you have both Part A and Part B) (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area)

Section 2.2 What are Medicare Part A and Medicare Part B?

As discussed in Section 1.1 above, you have chosen to get your prescription drug coverage (sometimes called Medicare Part D) through our plan. Our plan has contracted with Medicare to provide you with most of these Medicare benefits. We describe the drug coverage you receive under your Medicare Part D coverage in Chapter 3.

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals for inpatient services, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for EnvisionRxPlus Employer Group Retiree PDP

Although Medicare is a Federal program, **EnvisionRxPlus Employer Group Retiree PDP** is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

We offer coverage in all states, Puerto Rico and Guam. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state or territory and into a state or territory that is still within our service area, you must call Member Services in order to update your information.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify **EnvisionRxPlus Employer Group Retiree PDP** if you are not eligible to remain a member on this basis. **EnvisionRxPlus Employer Group Retiree PDP** must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

While you are a member of our plan, you must use your membership card for our plan for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

ENVISIONINSURANCE

RxBIN: 012312
RxPCN: PARTD
RxGRP: <EICXXX>
Issuer: (80840) 9151 014 609
ID: <EICXXXXXXX>
Plan: EnvisionRxPlus
NAME: <VARIABLE>

SAMPLE

S7694/<VARIABLE PBP>

MedicareRx
Prescription Drug Coverage

Submit Paper Claims to:
EnvisionInsurance
2181 East Aurora Rd.
Suite 201
Twinsburg, Ohio 44087

www.envisionrxplus.com

Customer Service:
<VARIABLE>
TTY/TDD: 711
Mail Order Pharmacy:
<Name VARIABLE>
<Address VARIABLE>
<Website VARIABLE>

SAMPLE

Claims administered by:
Rx Options, LLC, a subsidiary of Rite Aid Corporation

Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Member Services

right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

Section 3.2 The *Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. We included a copy of our Pharmacy Directory in the envelope with this booklet. An updated Pharmacy Directory is located on our website at www.EnvisionRxPlus.com. You may also call Member Services for updated pharmacy information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network**.

The *Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies for some drugs.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.EnvisionRxPlus.com.

Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by **EnvisionRxPlus Employer Group Retiree PDP**. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the **EnvisionRxPlus Employer Group Retiree PDP** Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs. In addition to the Drug List, your Employer Group *may* provide coverage for some additional drugs as a supplemental benefit. If so, you will receive a Supplemental Formulary addendum from us.

We will provide you a copy of the Drug List and your Group's Supplemental Formulary addendum (if applicable). The Drug List we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.EnvisionRxPlus.com) or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 3.4 The *Part D Explanation of Benefits* (the "Part D EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the "Part D EOB").

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

You can also get your *Explanation of Benefits* on our website at www.envisionrxplus.com. To access this information online, go to www.envisionrxplus.com and click "sign in" in the top right corner (if you have not yet registered, you will need to click "register now" and follow the registration steps to proceed).

SECTION 4 Your monthly premium for EnvisionRxPlus Employer Group Retiree PDP

Section 4.1 How much is your plan premium?

Your coverage is provided through a contract with your current employer or former employer or union. Your current employer or former employer or union may pay monthly premiums to the plan. You may be required to contribute a portion or all of the premium amount. If so, this amount may be collected by your employer (or former employer or union). If we collect any portion of the premium directly from you, you will receive an invoice. Please contact the employer's or union's Benefits Administrator for information about your plan premium.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, the **information about premiums in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.

- If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.
- If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.
- If you have a late enrollment penalty but have had creditable coverage through your employer or Group as a retiree or working aged, please contact your Benefit Administrator for proof of coverage. Upon submission of creditable coverage documentation to the plan your Late Enrollment Penalty will be either be reduced or eliminated.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in **EnvisionRxPlus Employer Group Retiree PDP**, we let you know the amount of the penalty.

Your Part D late enrollment penalty is considered part of your plan premium. If your employer (or former employer or union) pays your monthly premiums, they may bill you for the late enrollment penalty.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2020, this average premium amount is $32.74.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $32.74, which equals $4.58. This rounds to $4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2020* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you **will** be disenrolled from the plan and lose prescription drug coverage

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B.

If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit https://www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2020* gives information about the Medicare premiums in the section called "2020 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2020* from the Medicare website

(https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 7.1 There are several ways you can pay your plan premium

This section is applicable if you pay your group premium directly and the group does not pay it on your behalf.

Section 7.2 Can we change your monthly plan premium during the year?

No. Please note that your employer (or former employer or union) may pay monthly premiums to the plan on your behalf. You may be required to contribute a portion of the premium. If so, this amount may be collected by your employer (or former employer or union). If you are to pay EnvisionRxPlus directly for your payment, we will send you an invoice.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

- If your designated responsible party (such as a caregiver) changes

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 **EnvisionRxPlus Employer Group Retiree PDP contacts** (how to contact us, including how to reach Member Services at the plan) **21**

SECTION 2 **Medicare** (how to get help and information directly from the Federal Medicare program) **24**

SECTION 3 **State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare) **25**

SECTION 4 **Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare) **25**

SECTION 5 **Social Security** **25**

SECTION 6 **Medicaid** (a joint Federal and state program that helps with medical costs for some people with limited income and resources) **27**

SECTION 7 **Information about programs to help people pay for their prescription drugs** **28**

SECTION 8 **How to contact the Railroad Retirement Board** **31**

SECTION 9 **Do you have "group insurance" or other health insurance from an employer?** **31**

SECTION 1 EnvisionRxPlus Employer Group Retiree PDP contacts
(how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to **EnvisionRxPlus Employer Group Retiree PDP** Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-833-682-1186 Calls to this number are free. Member Services, including TTY/TDD, is open 24 hours a day, 7 days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The TTY/TDD is available 24 hours a day, 7 days a week.
FAX	1-866-250-5178
WRITE	**EnvisionRxPlus Employer Group Retiree PDP** 2181 E. Aurora Rd, Suite 201 Twinsburg, OH 44087 customerservice@EnvisionRxPlus Employer Group Retiree PDP.com
WEBSITE	www.EnvisionRxPlus.com

How to contact us when you are asking for a coverage decision about your Part D prescription drugs, or when you are making an appeal or complaint about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions, Appeals and Complaints for Part D Prescription Drugs – Contact Information
CALL	1-833-682-1186 Calls to this number are free. Hours are 24 hours a day, 7 days a week.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are 24 hours a day, 7 days a week.
FAX	1-877-503-7231
WRITE	**EnvisionRxPlus Employer Group Retiree PDP** 2181 E. Aurora Rd., Suite 201 Twinsburg, OH 44087
WEBSITE	www.EnvisionRxPlus.com
MEDICARE WEBSITE	You can submit a complaint about **EnvisionRxPlus Employer Group Retiree PDP** directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of the costs for covered drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests – Contact Information
CALL	1-833-682-1186. Member Services is open 24 hours a day, 7 days a week. Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. The TTY/TDD is available 24 hours a day, 7 days a week.
FAX	1-866-250-5178
WRITE	**EnvisionRxPlus Employer Group Retiree PDP** 2181 E. Aurora Rd, Suite 201 Twinsburg, OH 44087 customerservice@EnvisionRxPlus Employer Group Retiree PDP.com
WEBSITE	www.EnvisionRxPlus.com

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Prescription Drug Plans, including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	https://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

Method	Medicare – Contact Information
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about **EnvisionRxPlus Employer Group Retiree PDP**: • **Tell Medicare about your complaint:** You can submit a complaint about **EnvisionRxPlus Employer Group Retiree PDP** directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. You can find the name of your state SHIP in Appendix A at the end of this document.

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. You can find the name of your state's Quality Improvement Organization in Appendix B at the end of this document.

A Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. A Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization if you have a complaint about the quality of care you have received. For example, you can contact the Quality Improvement Organization if you were given the wrong medication or if you were given medications that interact in a negative way.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am ET to 7:00 pm, Monday through Friday.
WEBSITE	https://www.ssa.gov/

SECTION 6 Medicaid
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
    - **Qualified Individual (QI):** Helps pay Part B premiums.
    - **Qualified Disabled & Working Individuals (QDWI)**: Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact your state's Medicaid agency listed at the end of this document in Appendix C.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments *or* coinsurance. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- For assistance obtaining evidence of your proper cost-sharing level, please contact Member Services. We may be able to help you identify the documentation you need. Once you have obtained the proper evidence, you may mail or fax the documentation to our Member Services department for processing. The documentation that you send must include an effective date for the current plan year.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

There are programs in Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about their rules (phone numbers are in Section 6 of this chapter). Or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit https://www.medicare.gov for more information.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving "Extra Help." For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?
What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance You can find the name

of your state ADAP in Appendix F at the end of this document. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. You can find the name of your state ADAP in Appendix F at the end of this document.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your state ADAP in Appendix F at the end of this document.

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

You can find out if your state has a State Pharmaceutical Assistance Program by looking in Appendix D at the end of this document.

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	https://secure.rrb.gov/

SECTION 9 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

CHAPTER 3

Using the plan's coverage for your Part D prescription drugs

Chapter 3. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction 35
Section 1.1 This chapter describes your coverage for Part D drugs 35
Section 1.2 Basic rules for the plan's Part D drug coverage 35

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service 36
Section 2.1 To have your prescription covered, use a network pharmacy 36
Section 2.2 Finding network pharmacies 36
Section 2.3 Using the plan's mail-order services 37
Section 2.4 How can you get a long-term supply of drugs? 38
Section 2.5 When can you use a pharmacy that is not in the plan's network? 39

SECTION 3 Your drugs need to be on the plan's "Drug List" 39
Section 3.1 The "Drug List" tells which Part D drugs are covered 39
Section 3.2 There are 5 "cost-sharing tiers" for drugs on the Drug List 40
Section 3.3 How can you find out if a specific drug is on the Drug List? 41

SECTION 4 There are restrictions on coverage for some drugs 41
Section 4.1 Why do some drugs have restrictions? 41
Section 4.2 What kinds of restrictions? 42
Section 4.3 Do any of these restrictions apply to your drugs? 42

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered? 43
Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered 43
Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way? 43
Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high? 46

SECTION 6 What if your coverage changes for one of your drugs? 46
Section 6.1 The Drug List can change during the year 46
Section 6.2 What happens if coverage changes for a drug you are taking? 47

SECTION 7 What types of drugs are *not* covered by the plan? 49
Section 7.1 Types of drugs we do not cover 49

SECTION 8 Show your plan membership card when you fill a prescription 50
Section 8.1 Show your membership card.....50
Section 8.2 What if you don't have your membership card with you?.....50

SECTION 9 Part D drug coverage in special situations 50
Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?.....50
Section 9.2 What if you're a resident in a long-term care (LTC) facility?.....51
Section 9.3 What if you are taking drugs covered by Original Medicare?.....51
Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?.....52
Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?.....52
Section 9.6 What if you are in Medicare-certified Hospice?.....53

SECTION 10 Programs on drug safety and managing medications 53
Section 10.1 Programs to help members use drugs safely.....53
Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications.....54
Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications.....54

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) Your Part D prescription drugs are covered under our plan.

Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If

not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.EnvisionRxPlus.com), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use

the *Pharmacy Directory*. You can also find information on our website at www.EnvisionRxPlus.com

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. The infusion drugs may be covered under Medicare Part D.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services. Prescriptions for formulary drugs are available up to 31 days in these types of pharmacies depending upon the dispensing increments of each LTC facility.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. Please contact Member Services to ensure your pharmacy is contracted.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

Our plan's mail-order service allows you to order **at least a 31-day supply of the drug and no more than a 90-day supply if your benefit plan covers a 90-day benefit.**

To get order forms and information about filling your prescriptions by mail please call Member Services at 1-844-293-4760. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your mail-order is delayed, you may be able to receive a temporary supply at your local pharmacy. Please contact Member Services at 1-844-293-4760, 24 hours a day, 7 days a week for more information.

New prescriptions the pharmacy receives directly from your doctor's office. After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 31 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling 1-866-909-5170 (TTY/TDD 711) to confirm your current contact information. The mail order operation hours are Monday – Friday 8:00am to 10:00pm EST and Saturday 8:30am to 4:30pm EST. Remember, your drugs will not be automatically shipped unless you confirm you still want to receive the order.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please call 1-866-909-51701 (TTY/TDD 711) to confirm your current contact information. The mail order operation hours are Monday – Friday 8:00am to 10:00pm EST and Saturday 8:30am to 4:30pm EST. Remember, your drugs will not be automatically shipped unless you confirm you still want to receive the order.

Section 2.4 How can you get a long-term supply of drugs?

1. If your plan allows you to obtain a long-term supply of drugs (i.e. up to 90 days), your cost sharing may be lower. "Maintenance drugs" are the type of drugs that can be obtained for a long term-supply. You are able to order your supply through the mail order service or perhaps from a retail pharmacy. All retail pharmacies do not provide a prescription for a long-term supply. See Section 2.3 on how to use the mail order service.

2. If you are uncertain if your plan allows for a long-term supply, please contact Member Services.

Section 2.5 When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If there are no participating pharmacies near you, we will cover prescriptions filled at an out-of-network pharmacy in the event of an emergency as determined by the plan. We will cover up to a 31-day supply only

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are 5 "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 drugs are preferred generic drugs and are the lowest cost-sharing tier.
- Tier 2 drugs are higher cost generic drugs.
- Tier 3 drugs are preferred brand drugs and includes some generic drugs.
- Tier 4 drugs are non-preferred brand drugs and non-preferred generic drugs, and are the highest cost-sharing tier.
- Tier 5 drugs are specialty drugs.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

Note: If your Group offers coverage of Non-Part D drugs this will be outlined in a Supplemental Formulary. These drugs are excluded from the above cost-sharing tiers and also from any out-of-pocket costs.

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have 3 ways to find out:

1. Check the most recent Drug List we sent you in the mail. (Please note: The Drug List we provide includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it.)
2. Visit the plan's website (www.EnvisionRxPlus.com). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or

form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **In most cases, a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called "**prior authorization**." Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**step therapy**."

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (www.EnvisionRxPlus.com).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 7, Section 5.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug**.** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts each covered drug into one of 5 different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- The drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year:**

  We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of 31 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 31 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply situation.

- For members who are outside their transition period, and experience a change in the level of care when changing from one treatment setting to another (example: long-term care facility to hospital, hospital to long-term care facility, hospital to home, home to long-term care facility, hospice to long-term care facility, hospice to home):

  We will allow an early refill for a 31-day supply of medication in the retail setting and up to a 31-day supply in the long-term care setting for formulary medications and an emergency transition fill for non-formulary medications (including those medications that

are on formulary but require prior authorization, step therapy, or are subject to quantity limit restrictions).

This does not apply for short-term leaves of absences (i.e. holidays or vacations) from LTC or hospital facilities.

If you are outside of your 90-day transition period, we will still provide an emergency 31-day supply in the retail setting or up to a 31-day supply in the long-term care setting of Part D covered non-formulary medications (including Part D covered drugs that are on our formulary that would otherwise require prior authorization, step therapy, or quantity limit restrictions), on a case by case basis, while an exception is being processed.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions. If your employer group offers any Non-Part D supplemental benefit, there are no exceptions allowed for any Non-Part D drugs that are offered through your employer group's supplemental benefit.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can ask for an exception before next year, and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs of our Specialty Tier (Tier 5) are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.

- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)

- We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.
- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug
- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**

  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List.

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs. However, they may still be covered by your employer under your plan, **EnvisionRxPlus Employer Group Retiree PDP.**

If some Medicare excluded drugs are covered by your plan, you must pay the defined cost-share for these medications. If they are not covered by your plan, you must pay for them yourself if you choose to fill them. . We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 7, Section 5.5 in this booklet.)

NOTE: Certain drugs listed in this section as "excluded" may be covered by your employer under EnvisionRxPlus Employer Group Retiree PDP. If applicable, refer to your plan's Supplemental Formulary for more information.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by Original Medicare?

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If

you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 8, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care (LTC) facility?

Usually, a long-term care facility (LTC) (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first **90 days** of your membership. The total supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 7, Section 5.4 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in **EnvisionRxPlus Employer Group Retiree PDP** doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled in this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through **EnvisionRxPlus Employer Group Retiree PDP** in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or **EnvisionRxPlus Employer Group Retiree PDP** for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medigap insurance company and ask for another copy.

Section 9.5 What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.6 What if you are in Medicare-certified Hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D. Chapter 4 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy
- Requiring you to get all your prescriptions for opioid benzodiazepine medications from one doctor
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 7 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and

over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

CHAPTER 4

What you pay for your Part D prescription drugs

Chapter 4. What you pay for your Part D prescription drugs

SECTION 1 Introduction 59

Section 1.1 Use this chapter together with other materials that explain your drug coverage 59

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs 60

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug 60

Section 2.1 What are the drug payment stages for EnvisionRxPlus Employer Group Retiree PDP members? 60

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in 61

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB") 61

Section 3.2 Help us keep our information about your drug payments up to date 62

SECTION 4 During the Deductible Stage (if applicable), you pay the full cost of your drugs 63

Section 4.1 You stay in the Deductible Stage until you have paid the deductible amount (if applicable) for your drugs 63

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share 64

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription 64

Section 5.2 Your costs for a *one-month* supply of a drug 65

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply 65

Section 5.4 Your costs for a *long-term* 90-day supply of a drug 66

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,020 66

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 25% of the costs for generic drugs 67

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $6,350 67

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs 67

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs 70

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year 70

SECTION 8 Additional benefits information 70

Section 8.1 Our plan offers additional benefits 70

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them 70

Section 9.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine 70

Section 9.2 You may want to call us at Member Services before you get a vaccination . 72

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the "LIS Rider." (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 3, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered by your group benefit plan if your employer has opted to provide any supplemental drug coverage. If applicable, please review the Supplemental Formulary you received.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the 5 "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.EnvisionRxPlus.com. The Drug List on the website is always the most current.

- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The **"deductible"** (if applicable) is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for EnvisionRxPlus Employer Group Retiree PDP members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under **EnvisionRxPlus Employer Group Retiree PDP**. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
This stage may not apply to you. Refer to your Plan Benefit Design Sheet to see if your **EnvisionRxPlus Employer Group Retiree PDP** has a deductible. If you have a deductible, you begin in this payment stage when you fill your first prescription of the year. During this stage, **you pay the full cost** of your drugs. You stay in this stage until you have paid your deductible amount. (Details are in Section 4 of this chapter.)	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** After you (or others on your behalf) have met your deductible, the plan pays its share of the costs of your drugs and you pay your share. You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $4,020. (Details are in Section 5 of this chapter.)	This stage may not apply to you. Refer to your Plan Benefit Design Sheet to see if your **EnvisionRxPlus Employer Group Retiree PDP** has a coverage gap. During this stage, you pay 25% of the price for brand name drugs **(**plus a portion of the dispensing fee) and 25% of the price for generic drugs. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $6,350 This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2020). (Details are in Section 7 of this chapter.)

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "Part D Explanation of Benefits" (the "Part D EOB")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next.

In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

  Note: Non-Part D drugs provided as a supplemental benefit by your employer group DO NOT count towards your out-of-pocket costs and will not be reflected on your EOB.

Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.

  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet). We can also provide your EOB electronically through the envisionrxplus.com member portal. This is a secure place on our website where you can find customized information like this document (if you sign up to receive it electronically), as well as search for in-network pharmacies, find drug costs, make premium payments and find details about your benefits and coverage. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage (if applicable), you pay the full cost of your drugs

Section 4.1 You stay in the Deductible Stage until you have paid the deductible amount (if applicable) for your drugs

This section may not apply to you because of your plan's participation in EnvisionRxPlus Employer Group Retiree PDP. Refer to your Plan Benefit Design Sheet for more information.

The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount, if applicable.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid your deductible (if applicable) for your drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has 5 Cost-Sharing Tiers

Every drug on the plan's Drug List is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 drugs are preferred generic drugs and are the lowest cost-sharing tier.
- Tier 2 drugs are higher cost generic drugs.
- Tier 3 drugs are preferred brand drugs and includes some generic drugs.
- Tier 4 drugs are non-preferred brand drugs and non-preferred generic drugs, and are the highest cost-sharing tier.
- Tier 5 drugs are specialty drugs.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy.
- A pharmacy that is not in the plan's network.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's *Pharmacy Directory.*

Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies.

Section 5.2 Your costs for a *one-month* supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

Refer to your Plan Benefit Design Sheet for cost-sharing information on a one-month supply of a drug.

The amount of the copayment or coinsurance depends on which tier your drug is in. Please note:

- If your covered drug costs less than a copayment amount, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 3, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is $31. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4 Your costs for a *long-term* 90-day supply of a drug

Refer to your Plan Benefit Design Sheet for cost-sharing information on a 90-day supply of a drug (if applicable to your plan benefit).

If your plan benefit permits, you may be able to get a long-term supply (also called an "extended supply") for some drugs when you fill your prescription. A long-term supply is a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 3, Section 2.4.)

- Please note: If your covered drug costs less than a *copayment amount*, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,020

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,020 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What <u>you</u> have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - If applicable to your employer group plan, the amount you paid when you were in the Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the <u>plan</u> has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2020, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $4,020 limit in a year.

We will let you know if you reach this $4,020 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 25% of the costs for generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $6,350

Your Employer Group Plan may provide additional coverage during the Coverage Gap Stage. Refer to the Benefit Plan Sheet.

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 25% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2020, that amount is $6,350.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $6,350, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments are included in your out-of-pocket costs

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 3 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (if applicable)
  - The Initial Coverage Stage
  - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $6,350 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium ***(if applicable to your group plan)***.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Part D Explanation of Benefits* (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $6,350 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $6,350 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- Your cost share may remain the same as the amounts you paid during the Initial Coverage Stage.
- **Or, your share** of the cost for a covered drug may be the *larger* amount of:
  - – *either* – Coinsurance of 5% of the cost of the drug
  - –*or* – $3.60 for a generic drug or a drug that is treated like a generic and $8.95 for all other drugs.
- **The plan pays the rest** of the cost.
- **Check your Summary of Benefits or your Annual Notice of Changes for the specific amounts you pay during the Catastrophic Coverage Stage.**

SECTION 8 Additional benefits information

Section 8.1 Our plan offers additional benefits

No additional benefits are offered under this plan.

SECTION 9 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 9.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.

- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
   - Other vaccines are considered medical benefits. They are covered under Original Medicare.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking us to pay our share of the costs for covered drugs*).

- You will be reimbursed the amount you paid less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your coinsurance *or* copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Section 9.2 You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 5

Asking us to pay our share of the costs for covered drugs

Chapter 5. Asking us to pay our share of the costs for covered drugs

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs 75

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment 75

SECTION 2 How to ask us to pay you back 76

Section 2.1 How and where to send us your request for payment 76

SECTION 3 We will consider your request for payment and say yes or no 77

Section 3.1 We check to see whether we should cover the drug and how much we owe 77

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal 77

SECTION 4 Other situations in which you should save your receipts and send copies to us 78

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs 78

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back. All of these examples are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 3, Section 2.5 to learn more.)

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or look up your enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

To ensure that the claims are applied to your annual out-of-pocket expenses appropriately, please submit your request for reimbursement with your receipt(s) that is normally attached to the bag and shows the National Drug Code no later than 3 months from the date the prescription was processed by the pharmacy. Requests received outside of this timeframe (but must be within the last 3 years) will be handled on a case-by-case basis per Medicare guidance but will require management approval prior to processing. In most cases, your reimbursement will be based on the network pharmacy rate not the cash price you paid at the pharmacy. If you fill a prescription at an out-of-network pharmacy, you may be responsible for the difference in cost between what you paid and the network pharmacy rate.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.

- Either download a copy of the form from our website (www.EnvisionRxPlus.com) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Mail your request for payment together with any receipts to us at this address:

EnvisionRxPlus Employer Group Retiree PDP
Attn: Direct Member Reimbursement
2181 E. Aurora Rd., Suite 201
Twinsburg, OH 44087

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage and Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible Stage and Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

SECTION 1 Our plan must honor your rights as a member of the plan 82

Section 1.1 We must provide information in a way that works for you (in Spanish and large print) 82

Section 1.2 We must ensure that you get timely access to your covered drugs 83

Section 1.3 We must protect the privacy of your personal health information 83

Section 1.4 We must give you information about the plan, its network of pharmacies, and your covered drugs 84

Section 1.5 We must support your right to make decisions about your care 85

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made 86

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected? 87

Section 1.8 How to get more information about your rights 87

SECTION 2 You have some responsibilities as a member of the plan 88

Section 2.1 What are your responsibilities? 88

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (in Spanish and large print)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact civilrights@envisionrx.com.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with 1-844-293-4760. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact our Member Services for additional information.

Sección 1.1 Debemos proveer información de una manera que funcione para usted (en español, en letra grande)

Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan tiene personas y servicios de intérpretes gratuitos disponibles para responder preguntas de miembros discapacitados y que no hablan inglés. También podemos brindarle información en Braille, en letra grande o en español sin costo alguno si la necesita. Estamos obligados a darle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros y solicite un supervisor (los números de teléfono están impresos en la contraportada de este folleto) o envíe un mensaje de correo electrónico a civilrights@envisionrx.com.

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja ante nosotros al 1-844-293-4760. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina de Derechos Civiles. La información de contacto está incluida en esta Evidencia de cobertura o con este envío por correo, o puede comunicarse con nuestro Servicio para los miembros para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered drugs

As a member of our plan, you have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7, Section 7 of this booklet tells what you can do. (If we have denied coverage for your prescription drugs and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

In order to release information we require a written request from the member or their Power of Attorney or Legal Representative.

Section 1.4 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of **EnvisionRxPlus Employer Group Retiree PDP**, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the pharmacy directory.
  - For more detailed information about our pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at www.envisionrxplus.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters,

together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
  - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
  - If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.5 We must support your right to make decisions about your care

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the appropriate state-specific agency as listed in Appendix E.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
  - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.
- **If you have any other prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and pharmacist that you are enrolled in our plan.** Show your plan membership card whenever you get your Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - If applicable, you must pay your plan premiums to continue being a member of our plan.

  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your Part D prescription drugs.
  - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND 93

SECTION 1 Introduction 93
Section 1.1 What to do if you have a problem or concern 93
Section 1.2 What about the legal terms? 93

SECTION 2 You can get help from government organizations that are not connected with us 94
Section 2.1 Where to get more information and personalized assistance 94

SECTION 3 To deal with your problem, which process should you use? 94
Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? 94

COVERAGE DECISIONS AND APPEALS 95

SECTION 4 A guide to the basics of coverage decisions and appeals 95
Section 4.1 Asking for coverage decisions and making appeals: the big picture 95
Section 4.2 How to get help when you are asking for a coverage decision or making an appeal 96

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal 97
Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug 97
Section 5.2 What is an exception? 99
Section 5.3 Important things to know about asking for exceptions 101
Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception 101
Section 5.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan) 105
Section 5.6 Step-by-step: How to make a Level 2 Appeal 107

SECTION 6 Taking your appeal to Level 3 and beyond 110
Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals 110

MAKING COMPLAINTS 111

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns 111

Section 7.1 What kinds of problems are handled by the complaint process? 111

Section 7.2 The formal name for "making a complaint" is "filing a grievance" 113

Section 7.3 Step-by-step: Making a complaint 114

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization 115

Section 7.5 You can also tell Medicare about your complaint 115

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Appendix A of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (https://www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 7** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other prescriber can make a request for you.** For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at

www.envisionrxplus.com.).) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 3 (*Using our plan's coverage for your Part D prescription drugs*) and Chapter 4 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 5.2** of this chapter
Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to **Section 5.4** of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 5.4** of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.5** of this chapter.

Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 4. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 3).

Legal Terms
Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of 5 cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms
Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
  - If the drug you're taking is a biological product you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.

  - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
  - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in our Specialty Drug Tier (Tier 5).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 5.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a

"fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called *How to contact us when you are asking for a coverage decision about your Part D prescription drugs, or when you are making an appeal or complaint about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called *Where to send a request that asks us to pay for our share of the cost for a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 5 of this booklet: *Asking us to pay our share of the costs for covered drugs.* Chapter 5 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 5.2 and 5.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **We also accept requests through our secure member portal at https://envision.promptpa.com or through our website at www.envisionrxplus.com**. Go to our Coverage Determination policy section and click on On-line Coverage Determination to submit your request on our website.

If your health requires it, ask us to give you a "fast coverage decision"

Legal Terms
A "fast coverage decision" is called an **"expedited coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you

an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
    - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
    - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a coverage decision made by our plan)

Legal Terms
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called *How to contact us when you are making an appeal about your Part D prescription drugs, or when you are making an appeal or complaint about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** *How to contact us when you are making an appeal about your Part D prescription drugs, or when you are making an appeal or complaint about your Part D prescription drugs.*
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **We also accept requests through our website at www.envisionrxplus.com.** Go to our Coverage Determination policy section and click on On-line Coverage Determination to submit your request on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

Legal Terms
A "fast appeal" is also called an **"expedited redetermination."**

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition

requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.

  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review**

Organization reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested**
- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 7 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Have you been kept waiting too long by pharmacists? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone or when getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a pharmacy?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**

Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-844-293-4760, TTY/TDD 711, 24 hours a day, 7 days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- Grievances can be filed orally by calling 1-844-293-4760 (TTY/TDD users should call 711) or in writing to EnvisionRxPlus, 2181 E. Aurora Rd., Suite 201, Twinsburg, OH 44087, Attn: Grievances. We are available 24 hours a day, 7 days a week. The grievance must be filed no later than 60 days after the incident that caused your grievance. Once **EnvisionRxPlus** receives your grievance, it will be resolved as quickly as possible, but no later than 30 days. The 30 day timeframe may be extended up to 14 days if you request the extension or if **EnvisionRxPlus** requires additional information and the delay is in your best interest. You can file an expedited grievance if your grievance is due to **EnvisionRxPlus's** refusal to grant your request for an expedited coverage determination or expedited redetermination. When filing this type of grievance, state that it is an expedited grievance and it will be responded to within 24 hours.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint**. If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar day's total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 7.5 You can also tell Medicare about your complaint

You can submit a complaint about **EnvisionRxPlus Employer Group Retiree PDP** directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction 118
Section 1.1 This chapter focuses on ending your membership in our plan 118

SECTION 2 When can you end your membership in our plan? 118
Section 2.1 Usually, you can end your membership during the Annual Enrollment Period 118
Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period 119
Section 2.3 Where can you get more information about when you can end your membership? 121

SECTION 3 How do you end your membership in our plan? 121
Section 3.1 Usually, you end your membership by enrolling in another plan 121

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan 123
Section 4.1 Until your membership ends, you are still a member of our plan 123

SECTION 5 EnvisionRxPlus Employer Group Retiree PDP must end your membership in the plan in certain situations 123
Section 5.1 When must we end your membership in the plan? 123
Section 5.2 We cannot ask you to leave our plan for any reason related to your health 124
Section 5.3 You have the right to make a complaint if we end your membership in our plan 125

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in **EnvisionRxPlus Employer Group Retiree PDP** may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.

- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare health plans, you will be disenrolled from **EnvisionRxPlus Employer Group Retiree PDP** when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep **EnvisionRxPlus Employer Group Retiree PDP** for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or drop Medicare prescription drug coverage.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of **EnvisionRxPlus Employer Group Retiree PDP** may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (https://www.medicare.gov):

- If you have moved out of your plan's service area.
- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are printed on the back cover of this booklet).

  If you're in a drug management program, you may not be able to change plans. Chapter 3, Section 10 tells you more about drug management programs.

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare prescription drug plan.
  - Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.
  - – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare health plans, you will automatically be disenrolled from **EnvisionRxPlus Employer Group Retiree PDP** when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep **EnvisionRxPlus Employer Group Retiree PDP** for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.3 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2020*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, there are two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep

EnvisionRxPlus Employer Group Retiree PDP for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. You will automatically be disenrolled from **EnvisionRxPlus Employer Group Retiree PDP** when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan by December 7. With most Medicare health plans, you will automatically be disenrolled from **EnvisionRxPlus Employer Group Retiree PDP** when your new plan's coverage begins. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send a written request to **your Group Benefit Administrator or Human Resources** or contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users should call 1-877-486-2048).

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan. **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 1, Section 5 for more information about the late enrollment penalty.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave **EnvisionRxPlus Employer Group Retiree PDP**, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

SECTION 5 EnvisionRxPlus Employer Group Retiree PDP must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

EnvisionRxPlus Employer Group Retiree PDP must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A or Part B (or both).
- If you move out of our service area.

- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get prescription drugs. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 60 consecutive days.
  - We must notify you in writing that you have 60 consecutive days (2 calendar months) to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

EnvisionRxPlus Employer Group Retiree PDP is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you file a grievance or can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law 128

SECTION 2 Notice about non-discrimination 128

SECTION 3 Notice about Medicare Secondary Payer subrogation rights 128

SECTION 4 Notice about third-party liability 129

SECTION 5 Notice of Privacy Practice 129

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare prescription drug plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare prescription drugs for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, **EnvisionRxPlus Employer Group Retiree PDP**, as a Medicare prescription drug plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about third-party liability

Right of Subrogation

You explicitly acknowledge **EnvisionRxPlus'** Right of Subrogation. When **EnvisionRxPlus** provides prescription drug benefits for injuries or illnesses for which another party is or may be responsible, **EnvisionRxPlus** shall be subrogated to your rights of recovery against any party to the extent of the full cost of all benefits provided by **EnvisionRxPlus** and may proceed against any party with or without your consent. This means that if prescription drug benefits are provided to you by **EnvisionRxPlus** for injuries or illness for which another party is or may be responsible, then **EnvisionRxPlus** reserves the right to obtain reimbursement from such other party for the full cost of all prescription drug benefits provided by **EnvisionRxPlus** on your behalf that are associated with the injury or illness.

Right of Reimbursement

You explicitly acknowledge **EnvisionRxPlus**' Right of Reimbursement. This means that if prescription drug benefits are provided to you by **EnvisionRxPlus** for injuries or illness for which another party is or may be responsible and you and/or your representative has recovered any amounts from another party or any party making payments on the party's behalf, then **EnvisionRxPlus** is hereby granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by **EnvisionRxPlus**. This Right of Reimbursement is cumulative with and not exclusive of **EnvisionRxPlus**' Right of Subrogation, and **EnvisionRxPlus** may choose to exercise either or both rights of recovery.

Cooperation with EnvisionRxPlus

You and your legal representatives agree to fully cooperate with **EnvisionRxPlus** in its efforts to recover the cost of all benefits provided by **EnvisionRxPlus** that is the responsibility of another party. It is your duty to notify **EnvisionRxPlus** within thirty (30) days of the date you provide notice to any party, including an insurance company or an attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation for your injury or illness. You and your agents or representatives agree to provide **EnvisionRxPlus** all information requested by **EnvisionRxPlus**. You agree to do nothing to prejudice **EnvisionRxPlus**'s Right of Reimbursement or Subrogation or its ability to enforce the terms of this section.

SECTION 5 Notice of Privacy Practice

This Notice of Privacy Practices applies to Envision Insurance Company's Medicare Part D Prescription Drug Plans. **EnvisionRxPlus** is a PDP with a Medicare contract. Enrollment in **EnvisionRxPlus** depends on contract renewal.

Para recibir esta notificación en español por favor llamar al número gratuito de Servicios a Miembros a 1-866-250-2005 (Los usuarios de TTY/TDD deben llamar al 711). El horario es 24 horas del día, 7 días a la semana.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how we may use and disclose information about you in administering your benefits, and it explains your legal rights regarding the information. When we use the term personal health information, we mean information that identifies you as an individual, such as your name, date of birth, or Social Security number and relates to your medical history, the health care you receive, or payment for health care services.

How EnvisionRxPlus Uses and Discloses Personal Information.

In order to provide you with insurance coverage, we need personal information about you, and we obtain that information from many different sources, including Medicare. In administering your pharmacy benefits, we may use and disclose your personal information in various ways, including:

Treatment. We may use and disclose your personal health information to doctors, dentists, pharmacies, hospitals and health care providers in furtherance of your care. For example, we may disclose information to the pharmacies where you receive covered medications.

Payment. We may use and disclose your personal health information to manage your pharmacy benefits, such as collecting premiums and calculating cost-sharing amounts. For example, we may use your health information to pay the pharmacies that fill your prescriptions.

Operations. We may use and disclose your personal health information to assess and improve quality, license and accredit companies, measure service performance and assess outcomes, determine formulary compliance, provide care management, and respond to complaints and appeals. For example, we may use the information to provide medication therapy management programs for members with specific medical conditions, such as diabetes. We may use and disclose information for the administration of reinsurance, underwriting and rating, detection and investigation of fraud, waste, and abuse, administration of pharmaceutical services and payments, and other general administrative activities. We may use your information, with the exception of genetic information, for underwriting purposes.

To Others Involved in Your Health Care. We may disclose your personal health information to a relative, a close friend, or any other person involved in your care, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling Member Services toll-free at 1-866-250-2005 (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week.

Business Associates. We enter into contracts with third parties known as business associates. These business associates provide services to us or perform functions on our behalf, *e.g.*, accountants, consultants and attorneys. We may disclose your health information to our business

associates once they have agreed in writing to safeguard your health information. Business associates are also required by law to secure and protect the privacy of your health information.

Special Circumstances. We may use or disclose your personal health information without your authorization in the following circumstances: for any purpose when required by law; for public health activities; to certain government authorities if we reasonably believe you are a victim of abuse, neglect or domestic violence; for health oversight activities; to avert a serious threat to your health and safety or the health and safety of the public or another person; for investigations or civil proceedings; if required by a court or administrative tribunal or in response to a subpoena, discovery request or other lawful process under certain circumstances; to law enforcement in limited circumstances; to coroners, medical examiners, and funeral directors or to organizations that handle organ and tissue donation or transplantation consistent with law; for certain specially-approved research projects; for specialized government functions (such as military, national security or intelligence activities or to correctional institutions); for disaster relief efforts; or to workers' compensation agencies if necessary to make a benefit determination.

Uses and Disclosures Requiring Your Written Authorization.

In all situations other than those described above, we will ask for your written authorization before using or disclosing your personal health information. For example, we will seek your authorization for (i) most uses or disclosures of psychotherapy notes (ii) uses or disclosures of your personal health information for marketing purposes (iii) disclosures of your personal health information that constitute the sale of your health information. If you have given us an authorization, you may revoke it at any time, if we have not already acted on it.

Your Legal Rights.

Federal regulations concerning the privacy and security of personal health information give you the right to make certain requests regarding your personal health information. By law, you have the right to:

- **See and get a copy of your personal health information held by EnvisionRxPlus**. If we maintain an electronic health record containing your personal health information, you have the right to ask to get the information in an electronic format. If we are not able to provide your personal health information in the electronic format you request, we will provide it in a mutually agreed upon electronic format. You may ask us to send a copy of your information to other individuals or entities that you designate. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed.
- **Request an amendment of your information**. If you feel that the personal health information we maintain about you is incomplete or incorrect, you may request that we amend it. You must include a reason that supports your request. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it.
- **Get a list of those who received your personal health information from EnvisionRxPlus**. Except for certain disclosures, you have a right to receive a list of the disclosures we have made of your personal health information in the six years prior to the date of your request.

The list will not include disclosures of your personal health information to you or your personal representative or for treatment, payment or operations reasons.

- **Ask EnvisionRxPlus to communicate confidential information with you in a different manner or at a different place** (for example, you may ask us to send materials to a P.O. Box instead of your home address).
- **Ask EnvisionRxPlus to restrict or limit how we use or disclose your personal health information**. You have the right to request restrictions on our use or disclosure of your information. We are not required to agree to the restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, is not otherwise required by law, and the information pertains solely to a health care item or service for which you, or a person on your behalf, has paid in full.
- **Receive a notice of a breach of certain health information**. We are required to notify you of any breach that involves your unsecure personal health information.
- **Get a separate paper copy of this notice**. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

You may make any of the requests described above, or may request a paper copy of this notice, by calling Member Services toll-free at 1-866-250-2005 (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week.

How to File a Complaint.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address: **EnvisionRxPlus**, 8957 Canyon Falls Blvd., Twinsburg, OH 44087, Attn: Privacy Officer. You also may write to the U.S. Department of Health and Human Services, Office for Civil Rights, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint and your benefits under the Plan will not be adversely affected by doing so.

Legal Obligations of EnvisionInsurance.

Federal privacy regulations require us to keep your personal health information private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect. Please note that we do not destroy your personal health information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

EnvisionInsurance complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

State Privacy Laws. Some state privacy laws may give you greater protection than those described in this notice. Depending on the state in which you live, there may be additional laws regarding the use and disclosure of health information such as that related to genetics,

HIV/AIDS, mental health, sexually transmitted diseases, and substance abuse. For more information, please contact the **EnvisionInsurance** Privacy Officer:

EnvisionInsurance

8957 Canyon Falls Blvd.

Twinsburg, OH 44087

Attn: Privacy Officer

This Notice is Subject to Change.

This notice is being provided to you herein and is also posted on our website. We may change the terms of this notice and our privacy policies at any time. If we do change the terms of this notice, the revised notice will be available upon request and posted to our website. The new terms will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

If you have questions regarding this notice, please contact Member Services toll-free at 1-866-250-2005 (TTY/TDD users should call 711). Hours are 24 hours a day, 7 days a week. Please include your name, phone number, and fax number.

The original version of this notice went into effect on September 10, 2009. The effective date of this notice is August 9, 2018.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Advance Directive – A legal document that controls critical decisions about your health care. You also have the right to give instructions for health care providers to follow if you become unable to direct your own care, an Advance Directive can be used in these circumstances.

Another Party - Any individual or entity, other than **EnvisionRxPlus**, that is liable or legally responsible to pay expenses, compensation or damages in connection with a beneficiary's injuries or illnesses. Another Party shall include the party or parties who caused the injuries or illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a beneficiary's own insurer, such as uninsured, underinsured, pharmacy payments, no-fault, homeowner's, renter's, or any other liability insurer; a workers' compensation insurer; a pharmacy malpractice or similar fund; and any other person, corporation, or entity that is liable or legally responsible for payment in connection with the injuries or illness.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $6,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $4,020.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 3, Section 3 for more information about a medically accepted indication.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the

plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their

Medicare and Medicaid benefits through the plan. PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a late enrollment penalty.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Recovery - Any and all money, fund, property, compensation, as well as all rights thereto, or damages paid or available to the beneficiary's by Another Party through insurance payments, settlement proceeds, first or third party payments or settlement proceeds, judgments, reimbursements or otherwise (no matter how those monies may be characterized, designated, or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness.

Reimbursement / **Reimburse -** Repayment to **EnvisionRxPlus** for pharmacy or other benefits paid or payable toward care and treatment of the illness or injury and for any other expenses incurred by **EnvisionRxPlus** in connection with benefits paid or payable.

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you permanently move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Standard Cost-sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Subrogation / Subrogate - EnvisionRxPlus's right to pursue the beneficiary's claims against Another Party for pharmacy or other charges paid by **EnvisionRxPlus**.

Appendix A - State Health Insurance Assistance Programs

Alabama	**Alaska**	**Arizona**	**Arkansas**
Alabama Dept. of Senior Services 201 Monroe St., Ste. 350 Montgomery, AL 36104 **Phone:** (800) 243-5463 **TTY:** (800) 243-5463	Medicare Information Office 400 Gambell St. Anchorage, AK 99501 **Phone:** (800) 478-6065 **TTY:** (800) 770-8973	Arizona State Health Insurance Assistance Program (SHIP) 1789 W. Jefferson St. #950a Phoenix, AZ 85007 **Phone:** (800) 432-4040 **TTY:** 711	Senior Health Insurance Information Program (SHIIP) 1200 W 3rd St. Little Rock, AR 72201 **Phone:** (800) 224-6330 **TTY:** (501) 683-4468
California	**Colorado**	**Connecticut**	**Delaware**
Health Insurance Counseling and Advocacy Program (HICAP) 1300 National Dr., Ste. 200 Sacramento, CA 95834 **Phone:** (800) 434-0222 **TDD:** (800) 735-2929	Senior Health Insurance Assistance Program (SHIP) 1560 Broadway Ste. 850 Denver, CO 80202 **Phone:** (888) 696-7213 **TTY:** (303) 894-7880	CHOICES 55 Farmington Ave., 10th Floor Hartford, CT 05 **Phone:** (800) 994-9422 **TTY:** (800) 842-4524	ELDERinfo 841 Silverlake Blvd. Dover, DE 19904 **Phone:** (800) 336-9500
Florida	**Georgia**	**Guam**	**Hawaii**
Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way Ste. 270 Tallahassee, FL 32399 **Phone:** (800) 963-5337 **TTY:** (800) 955-8770	GeorgiaCares 2 Peachtree St., NW 33rd Floor Atlanta, GA 30303 **Phone:** (866) 552-4464 **TTY:** (404) 657-1929	Guam Medicare Assistance Program (Guam MAP) 130 University Dr., Ste. 8 University Castle Mall, Mangiloa, Guam 96913 **Phone:** (671) 735-7011 or (671) 735-7382 **TTY:** (671) 735-7415	Sage PLUS 250 South Hotel St. Ste. 406 Honolulu, HI 96813 **Phone:** (888) 875-9229 **TTY:** (866) 810-4379
Idaho	**Illinois**	**Indiana**	**Iowa**
Senior Health Insurance Benefits Advisors (SHIBA) 700 West State St., 3rd Floor P.O. Box 83720 Boise, ID 83720 **Phone:** (800) 247-4422	Senior Health Insurance Program (SHIP) One Natural Resources Way, #100 Springfield, IL 62702 **Phone:** (800) 252-8966 **TTY:** (888) 206-1327	State Health Insurance Assistance Program (SHIP) 311 W. Washington St. Ste. 300 Indianapolis, IN 46204 **Phone:** (800) 452-4800 **TDD:** (866) 846-0139	Senior Health Insurance Information Program (SHIIP) 601 Locust St., 4th Floor Des Moines, IA 50309 **Phone:** (800) 351-4664 **TTY:** (800) 735-2942

Kansas	**Kentucky**	**Louisiana**	**Maine**
Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Ave. New England Bldg. Topeka, KS 66603 **Phone:** (800) 860-5260	State Health Insurance Assistance Program (SHIP) 275 E. Main St. Frankfort, KY 40621 **Phone:** (877) 293-7447	Senior Health Insurance Information Program (SHIIP) PO Box 94214 1702 N. 3rd St. P.O. Box 94214 Baton Rouge, LA 70802 **Phone:** (800) 259-5300	Maine State Health Insurance Assistance Program (SHIP) SHS 11 Augusta, ME 04333 **Phone:** (877) 353-3771 **TTY:** 711
Maryland	**Massachusetts**	**Michigan**	**Minnesota**
Senior Health Insurance Assistance Program (SHIP) 301 West Preston St. Room 1007 Baltimore, MD 21201 **Phone:** (800) 243-3425 **TTY:** 711	Serving Health Information Needs of Elders (SHINE) 1 Ashburton Place, 5th Floor Boston, MA 02108 **Phone:** (800) 243-4636 **TTY:** 711	MMAP, Inc. 6105 W St. Joseph Hwy, Ste. 204 Lansing, MI 48917 **Phone:** (800) 803-7174	Minnesota State Health Insurance Assistance Program Senior LinkAge Line PO Box 64976 Saint Paul, MN 55164 **Phone:** (800) 333-2433
Mississippi	**Missouri**	**Montana**	**Nebraska**
MS Dept. of Human Services-Division of Aging & Adult Services 750 N. State St. Jackson, MS 39202 **Phone:** (800) 948-3090	CLAIM 200 N. Keene St. Ste. 101 Columbia, MO 65201 **Phone:** (800) 390-3330	Montana State Health Insurance Assistance Program (SHIP) 2030 11th Ave. Helena, MT 59601 **Phone:** (800) 551-3191	Nebraska Senior Health Insurance Information Program (SHIIP) 941 O St., Ste. 400 Lincoln, NE 68508 **Phone:** (800) 234-7119 **TTY:** (800) 833-7352
Nevada	**New Hampshire**	**New Jersey**	**New Mexico**
State Health Insurance Advisory Program (SHIP) 3416 Goni Rd., Ste. D-132 Carson City, NV 89706 **Phone:** (800) 307-4444	NH SHIP - ServiceLink & Disability Resource Center 129 Pleasant St. Gallen State Office Park Concord, NH 03301 **Phone:** (866) 634-9412	State Health Insurance Assistance Program (SHIP) Division of Aging Services P.O. Box 715 Mercerville, NJ 08625 **Phone:** (800) 792-8820	Benefits Counseling Program 2550 Cerrillos Rd. Santa Fe, NM 87505 **Phone:** (800) 432-2080

New York Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza New York City, NY 12223 **Phone:** (800) 701-0501	**North Carolina** Seniors' Health Insurance Information Program (SHIIP) 11 South Boylan Ave. Raleigh, NC 27603 **Phone:** (855) 408-1212 **TTY:** 711	**North Dakota** Senior Health Insurance Counseling (SHIC) 600 East Blvd. Bismarck, ND 58505 **Phone:** (888) 575-6611 **TTY:** (800) 366-6888	**Ohio** Ohio Senior Health Insurance Information Program (OSHIIP) 50 West Town St., 3rd Floor Ste. 300 Columbus, OH 43215 **Phone:** (800) 686-1578
Oklahoma Senior Health Insurance Counseling Program (SHIP) Five Corporate Plaza 3625 NW 56th St., Ste. 100 Oklahoma City, OK 73112 **Phone:** (800) 763-2828	**Oregon** Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480 Salem, OR 97309 **Phone:** (800) 722-4134	**Pennsylvania** APPRISE 555 Walnut St. 5th Floor Harrisburg, PA 17101 **Phone:** (800) 783-7067	**Puerto Rico** State Health Insurance Assistance Program (SHIP) P.O. Box 191179 San Juan, PR 00919 **Phone:** (877) 725-4300
Rhode Island Senior Health Insurance Program (SHIP) 74 West Rd., 2nd Floor Cranston, RI 02920 **Phone:** (401) 462-3000 **TTY:** (401) 462-0740	**South Carolina** (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais St. Ste. 350 Columbia, SC 29201 **Phone:** (800) 868-9095	**South Dakota** Senior Health Information & Insurance Education (SHIINE) 700 Governors Dr. Pierre, SD 57501 **Phone:** Eastern (800) 536-8197, Central (877) 331-4834, Western (877) 286-9072	**Tennessee** Tennessee SHIP 502 Deaderick St., 9th Floor Nashville, TN 37243 **Phone:** (877) 801-0044 **TTY:** (615) 532-3893
Texas Texas Dept. of Aging & Disability Services 701 West 51st St. Austin, TX 78751 **Phone:** (800) 252-9240 **TTY:** (800) 735-2989	**Utah** Senior Health Insurance Information Program (SHIP) 195 North 1950 West Salt Lake City, UT 84116 **Phone:** (800) 541-7735	**Vermont** State Health Insurance Assistance Program (SHIP) 481 Summer St. Suite 101 St. Johnsbury, VT 05819 **Phone:** (800) 642-5119	**Virginia** Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest Ave. , Ste. 100 Henrico, VA 23229 **Phone:** (800) 552-3402 **TTY:** 711
Washington Statewide Health Insurance Benefits Advisors (SHIBA) PO Box 40256 Olympia, WA 98504 **Phone:** (800) 562-6900 **TTY:** (360) 586-0241	**Washington D.C.** Health Insurance Counseling Project (HICP) 650 20th St., NW Washington, DC 20052 **Phone:** ((202) 739-0668 **TTY:** (202) 994-6656	**West Virginia** West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha Blvd. Charleston, WV 25305 **Phone:** (877) 987-4463	**Wisconsin** Wisconsin SHIP (SHIP) One West Wilson St. Madison, WI 53703 **Phone:** (800) 242-1060 **TTY:** (888) 701-1251

Wyoming
Wyoming State Health
Insurance Information
Program (WSHIIP)
106 W. Adams
Riverton, WY 82501
Phone: (800) 856-4398

Appendix B - Quality Improvement Organizations

States: CT, ME, MA, NH, RI, VT		
Address	Toll-free Number	Fax Number
KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-319-8452	833-868-4055

States: NJ, NY, PR		
Address	Toll-free Number	Fax Number
Livanta BFCC-QIQ Program 9090 Junction Dr, Suite 10 Suite 900 Annapolis Junction, MD 20701	866-815-5440	833-868-4056

States: DE, D.C., MD, PA, VA, WV		
Address	Toll-free Number	Fax Number
Livanta BFCC-QIQ Program 9090 Junction Dr, Suite 10 Suite 900 Annapolis Junction, MD 20701	888-396-4646	833-868-4057

States: AL, FL, GA, KY, MS, NC, SC, TN		
Address	Toll-free Number	Fax Number
KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	888-317-0751	833-868-4058

States: IL, IN, MI, MN, OH, WI		
Address	Toll-free Number	Fax Number
Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	888-524-9900	833-868-4059

States: AR, LA, NM, OK, TX		
Address	Toll-free Number	Fax Number
KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609	888-315-0636	833-868-4060

States: IA, KS, MO, NE		
Address	Toll-free Number	Fax Number
Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	888-755-5580	833-868-4061

States: CO, MT, ND, SD, UT, WY		
Address	Toll-free Number	Fax Number
KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-317-0891	833-868-4062

States: AZ, CA, HI, NV, Pacific Islands		
Address	Toll-free Number	Fax Number
Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701	877-588-1123	833-868-4063

States: AK, ID, OR, WA		
Address	Toll-free Number	Fax Number
KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131	888-305-6759	833-868-4064

Appendix C - State Medicaid Agencies

Alabama	**Alaska**	**Arizona**	**Arkansas**
Medicaid Agency of Alabama 501 Dexter Ave. Montgomery, AL 36104 **Phone:** (800) 362-1504	Alaska Dept. of Health and Social Services 350 Main St. Rm. 103 Juneau, AK 99811 **Phone:** (907) 465-3347	AHCCCS 801 E. Jefferson St. MD 4100 Phoenix, AZ 85034 **Phone:** (800) 523-0231	Dept. of Human Services of Arkansas Donaghey Plaza South P O Box 1437, Slot s401 Little Rock, AR 72203 **Phone:** (800) 482-5431 **Spanish:** (800) 482-8988

California	**Colorado**	**Connecticut**	**Delaware**
California Dept. of Health Services P O Box 997413 Sacramento, CA 95899 **Phone:** (916) 552-9200	Health First Colorado 1570 Grant St. Denver, CO 80203 **Phone:** (800) 221-3943	Dept. of Social Services of Connecticut 25 Sigourney St. Hartford, CT 06106 **Phone:** (800) 842-1508 **TTY/TDD:** (800) 842-4524)	Delaware Health and Social Services 1901 N. DuPont Highway PO Box 906, Lewis Bldg. New Castle, DE 19720 **Phone:** (800) 372-2022
Florida	**Georgia**	**Hawaii**	**Idaho**
Agency for Health Care Administration of Florida 1317 Winewood Blvd. Bldg. 1, Room 202 Tallahassee, FL 32399 **Phone:** (888) 419-3456 **TDD:** 1-800-955-8771	Georgia Dept. of Community Health 2 Peachtree St., N.W. Atlanta, GA 30303 **Phone:** (877-423-4746)	Dept. of Human Services of Hawaii 801 Dillingham Blvd. 3rd Floor Honolulu, HI 96817 **Phone:** (808) 586-5390 **TTY:** (800) 603-1201 **Spanish:** (800) 316-8005	Idaho Dept. of Health and Welfare 450 W. State St., 10th Floor P.O. Box 83720 Boise, ID 83720 **Phone:** (877) 456-1233
Illinois	**Indiana**	**Iowa**	**Kansas**
Illinois Dept. of Healthcare and Family Services 100 South Grand Ave. East Springfield, IL 62762 **Phone:** (866) 468-7543 **TTY:** (877) 204-1012	Family and Social Services Administration of Indiana 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207 **Phone:** (800) 457-4584	Dept. of Human Services of Iowa 100 Army Post Rd. Des Moines, IA 50315 **Phone:** (800) 338-8366	Kansas Medical Assistance Program P.O. Box 3571 Topeka, KS 66601 **Phone:** (800) 766-9012
Kentucky	**Louisiana**	**Maine**	**Maryland**
Cabinet for Health Services of Kentucky 275 East Main St. Frankfort, KY 40621 **Phone:** (800) 635-2570	Louisiana Dept. of Health 628 N. 4th St Baton Rouge, LA 70821 Mailing: P.O. Box 91278 Baton Rouge, LA 70821 **Phone:** (888) 342-6207	Maine Dept. of Health and Human Services 11 State House Station 242 State St. Augusta, ME 04333 **Phone:** (800) 977-6740 **TTY:** 711	Dept. of Health and Mental Hygiene 201 W. Preston St. Baltimore, MD 21201 **Phone:** (410) 767-1594
Massachusetts	**Michigan**	**Minnesota**	**Mississippi**
Office of Health and Human Services of Massachusetts 55 Summer St. Boston, MA 02110 **Phone:** (800) 841-2900 **TTY:** (800) 497-4648	Michigan Dept. of Health & Human Services 333 S. Grand Ave P.O. Box 30195 Lansing MI 48909 **Phone:** (517) 373-3740 **TTY:** 711	Dept. of Human Services of Minnesota P.O. Box 64838 St. Paul, MN 55155 **Phone:** (800) 657-3739	Mississippi Division of Medicaid 550 High St., Ste. 1000 Jackson, MS 39202 **Phone:** (800) 421 2408

Missouri	**Montana**	**Nebraska**	**Nevada**
Dept. of Social Services of Missouri 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102 **Phone:** (573) 751-3425	MT Dept. of Public Health & Human Services 1400 Broadway Cogswell Bldg. Helena, MT 59620 **Phone:** (800) 362-8312	Nebraska Dept. of Health and Human Services P.O. Box 95026 Lincoln, NE 68509 **Phone:** (800) 254-4202	Nevada Dept. of Health and Human Services Division of Welfare and Supportive Services 3330 E. Flamingo Rd #55 Las Vegas, NV 89121 **Phone:** (877) 543-7669
New Hampshire	**New Jersey**	**New Mexico**	**New York**
New Hampshire Dept. of Health and Human Services 129 Pleasant St. Concord, NH 03301 **Phone:** (800) 852-3345 **TDD:** (800) 735-2964	Dept. of Human Services of New Jersey Quakerbridge Plaza Bldg. 7 P.O. Box 712 Trenton, NJ 08619 **Phone:** (800) 356-1561	Dept. of Human Services of New Mexico P.O. Box 2348 Sante Fe, NM 87504 **Phone:** (888) 997-2583	NY State Dept. of Health Office of Medicare Management 800 N Pearl Street Albany, NY 12204 **Phone:** (800) 541-2831
North Carolina	**North Dakota**	**Ohio**	**Oklahoma**
North Carolina Dept. of Health and Human Services 2501 Mail Service Center Raleigh, NC 27699 **Phone:** (800) 662-7030	Dept. of Human Services of North Dakota - Medical Services 600 E. Blvd. Ave. Dept. 325 Bismarck, ND 58505 **Phone:** (800) 755-2604 **TTY:** 711	Dept. of Medicaid 50 West Town St., Ste. 400 Columbus, OH 43215 **Phone:** (800) 324-8680	Health Care Authority of Oklahoma 4345 N. Lincoln Blvd. Oklahoma City, NE 73105 **Phone:** (800) 987-7767
Oregon	**Pennsylvania**	**Puerto Rico**	**Rhode Island**
Oregon Health Plan 500 Summer St., N.E. Salem, OR 97301 **Phone:** (800) 699-9075	Dept. of Human Services of Pennsylvania P.O. Box 2675 Harrisburg, PA 17105 **Phone:** (800) 692-7462 **TDD:** (800) 451-5886	Medicaid Office of Puerto Rico and Virgin Islands P.O. Box 70184 San Juan, Puerto Rico 93681 **Phone:** (787) 765-2929	Dept. of Human Services of Rhode Island Louis Pasteur Bldg, 57 Howard Ave. Cranston, RI 02921 **Phone:** (401) 462-5300
South Carolina	**South Dakota**	**Tennessee**	**Texas**
South Carolina Dept. of Health and Human Services P.O. Box 8206 Columbia, SC 29202 **Phone:** (888) 549-0820 **TDD:** (888) 842-3620	Dept. of Social Services of South Dakota 700 Governors Dr. Richard F Kneip Bldg. Pierre, SD 57501 **Phone:** (800) 597-1603	TennCare 310 Great Circle Rd. Nashville, TN 37243 **Phone:** (855) 259-0701 **TTY:** (877) 779-3103 **Spanish:** (866) 311-4290	Health and Human Services Commission of Texas 4900 N Lamar Blvd. Austin, TX 78751 **Phone:** (877) 541-7905 **TTY:** (512) 407-3250

Utah	**Vermont**	**Virginia**	**Washington**
Utah Dept. of Health 288 North 1460 West Salt Lake City, UT 84114 **Phone:** (800) 662-9651	Agency of Human Services of Vermont 280 State Dr. Waterbury, VT 05671 **Phone:** (800) 250-8427 **TTY:** 711	Dept. of Medical Assistance Services 600 E. Broad St. Ste. 1300 Richmond, VA 23219 **Phone:** (804) 786-7933 **TDD:** (800) 343-0634	Dept. of Social and Health Services of Washington Cherry St. Plaza 626 8th Ave. SE Olympia, WA 98501 **Phone:** (800) 865-7801
Washington D.C.	**West Virginia**	**Wisconsin**	**Wyoming**
Dept. of Health – District of Columbia 899 N Capitol Street NE Washington, DC 20002 **Phone:** (202) 442-5955	West Virginia Dept. of Health & Human Resources 350 Capitol St. Charleston, WV 25301 **Phone:** (304) 558-1700	Wisconsin Dept. of Health Services 1 West Wilson St. Madison, WI 3 **Phone:** (800) 362-3002 **TTY: 711**	Wyoming Dept. of Health 2300 Capital Ave, Suite 401 Hathaway Bldg Cheyenne, WY 82002 **Phone:** (866) 571-0944

Appendix D - State Pharmacy Assistance Programs

Colorado	**Connecticut**	**Delaware**	**Idaho**
Colorado Bridging the Gap 4300 Cherry Creek Dr. South Denver, CO 80246 **Phone:** (303) 692-2783 or (303) 692-2716	Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE) PO Box 5011 Hartford, CT 06102 **Phone:** (800) 423-5026 or (800) 269-2029	Delaware Prescription Assistance Program (PDAP) PO Box 950. New Castle, DE 19720 **Phone:** ((800) 996-9969, EXT: 2	Idaho AIDS Drug Assistance Program (IDAGAP) Dept. of Health & Welfare PO Box 83720 Boise, ID 83720 **Phone:** (208) 334-5943 or (800) 926-2588
Indiana	**Maine**	**Maryland**	**Maryland (cont)**
Hoosier Rx 402 W. Washington St., Room W374, MS07 Indianapolis, IN 4 **Phone:** (866) 267-4679 (317) 234-1381	Low Cost Drugs for the Elderly and Disabled Program 242 State St. Augusta, ME 04333 **Phone:** (866) 796-2463 **TTY:** (800) 606-0215	Maryland Senior Prescription Drug Assistance Program c/o Pool Administrators 628 Hebron Ave., Ste. 100 Glastonbury, CT 06033 **Phone:** (800) 551-5995	Maryland Kidney Disease Program 201 W. Preston St., Room SS-3 Baltimore, MD 21201 **Phone:** (800) 767-5000 or (410) 226-2142

Maryland (cont)	**Massachusetts**	**Missouri**	**Montana**
Primary Adult Care Program (PAC) P.O. Box 386 Baltimore, MD 21203 **Phone:** (800) 226-2142	Massachusetts Prescription Advantage PO Box 15153 Worcester, MA 01615 **Phone:** (800) 243-4636 EXT: 2	Missouri Rx Plan PO Box 6500 Jefferson City, MO 65102 **Phone:** (800) 375-1406	Big Sky Rx Program PO Box 202915 Helena, MT 59620 **Phone:** (866) 369-1233 or (406) 444-1233
Nevada	**New Jersey**	**New Jersey (cont)**	**New Jersey (cont)**
Nevada Senior Rx Department of Health and Human Services 3416 Goni Rd. Ste. D-132 Carson City, NV 89706 **Phone:** (866) 303-6323 or (775) 687-4210	Senior Gold Prescription Discount Program PO Box 715 Trenton, NJ 08625 **Phone:** (800) 792-9745	Pharmaceutical Assistance to the Aged and Disabled Program (PAAD). Dept. of Human Services P.O. Box 715 Trenton, NJ 08625 **Phone:** (800) 792-9745	Division of Medical Assistance and Health Ser. PO Box 712 Trenton, NJ 08625 **Phone:** (800) 356-1561
New York	**North Carolina**	**Pennsylvania**	**Pennsylvania (cont)**
Elderly Pharmaceutical Insurance Coverage (EPIC) PO Box 15018 Albany, NY 12212 **Phone:** (800) 332-3742	North Carolina HIV SPAP 1902 Mail Service Center Raleigh, NC 27699 **Phone:** (877) 466-2232 or (919) 733-7301	Pharmaceutical Assistance Contract for the Elderly (PACE) PACE/PACENET Program P.O. Box 8806 Harrisburg, PA 17105 **Phone:** (800) 225-7223 or (717) 651-3600	PACE Needs Enhancement Tier (PACENET) PACENET Program P.O. Box 8806 Harrisburg, PA 17105 **Phone:** (800) 225-7223 or (717) 651-3600
Pennsylvania (cont)	**Pennsylvania (cont)**	**Rhode Island**	**Texas**
Special Pharmaceutical Benefits Program- HIV/AIDS P.O. Box 8808 Harrisburg, PA 17105 **Phone:** (800) 922-9384	Special Pharmaceutical Benefits Program- Mental Health SPBPMH P.O. Box 8808 Harrisburg, PA 17105 **Phone:** (800) 433-4459	Rhode Island Prescription Assistance for the Elderly (RIPAE) ATTN: RIPAE Hazard Bldg., 2nd Floor 74 West Rd. Cranston, RI 02920 **Phone:** (401) 462-3000 or (401) 462-0740	Kidney Health Care Program (KHC) Dept of State Health Services, MC 1938 P.O. Box 149347 Austin, TX 78714 **Phone:** (800) 222-3986 or (512) 776-7150

Vermont	**Virginia**	**Washington**	**Wisconsin**
V-Pharm 312 Hurricane Ln. Ste. 201 Williston, VT 05495 **Phone:** (800) 250-8427	Virginia HIV SPAP HCS Unit, 1st Floor James Madison Bldg. 109 Governor St. Richmond, VA 23219 **Phone:** (855) 362-0658	Washington State Health Insurance Pool PO Box 1090 Great Bend, KS 67530 **Phone:** (800) 877-5187	SeniorCare P.O. Box 6710 Madison, WI 53716 **Phone:** (800) 657-2038
Wisconsin (cont)	**Wisconsin (cont)**	**Wisconsin (cont)**	
Chronic Renal Disease ATTN: Eligibility Unit P.O. Box 6410 Madison, WI 53716 **Phone:** (800) 947-9627 or (800) 362-3002	Cystic Fibrosis Program Chronic Disease program P.O. Box 6410 Madison, WI 53716 **Phone:** (800) 947-9627 or (800) 362-3002	Hemophilia Home Care Chronic Disease program P.O. Box 6410 Madison, WI 53716 **Phone:** (800) 947-9627 or (800) 362-3002	

Appendix E – Advance Directives Assistance

Alabama	**Alaska**	**Arizona**	**Arkansas**
Area Agency on Aging 4200 Highway 69 North Northport, AL 35476-0509 **Phone:** (800) 243-5463	Dept of Health & Social Services Division of Public Health 350 Main Street, Room 508 Juneau, AK 99801 **Phone:** (907) 465-3090	Arizona Attorney General Community Outreach and Education 1275 W. Washington St. Phoenix, AZ 85007-2926 **Phone:** (800) 352-8431 or (602) 542-2123	Division of Aging and Adult Services PO Box 1437 Slot S-530 Little Rock, AR 72203-1437 **Phone:** (501) 682-2441
California	**Colorado**	**Connecticut**	**Delaware**
California Department of Aging 1300 National Drive, Suite 200 Sacramento, CA 95834 **Phone:** (916) 419-7500 **TTY:** (800) 735-2929	Colorado Commission on Aging 1575 Sherman Street Denver, Colorado 80203 **Phone:** (888) 866-4243 or (303) 866-5288	Connecticut Dept of Social Services 55 Farmington Ave. Hartford, CT 06105 **Phone:** (800) 842-1508 **TTY:** (800) 842-4524	Delaware Division of Services for Aging and Adults with Physical Disabilities 1901 N. Du Pont Highway Main Bldg. New Castle, DE 19720 Dover, DE 19904 **Phone:** (800) 223-9074

Florida	**Georgia**	**Hawaii**	**Idaho**
Florida Dept of Elder Affairs 4040 Esplanade Way Tallahassee, FL 32399 **Phone:** (850) 414-2000 **TDD:** (850) 414-2001	Georgia DHS Division of Aging Services 2 Peachtree Street, NW Atlanta, GA 30303-3142 **Phone:** (866) 552-4464 or (404) 657-5258	Dept of Health Elderly Affairs Division Standard Finance Bldg. 715 South King Street, Suite 200 Honolulu, Hawaii 96813 **Phone:** (808) 768-7700 or (808) 808 768-7705	Idaho Commission on Aging 341 W Washington Boise, ID 83702 **Phone:** (800) 926-2588 or (208) 334-3833
Illinois	**Indiana**	**Iowa**	**Kansas**
Illinois Dept on Aging One Natural Resources Way, Suite 100 Springfield, Illinois 62702-1271 **Phone:** (800) 252-8966	Indiana Association of Area Agencies on Aging 4755 Kingsway Drive Suite 318 Indianapolis, IN 46205 **Phone:** (317) 205-9201	Iowa Dept on Aging Jessie M. Parker Bldg 510 East 12th St., Ste. 2 Des Moines, IA 50319 **Phone:** (800) 532-3213 or (515) 725-3333	Dept on Aging New England Bldg. 503 S. Kansas Ave. Topeka, KS 66603-3404 **Phone:** (800) 432-3535 **TTY:** (785) 291-3167
Kentucky	**Louisiana**	**Maine**	**Maryland**
CHFS Dept for Aging and Independent Living 400 Old Vine St. Ste. 203 Lexington, KY 40507 **Phone:** (877) 293-7447	Dept of Health and Hospitals Office of Aging and Adult Services 628 N 4th Street Baton Rouge, LA 70802 **Phone:** (225) 219-1917	OADS Aging Services Maine Dept of Health and Human Services 11 State House Station 41 Anthony Ave. Augusta, ME 04333 **Phone:** (800) 262-2232 or (207) 287-9200 **TTY:** 711	Maryland Dept of Aging 301 West Preston Street Suite 1007 Baltimore, MD 21201 **Phone:** (401) 767-1100
Massachusetts	**Michigan**	**Minnesota**	**Mississippi**
Executive Office of Elder Affairs One Ashburton Place, 5th Floor Boston, MA 02108 **Phone:** (800) 243-4636 or (617) 727-7750 **TTY:** (800) 872-0166	Aging and Adult Services Agency 300 E. Michigan Ave., 3rd Floor Lansing, MI 48933 **Phone:** (517) 373-8230	Minnesota Board on Aging Elmer L. Anderson Human Services Building 540 Cedar Street St. Paul, MN 55155 **Phone:** (800) 882-6262 or (651) 431-2500 **TTY:** (800) 627-3529	Dept of Human Services Division of Aging and Adult Services 750 North State Street Jackson, MS 39202 **Phone:** (800) 948-3090 or (601) 359-4929

Missouri	**Montana**	**Nebraska**	**Nevada**
Division of Senior and Disability Services Area Agencies on Aging Missouri Department of Health and Senior Services P.O. Box 570 Jefferson City, MO 65102 **Phone:** (573) 526-4542	Dept of Public Health and Human Services Area Agencies on Agencies P.O. Box 1717 Helena, MT 59624 **Phone:** (800) 551-3191	Dept of Health and Human Services State Unit on Aging P.O. Box 95026 Lincoln, NE 68509-5026 **Phone:** (800) 942-7830	Dept of Health and Human Services Aging and Disability Services Division 3416 Goni Road, Suite D-132 Carson City, NV 89706 **Phone:** (775) 687-4210
New Hampshire	**New Jersey**	**New Mexico**	**New York**
New Hampshire Dept of Health and Human Services Bureau of Elderly and Adult Services 129 Pleasant Street Concord, NH 03301 **Phone:** (800) 351-1888 or (603) 271-9203 **TDD:** (800) 735-2964	Division of Aging Services New Jersey Department of Human Services 12B Quakerbridge Plaza PO Box 715 Mercerville, NJ 08625-0715 **Phone:** (877) 222-3737	New Mexico Aging and Long-Term Services Toney Anaya Bldg. 2550 Cerrillos Rd. Santa Fe, NM 87505 **Phone:** (866) 451-2901 or (505) 476-4799	NYC Dept for the Aging Office of Public Affairs 2 Lafayette Street New York, NY 10007 **Phone:** (212) 639-9675
North Carolina	**North Dakota**	**Ohio**	**Oklahoma**
NC Health and Human Services Aging and Adult Services 2101 Mail Service Center Raleigh, NC 27699-2101 **Phone:** (919) 855-3400	Dept of Human Services 1237 W Divide Ave., Suite 6 Bismarck, ND 58501 **Phone:** (855) 462-5465 or (701) 328-4601 **TTY:** (800) 366-6888	Ohio Dept of Aging 246 N. High Street, 9th Floor Columbus, Ohio 43215-2406 **Phone:** (800) 266-4346 **TTY:** 711	Oklahoma Dept of Human Services Aging Services 2401 NW 23rd Street, Suite 40 Oklahoma City, OK 73107 **Phone:** (405) 521-2281
Oregon	**Pennsylvania**	**Rhode Island**	**South Carolina**
Oregon Department of Human Services Seniors and People with Disabilities 500 Summer Street NE E12 Salem, OR 97301-1073 **Phone:** (800) 282-8096 **TTY:** (800) 282-8096	Pennsylvania Dept of Aging 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 **Phone:** (717) 783-1550	Rhode Island Dept of Human Service, Division of Elderly Affairs 74 West Road Hazard Bldg, 2nd Floor Cranston, RI 02920 **Phone:** (401) 462-3000 **TTY:** (401) 462-0740	Office on Aging 1301 Gervais St. Ste. 350 Columbia, SC 29201 **Phone:** (800) 868-9095 or (803) 734-9900

South Dakota	**Tennessee**	**Texas**	**Utah**
Adult Services and Aging 700 Governors Drive Pierre, SD 57501 **Phone:** (605) 773-3165	Tennessee Commission on Aging and Disability 502 Deaderick Street, 9th Floor Nashville, TN 37243-0860 **Phone:** (615) 741-2056	Texas Dept of Aging and Disability Services 701 W. 51st St. Austin, TX 78751 **Phone:** (512) 438-3011	Health and Human Services Aging and Adult Services 195 North 1950 West Salt Lake City, UT 84116 **Phone:** (877) 424-4640 or (801) 538-3910
Vermont	**Virginia**	**Washington**	**Washington, D.C.**
Vermont Dept of Disabilities, Aging and Independent Living 103 South Main Street Weeks Building Waterbury, VT 05671 **Phone:** (802) 871-3065	Virginia Dept for the Aging 1610 Forest Ave. Ste. 100 Richmond, VA 23229 **Phone:** (800) 552-3402 **TTY:** 711	Washington State Dept of Social and Health Services, Aging and Long-Term Support Administration Area Agency on Aging 50 Simon Street SE East Wenatchee, WA 98802 **Phone:** (800) 572-4459	D.C. Office on Aging 500 K Street NE Washington, DC 20002 **Phone:** (202) 724-5622
West Virginia	**Wisconsin**	**Wyoming**	
West Virginia Bureau of Senior Services 1900 Kanawha Blvd E Charleston, WV 25305 **Phone:** (877) 987-3646 or (304) 558-3317	Dept of Health Services 1 West Wilson St. Madison, WI 53703 **Phone:** (608) 266-1865 **TTY:** (888) 701-1251	Dept of Health, Aging Division 401 Hathaway Bldg. Cheyenne, WY 82002 **Phone:** (866) 571-0944 or (307) 777-7656	

Appendix F – AIDS Drug Assistance Programs

Alabama	**Alaska**	**Arizona**	**Arkansas**
HIV/AIDS Division Alabama Dept of Public Health The RSA Tower 201 Monroe Street, Suite 1400 Montgomery, Alabama 36104 **Phone:** (866) 574-9964	Alaskan AIDS Assistance Association 3601 C Street, Suite 540 Anchorage, Alaska 99503 **Phone:** (907) 269-8000 Alaskan Statewide AIDS Helpline: (800) 478-AIDS	Arizona Dept of Health Services 150 N. 18th Avenue, Suite 110 Phoenix, AZ 85007 **Phone:** (602) 364-3610	Arkansas Dept of Health 4815 West Markham Street Little Rock, Arkansas 72205 **Phone:** (888) 499-6544 or (501) 661-2408

California	**Colorado**	**Connecticut**	**Delaware**
Office of AIDS PO Box 997377, MS 0500 Sacramento, CA 95899-7377 **Phone:** (916) 558-1784 MCI TDD (800) 735-2929 or MCI voice telephone (800) 735-2922; Sprint TDD (888) 877-5378 or Sprint voice telephone (888) 877-5379	CDPHE Care and Treatment Program 4300 Cherry Creek Drive South Denver, CO 80246 **Phone:** (800) 886-7689 or (303) 692-2000 **TDD:** (303) 691-7700	Dept of Social Services Medical Operations Unit #4 25 Sigourney Street Hartford, CT 06106 **Phone:** (800) 233-2503 **TDD/TYY:** 800-842-4524	Delaware HIV Consortium 100 W. 10th St., Suite 415 Wilmington, DE 19801 **Phone:** (302) 654-5471
Florida	**Georgia**	**Guam**	**Hawaii**
Section of HIV/AIDS AIDS Drug Assistance Program 4052 Bald Cypress Way Tallahassee, FL 32399 **Phone:** (800) 352-2437 **Spanish:** (800) 545-7432 **Creole:** (800) 243-7101 **TTY:** (888) 503-7118	Health and Human Ser. 2 Peachtree St., NW 15th Floor Atlanta, GA 30303 **Phone:** (800) 551-2728	Guam Medicare Assistance Program (Guam MAP) 130 University Drive, University Castle Mall, Room 156 Guam, 96913 **Phone:** (671) 735-7421 **TTY:** (671) 735-7415	STD/AIDS Prevention Branch HIV Drug Assistance Program 3627 Kilauea Avenue, Room 306 Honolulu, Hawaii 96816-2399 **Phone:** (808) 732-0026
Idaho	**Illinois**	**Indiana**	**Iowa**
Idaho AIDS Drug Assistance Program (IDAGAP) 40 West State Street Boise, ID 83720 **Phone:** (208) 334-6527 or (800-926-2588	Illinois ADAP Office 525 West Jefferson Street, First Floor Springfield, IL 62761 **Phone:** (217) 782-4977 **TTY:** (800) 547-0466	Indiana State Dept of Health 2 N. Meridian St., 6-C Indianapolis, IN 46204 **Phone:** (866) 588-4948	Iowa Dept of Public Health 321 E. 12th Street Lucas State Office Bldg 5th Flr Des Moines, IA 50319 **Phone:** (800) 445-2437
Kansas	**Kentucky**	**Louisiana**	**Maine**
Kansas Dept of Health and Environment 1000 SW Jackson, Suite 210 Topeka, KS 66612 **Phone:** (785) 296-8701	KY Cabinet for Health and Family Services HIV/AIDS Branch 275 E Main Street, HS2E-C Frankfort, KY 40621 **Phone:** (866) 510-0005	Louisiana Dept of Health and Hospitals 628 N. 4th Street Baton Rouge, LA 70802 **Phone:** (225) 342-9500	Maine ADAP 40 State House Station Augusta, ME 04330-9758 **Phone:** (207) 287-3747

Maryland	**Massachusetts**	**Michigan**	**Minnesota**
Maryland AIDS Administration 500 North Calvert Street, 5th Floor Baltimore, MD, 21202 **Phone:** (800) 205-6308 or (410) 767-6535 **TTY:** (800) 735-2258	Massachusetts Community Research Initiative of New England/HDAP 38 Chauncy Street, Suite 500 Boston, MA 02111 **Phone:** (800) 228-2714 or (617) 502-1700	Attn: Michigan Drug Assistance Program HIV Care Section Div. of Health, Wellness and Disease Control, Michigan Dept of Health and Human Services 109 Michigan Avenue, 9th Floor Lansing, MI 48913 **Phone:** (888) 826-6565	HIV/AIDS Programs Dept of Human Services PO Box 64972 St. Paul, MN 55164 **Phone:** (800) 657-3761 or (651) 431-2414 **TTY:** (800) 627-3529
Mississippi	**Missouri**	**Montana**	**Nebraska**
State Dept. of Health 570 East Woodrow Wilson Dr. Jackson, MS 39216 **Phone:** (866) 458-4948 or AIDS Hotline: (800) 826-2961	Missouri Dept. of Health and Senior Services PO Box 570 Jefferson City, MO 65102 **Phone:** (573) 751-6439	HIV Treatment Assistance Program Cogswell Building Room C-211 1400 Broadway Helena, MT 59620 **Phone:** (406) 444-3565	Nebraska Dept. of Health & Human Services P.O. Box 95026 Lincoln, Nebraska 68509 **Phone:** (402) 559-4673 or (800) 782-2437
Nevada	**New Hampshire**	**New Jersey**	**New Mexico**
Nevada State Health Division 4150 Technology Way, Suite 106 Carson City, NV 89706 **Phone:** (800) 842-2437 or (775) 684-3499	DHHS- NH CARE Program 29 Hazen Drive Concord, NH 03301 **Phone:** (603)271-4502	NJ AIDS Drug Assistance Program (ADAP) - NJ PO Box 722 Trenton, NJ 08625 **Phone:** (800) 624-2377	New Mexico HIV/AIDS Services Program – AIDS Drug Assistance Program (ADAP) 1190 St. Francis Dr. Runnels Bldg S-1207 Santa Fe, NM 87502 **Phone:** (888) 882-2497
New York	**North Carolina**	**North Dakota**	**Ohio**
New York HIV Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220-0052 **Phone:** (800) 542-2437 **TTY:** (518) 459-0121	N.C. Dept. of Health and Human Services Division of Public Health Purchase of Medical Care Services 1907 Mail Service Center Raleigh, NC 27699 **Phone:** (919) 733-9576	North Dakota Dept. of Health HIV/AIDS Program 2635 East Main Ave Bismarck, ND 58506 **Phone:** (701) 328-2378 or (800) 472-2180	Ohio HIV Drug Assistance Program (OHDAP) HIV Care Services Section Ohio Dept of Health 246 N. High Street Columbus, OH 43215 **Phone:** (800) 777-4775

Oklahoma	**Oregon**	**Pennsylvania**	**Rhode Island**
Oklahoma State Dept. of Health HIV/STD Services Division 1000 NE 10th, Room 614 Oklahoma City, OK 73117 **Phone:** (405) 271-4636	CARE Assist 800 NE Oregon Street, Suite 1105 Portland, OR 97232 **Phone:** (800) 805-2313 or (971) 673-0144	Bureau of Epidemiology Health and Welfare Building, Room 933 Harrisburg, PA 17108 **Phone:** (717) 783-4677	RI Dept. of Health, Office of HIV/AIDS & Viral Hepatitis 3 Capitol Hill, Room 302 Providence, RI 02908 **Phone:** (401) 222-4610
South Carolina	**South Dakota**	**Tennessee**	**Texas**
South Carolina Dept. of Health and Environmental Control 2600 Bull Street Columbia, SC 29201 **Phone:** (800) 856-9954	South Dakota Dept of Health 615 East 4th Street Pierre, SD 57501 **Phone:** (650) 773- 3737	TN Dept of Health 425 5th Ave. North, Cordell Hull Bldg. 3rd Fl. Andrew Johnson Tower Nashville, TN 37243 **Phone:** (615) 741-7500	Texas HIV State Pharmacy Assistance Program (SPAP) ATTN: MSJA, MC 1873 PO Box 149347 Austin, Texas 78714 **Phone:** (800) 255-1090 or (512) 533-3000
Utah	**Vermont**	**Virginia**	**Washington**
Utah Dept. of Health Bureau of Epidemiology 288 North 1460 West PO Box 142104 Salt Lake City, Utah 84114 **Phone:** (801) 538-6397	Division of Alcohol & Drug Abuse Programs, Vermont Dept of Health 108 Cherry Street, Rm 202 P.O. Box 70, Drawer 27 Burlington, VT 05402-0070 **Phone:** (802) 651-1550	Virginia Dept. of Health 109 Governor Street Richmond, Virginia 23219 **Phone:** (855) 362-0658	Washington State Dept. of Health HIV Client Services P.O. Box 47890 Olympia, Washington 98504 **Phone:** (360) 236-3426
Washington, D.C.	**West Virginia**	**Wisconsin**	**Wyoming**
Washington, DC Dept. of Health 899 North Capitol Street, NE Washington, DC 20002 **Phone:** (202) 671-4900 **TTY:** 711	Office of Epidemiology & Prevention Services 350 Capitol Street Room 125 Charleston, WV 25301 **Phone:** (800) 642-8244	Wisconsin Dept. of Health Services Division of Public Health Attn: ADAP 1 West Wilson Street Madison, WI 53703 **Phone:** (800) 991-5532 or (608) 267-6875	Wyoming Dept. of Health 401 Hathaway Building Cheyenne, WY 82002 **Phone:** (307) 777-5856

EnvisionRxPlus Employer Group Retiree PDP Member Services

Method	Member Services – Contact Information
CALL	1-833-682-1186 Calls to this number are free. Member Services, including TTY/TDD, is open 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
FAX	1-866-250-5178
WRITE	**EnvisionRxPlus** 2181 E. Aurora Rd., Suite 201 Twinsburg, OH 44087 customerservice@envisionrxplus.com
WEBSITE	www.envisionrxplus.com

State Health Insurance Assistance Program

State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. You can find the name of your state SHIP in Appendix A.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

EnvisionRxPlus Employer Group Retiree PDP

2020 Abridged Formulary

(Partial List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN

HPMS Approved Formulary File Submission 20431, Version Number 8

This abridged formulary was updated on 10/21/2019. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact **EnvisionRxPlus Employer Group Retiree PDP** Member Services at 1-844-293-4760 or, for TTY users, 711, 24 hours a day, 7 days a week, or visit www.envisionrxplus.com.

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means Envision Insurance Company. When it refers to "plan" or "our plan," it means **EnvisionRxPlus Employer Group Retiree PDP**.

This document includes a partial list of the drugs (formulary) for our plan which is current as of October 21, 2019. For a complete, updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2021, and from time to time during the year.

What is the EnvisionRxPlus Employer Group Retiree PDP Abridged Formulary?

A formulary is a list of covered drugs selected by **EnvisionRxPlus Employer Group Retiree PDP** in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. **EnvisionRxPlus Employer Group Retiree PDP** will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an **EnvisionRxPlus Employer Group Retiree PDP** network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

This document is a partial formulary and includes only some of the drugs covered by **EnvisionRxPlus Employer Group Retiree PDP**. For a complete listing of all prescription drugs covered by **EnvisionRxPlus Employer Group Retiree PDP**, please visit our website or call us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the **EnvisionRxPlus** Formulary?"

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug *or* move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 31-day supply of the drug.
    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled "How do I request an exception to the **EnvisionRxPlus** Formulary?"

Changes that will not affect you if you are currently taking the drug.

Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year.

The enclosed formulary is current as of October 21, 2019. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages. If we make certain non-routine changes to coverage for drugs, we will send members an errata sheet to update the formulary they received.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "cardiovascular agents". If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 95. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list

What are generic drugs?

EnvisionRxPlus Employer Group Retiree PDP covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization: EnvisionRxPlus Employer Group Retiree PDP** requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from **EnvisionRxPlus Employer Group Retiree PDP** before you fill your prescriptions. If you don't get approval, **EnvisionRxPlus Employer Group Retiree PDP** may not cover the drug.

- **Quantity Limits:** For certain drugs, **EnvisionRxPlus Employer Group Retiree PDP** limits the amount of the drug that **EnvisionRxPlus Employer Group Retiree PDP** will cover. For example, **EnvisionRxPlus Employer Group Retiree PDP** provides 240 tablets per 30-day prescription for Tramadol. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, **EnvisionRxPlus Employer Group Retiree PDP** requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, **EnvisionRxPlus Employer Group Retiree PDP** may not cover Drug B unless you try Drug A first. If Drug A does not work for you, **EnvisionRxPlus Employer Group Retiree PDP** will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted on line documents that explain our prior authorization and step therapy restrictions.You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask **EnvisionRxPlus Employer Group Retiree PDP** to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the **EnvisionRxPlus Employer Group Retiree PDP** formulary?" on page iv for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered. This document includes only a partial list of covered drugs, so **EnvisionRxPlus Employer Group Retiree PDP** may cover your drug. For more information, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you learn that **EnvisionRxPlus Employer Group Retiree PDP** does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by **EnvisionRxPlus Employer Group Retiree PDP**. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by **EnvisionRxPlus Employer Group Retiree PDP**.

- You can ask **EnvisionRxPlus Employer Group Retiree PDP** to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the EnvisionRxPlus Employer Group Retiree PDP Formulary?

You can ask **EnvisionRxPlus Employer Group Retiree PDP** to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, **EnvisionRxPlus Employer Group Retiree PDP** limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, **EnvisionRxPlus Employer Group Retiree PDP** will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, or utilization restriction exception. **When you request a formulary or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you experience a change in your level of care, such as a move from a home to a long-term care setting, and need a drug that is not on our formulary (or if your ability to get your drugs is limited), we may cover a one-time temporary supply from a network long-term care pharmacy for up to 31 days unless you have a prescription for fewer days. If you experience a change in your level of care, such as a move from a hospital to home, and need a drug that is not on our formulary (or if your ability to get your drugs is limited), we may cover a one-time temporary supply from a network pharmacy for up to 30 days unless you have a prescription for fewer days. You should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For more information

For more detailed information about your **EnvisionRxPlus Employer Group Retiree PDP** prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about **EnvisionRxPlus Employer Group Retiree PDP**, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit http://www.medicare.gov.

EnvisionRxPlus Employer Group Retiree PDP Formulary

The abridged formulary that begins on page 1 provides coverage information about some of the drugs covered by **EnvisionRxPlus Employer Group Retiree PDP**. If you have trouble finding your drug in the list, turn to the Index that begins on page 95.

Remember: This is only a partial list of drugs covered by **EnvisionRxPlus Employer Group Retiree PDP**. If your prescription is not in this partial formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., SYNTHROID) and generic drugs are listed in lower-case italics (e.g., levothyroxine).

The information in the Requirements/Limits column tells you if **EnvisionRxPlus Employer Group Retiree PDP** has any special requirements for coverage of your drug.

Abbreviation /Symbol	**Short Definition**	**Explanation**
BD	Part B vs Part D	This drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
HR	High Risk Medication	According to medical experts, these drugs may cause more side effects if you are 65 years of age or older. If you are taking one of these drugs, ask your doctor if there are safer options available. **These medications require prior authorization if you are 65 years of age or older.**
LA	Limited Access	This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-844-293-4760, 24 hours a day, 7 days a week. TTY/TDD users should call 711.
PA	Prior Authorization	This medication requires that you or your provider get approval from the plan before we will agree to cover the drug for you.
QL	Quantity Limit	Most limits per 30-day supply. If the limit is for a day supply other than 30 the entry will read quantity/day supply (i.e. REVLIMID 28/28 means you can only fill 28 capsules for 28 day supply).
ST	Step Therapy	This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

The Tier column of the drug list that begins on page 1 tells you which tier your drug is in.

Drug Name	Drug Tier	Requirements/Limits
ANALGESICS		
Nonsteroidal Anti-Inflammatory Drugs		
celecoxib oral capsule 100 mg, 200 mg, 400 mg	2	
celecoxib oral capsule 50 mg	1	
diclofenac potassium oral tablet 50 mg	2	
diclofenac sodium er oral tablet extended release 24 hour 100 mg	2	
diclofenac sodium oral tablet delayed release 25 mg	2	
diclofenac sodium oral tablet delayed release 50 mg, 75 mg	1	
diclofenac sodium transdermal gel 3 %	4	
diflunisal oral tablet 500 mg	4	
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	4	
etodolac oral capsule 200 mg, 300 mg	4	
etodolac oral tablet 400 mg, 500 mg	2	
flurbiprofen oral tablet 100 mg, 50 mg	1	
IBU ORAL TABLET 600 MG, 800 MG	1	
ibuprofen oral suspension 100 mg/5ml	1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
indomethacin oral capsule 25 mg, 50 mg	4	
ketoprofen oral capsule 25 mg	1	
meloxicam oral tablet 15 mg, 7.5 mg	1	
nabumetone oral tablet 500 mg, 750 mg	1	
naproxen dr oral tablet delayed release 375 mg, 500 mg	1	
naproxen oral suspension 125 mg/5ml	4	
naproxen oral tablet 250 mg, 375 mg, 500 mg	1	
naproxen sodium er oral tablet extended release 24 hour 500 mg	4	
naproxen sodium oral tablet 275 mg	1	
naproxen sodium oral tablet 550 mg	2	
oxaprozin oral tablet 600 mg	4	
piroxicam oral capsule 10 mg, 20 mg	1	
sulindac oral tablet 150 mg, 200 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
VIVLODEX ORAL CAPSULE 5 MG	4	
ZORVOLEX ORAL CAPSULE 18 MG, 35 MG	4	
Opioid Analgesics, Long-Acting		
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	5	PA; QL (180 EA per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	2	QL (10 EA per 30 days)
methadone hcl oral tablet 10 mg, 5 mg	2	QL (240 EA per 30 days)
morphine sulfate (concentrate) oral solution 100 mg/5ml	2	QL (600 ML per 30 days)
morphine sulfate er oral capsule extended release 24 hour 100 mg, 40 mg	4	QL (90 EA per 30 days)
morphine sulfate er oral tablet extended release 100 mg	4	QL (90 EA per 30 days)
morphine sulfate er oral tablet extended release 15 mg, 200 mg, 30 mg, 60 mg	2	QL (90 EA per 30 days)
morphine sulfate oral solution 10 mg/5ml	2	QL (3600 ML per 30 days)
morphine sulfate oral solution 20 mg/5ml	2	QL (2700 ML per 30 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	3	QL (90 EA per 30 days)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 80 MG	3	QL (120 EA per 30 days)
tramadol hcl er (biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	2	QL (30 EA per 30 days)
tramadol hcl er oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	2	QL (30 EA per 30 days)
Opioid Analgesics, Short-Acting		
acetaminophen-codeine #3 oral tablet 300-30 mg	2	QL (400 EA per 30 days)
acetaminophen-codeine oral solution 120-12 mg/5ml	2	QL (5000 ML per 30 days)
acetaminophen-codeine oral tablet 300-15 mg, 300-60 mg	2	QL (400 EA per 30 days)
BUPAP ORAL TABLET 50-300 MG	2	QL (400 EA per 30 days)
butalbital-acetaminophen oral tablet 50-325 mg	2	QL (360 EA per 30 days)
butalbital-apap-caff-cod oral capsule 50-325-40-30 mg	4	QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
butalbital-apap-caffeine oral capsule 50-300-40 mg, 50-325-40 mg	4	QL (180 EA per 30 days)
butalbital-apap-caffeine oral tablet 50-325-40 mg	4	QL (180 EA per 30 days)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	4	QL (180 EA per 30 days)
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	4	QL (180 EA per 30 days)
codeine sulfate oral tablet 30 mg	4	QL (240 EA per 30 days)
codeine sulfate oral tablet 60 mg	4	QL (180 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	2	QL (370 EA per 30 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml	2	QL (5500 ML per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	2	QL (370 EA per 30 days)
hydrocodone-acetaminophen oral tablet 5-300 mg, 7.5-300 mg	2	QL (400 EA per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	2	QL (180 EA per 30 days)
hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 16 mg	4	QL (120 EA per 30 days)
hydromorphone hcl er oral tablet er 24 hour abuse-deterrent 32 mg	5	QL (60 EA per 30 days)
hydromorphone hcl injection solution 2 mg/ml	4	QL (120 ML per 30 days)
hydromorphone hcl oral liquid 1 mg/ml	2	QL (1984 ML per 30 days)
hydromorphone hcl oral tablet 2 mg, 4 mg	2	QL (360 EA per 30 days)
hydromorphone hcl oral tablet 8 mg	2	QL (240 EA per 30 days)
hydromorphone hcl pf injection solution 10 mg/ml, 50 mg/5ml	4	QL (240 ML per 30 days)
LORCET HD ORAL TABLET 10-325 MG	2	QL (370 EA per 30 days)
LORCET ORAL TABLET 5-325 MG	2	QL (370 EA per 30 days)
methadone hcl oral solution 10 mg/5ml	2	QL (1800 ML per 30 days)
methadone hcl oral solution 5 mg/5ml	2	QL (3600 ML per 30 days)
morphine sulfate oral tablet 15 mg, 30 mg	2	QL (180 EA per 30 days)
oxycodone hcl oral capsule 5 mg	2	QL (180 EA per 30 days)
oxycodone hcl oral concentrate 100 mg/5ml	4	QL (180 ML per 30 days)
oxycodone hcl oral solution 5 mg/5ml	2	QL (1080 ML per 30 days)
oxycodone hcl oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg	2	QL (180 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	2	QL (370 EA per 30 days)
oxycodone-aspirin oral tablet 4.8355-325 mg	2	QL (360 EA per 30 days)
oxycodone-ibuprofen oral tablet 5-400 mg	2	QL (360 EA per 30 days)
oxymorphone hcl oral tablet 10 mg	4	QL (120 EA per 30 days)
oxymorphone hcl oral tablet 5 mg	2	QL (180 EA per 30 days)
tramadol hcl oral tablet 50 mg	2	QL (240 EA per 30 days)
tramadol-acetaminophen oral tablet 37.5-325 mg	2	QL (370 EA per 30 days)
VICODIN ES ORAL TABLET 7.5-300 MG	2	QL (400 EA per 30 days)
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
Alcohol Deterrents/Anti-Craving		
acamprosate calcium oral tablet delayed release 333 mg	4	
disulfiram oral tablet 250 mg, 500 mg	2	
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG	5	
Opioid Antagonists		
buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg	2	
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	2	
naloxone hcl injection solution 0.4 mg/ml	2	
naloxone hcl injection solution cartridge 0.4 mg/ml	2	
naloxone hcl injection solution prefilled syringe 2 mg/2ml	2	
naltrexone hcl oral tablet 50 mg	2	
NARCAN NASAL LIQUID 4 MG/0.1ML	3	
SUBOXONE SUBLINGUAL FILM 12-3 MG, 2-0.5 MG, 4-1 MG, 8-2 MG	3	
Smoking Cessation Agents		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	2	
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG	3	
CHANTIX ORAL TABLET 0.5 MG, 1 MG	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
CHANTIX STARTING MONTH PAK ORAL TABLET 0.5 MG X 11 & 1 MG X 42	3	
NICOTROL INHALATION INHALER 10 MG	4	
ANTIBACTERIALS		
Aminoglycosides		
amikacin sulfate injection solution 500 mg/2ml	1	B/D
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML	4	PA; QL (235.2 ML per 28 days)
gentamicin in saline intravenous solution 0.8-0.9 mg/ml-%	1	
gentamicin in saline intravenous solution 1-0.9 mg/ml-%, 1.2-0.9 mg/ml-%, 1.6-0.9 mg/ml-%	2	
gentamicin sulfate injection solution 40 mg/ml	1	
neomycin sulfate oral tablet 500 mg	1	
paromomycin sulfate oral capsule 250 mg	1	
polymyxin b sulfate injection solution reconstituted 500000 unit	2	
tobramycin sulfate injection solution 10 mg/ml	4	
tobramycin sulfate injection solution 80 mg/2ml	2	
Antibacterials, Other		
clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg	1	
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	4	
clindamycin phosphate in d5w intravenous solution 300 mg/50ml, 600 mg/50ml	2	
clindamycin phosphate in d5w intravenous solution 900 mg/50ml	4	
clindamycin phosphate injection solution 300 mg/2ml, 600 mg/4ml, 900 mg/6ml	2	
colistimethate sodium (cba) injection solution reconstituted 150 mg	4	
dapsone oral tablet 100 mg	1	
dapsone oral tablet 25 mg	2	
daptomycin intravenous solution reconstituted 350 mg, 500 mg	4	
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
linezolid intravenous solution 600 mg/300ml	5	PA
linezolid oral suspension reconstituted 100 mg/5ml	5	PA
linezolid oral tablet 600 mg	4	PA
methenamine hippurate oral tablet 1 gm	1	
metronidazole in nacl intravenous solution 500-0.79 mg/100ml-%	2	
metronidazole oral tablet 250 mg, 500 mg	1	
NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG	4	B/D
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	1	
nitrofurantoin macrocrystal oral capsule 25 mg	2	
nitrofurantoin monohyd macro oral capsule 100 mg	2	
nitrofurantoin oral suspension 25 mg/5ml	4	
PENTAM INJECTION SOLUTION RECONSTITUTED 300 MG	4	
SIVEXTRO INTRAVENOUS SOLUTION RECONSTITUTED 200 MG	5	
SIVEXTRO ORAL TABLET 200 MG	5	
tigecycline intravenous solution reconstituted 50 mg	4	
tinidazole oral tablet 500 mg	4	
trimethoprim oral tablet 100 mg	1	
vancomycin hcl intravenous solution reconstituted 1 gm, 10 gm, 250 mg, 500 mg, 750 mg	4	
vancomycin hcl oral capsule 125 mg	4	
vancomycin hcl oral capsule 250 mg	5	
XIFAXAN ORAL TABLET 200 MG, 550 MG	4	
Beta-Lactam, Cephalosporins		
cefaclor er oral tablet extended release 12 hour 500 mg	4	
cefaclor oral capsule 250 mg, 500 mg	2	
cefaclor oral suspension reconstituted 125 mg/5ml, 250 mg/5ml, 375 mg/5ml	2	
cefadroxil oral capsule 500 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml	2	
cefadroxil oral tablet 1 gm	1	
cefazolin sodium injection solution reconstituted 1 gm	2	
cefazolin sodium injection solution reconstituted 10 gm, 500 mg	1	
cefdinir oral capsule 300 mg	1	
cefdinir oral suspension reconstituted 125 mg/5ml	1	
cefdinir oral suspension reconstituted 250 mg/5ml	4	
cefepime hcl injection solution reconstituted 1 gm, 2 gm	2	
cefixime oral capsule 400 mg	4	
cefoxitin sodium injection solution reconstituted 10 gm	2	
cefoxitin sodium intravenous solution reconstituted 1 gm, 2 gm	2	
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	1	
cefpodoxime proxetil oral tablet 100 mg	1	
cefpodoxime proxetil oral tablet 200 mg	2	
cefprozil oral suspension reconstituted 125 mg/5ml	1	
cefprozil oral suspension reconstituted 250 mg/5ml	4	
cefprozil oral tablet 250 mg, 500 mg	1	
ceftazidime injection solution reconstituted 1 gm, 6 gm	1	
ceftazidime injection solution reconstituted 2 gm	2	
ceftriaxone sodium injection solution reconstituted 1 gm, 2 gm	1	
ceftriaxone sodium injection solution reconstituted 250 mg	4	
ceftriaxone sodium injection solution reconstituted 500 mg	2	
ceftriaxone sodium intravenous solution reconstituted 10 gm	1	
cefuroxime axetil oral tablet 250 mg, 500 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
cefuroxime sodium injection solution reconstituted 7.5 gm, 750 mg	2	
cefuroxime sodium intravenous solution reconstituted 1.5 gm	2	
cephalexin oral capsule 250 mg, 500 mg	1	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	1	
cephalexin oral tablet 250 mg, 500 mg	1	
TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG	5	
ZERBAXA INTRAVENOUS SOLUTION RECONSTITUTED 1.5 (1-0.5) GM	4	
Beta-Lactam, Other		
AZACTAM INJECTION SOLUTION RECONSTITUTED 2 GM	4	B/D
aztreonam injection solution reconstituted 1 gm	2	
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG	5	PA; QL (84 ML per 28 days)
ertapenem sodium injection solution reconstituted 1 gm	4	
imipenem-cilastatin intravenous solution reconstituted 250 mg, 500 mg	4	B/D
meropenem intravenous solution reconstituted 1 gm, 500 mg	4	
Beta-Lactam, Penicillins		
amoxicillin oral capsule 250 mg, 500 mg	1	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	1	
amoxicillin oral tablet 500 mg, 875 mg	1	
amoxicillin oral tablet chewable 125 mg, 250 mg	1	
amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg	2	
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	1	
amoxicillin-pot clavulanate oral suspension reconstituted 250-62.5 mg/5ml	2	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
amoxicillin-pot clavulanate oral tablet chewable 200-28.5 mg, 400-57 mg	1	
ampicillin oral capsule 500 mg	1	
ampicillin sodium injection solution reconstituted 1 gm	2	
ampicillin sodium injection solution reconstituted 125 mg	4	
ampicillin sodium intravenous solution reconstituted 10 gm	2	
ampicillin-sulbactam sodium injection solution reconstituted 1.5 (1-0.5) gm, 3 (2-1) gm	4	
ampicillin-sulbactam sodium injection solution reconstituted 15 (10-5) gm	2	
BICILLIN L-A INTRAMUSCULAR SUSPENSION 1200000 UNIT/2ML, 2400000 UNIT/4ML	4	
BICILLIN L-A INTRAMUSCULAR SUSPENSION 600000 UNIT/ML	1	
dicloxacillin sodium oral capsule 250 mg, 500 mg	1	
nafcillin sodium injection solution reconstituted 1 gm	2	
nafcillin sodium injection solution reconstituted 2 gm	4	
nafcillin sodium intravenous solution reconstituted 10 gm	4	
oxacillin sodium injection solution reconstituted 1 gm, 10 gm, 2 gm	4	
penicillin g pot in dextrose intravenous solution 40000 unit/ml, 60000 unit/ml	2	
penicillin g potassium injection solution reconstituted 20000000 unit	4	
penicillin g procaine intramuscular suspension 600000 unit/ml	4	
penicillin g sodium injection solution reconstituted 5000000 unit	2	
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	1	
penicillin v potassium oral tablet 250 mg, 500 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm, 3.375 (3-0.375) gm, 4.5 (4-0.5) gm, 40.5 (36-4.5) gm	4	
Macrolides		
azithromycin intravenous solution reconstituted 500 mg	2	
azithromycin oral packet 1 gm	4	
azithromycin oral suspension reconstituted 100 mg/5ml	3	
azithromycin oral suspension reconstituted 200 mg/5ml	2	
azithromycin oral tablet 250 mg, 250 mg (6 pack), 500 mg, 500 mg (3 pack), 600 mg	1	
clarithromycin er oral tablet extended release 24 hour 500 mg	2	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	4	
clarithromycin oral tablet 250 mg, 500 mg	2	
ERY-TAB ORAL TABLET DELAYED RELEASE 250 MG, 333 MG, 500 MG	4	
ERYTHROCIN LACTOBIONATE INTRAVENOUS SOLUTION RECONSTITUTED 500 MG	4	
ERYTHROCIN STEARATE ORAL TABLET 250 MG	4	
erythromycin base oral capsule delayed release particles 250 mg	4	
erythromycin base oral tablet 250 mg, 500 mg	4	
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	4	
erythromycin ethylsuccinate oral tablet 400 mg	4	
Quinolones		
ciprofloxacin hcl oral tablet 100 mg	4	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	
ciprofloxacin in d5w intravenous solution 200 mg/100ml	4	
ciprofloxacin oral suspension reconstituted 500 mg/5ml (10%)	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
levofloxacin in d5w intravenous solution 500 mg/100ml, 750 mg/150ml	4	
levofloxacin intravenous solution 25 mg/ml	4	
levofloxacin oral solution 25 mg/ml	4	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	1	
ofloxacin oral tablet 400 mg	1	
Sulfonamides		
sulfacetamide sodium ophthalmic ointment 10 %	4	
sulfacetamide sodium ophthalmic solution 10 %	1	
sulfadiazine oral tablet 500 mg	2	
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	1	
Tetracyclines		
DOXY 100 INTRAVENOUS SOLUTION RECONSTITUTED 100 MG	2	
doxycycline hyclate oral capsule 100 mg	2	
doxycycline hyclate oral capsule 50 mg	1	
doxycycline hyclate oral tablet 100 mg	2	
doxycycline hyclate oral tablet 20 mg	1	
doxycycline monohydrate oral capsule 100 mg, 150 mg, 50 mg, 75 mg	2	
doxycycline monohydrate oral tablet 100 mg, 150 mg, 75 mg	2	
doxycycline monohydrate oral tablet 50 mg	1	
minocycline hcl oral capsule 100 mg, 50 mg, 75 mg	1	
minocycline hcl oral tablet 100 mg, 50 mg, 75 mg	2	
tetracycline hcl oral capsule 250 mg, 500 mg	4	
ANTICONVULSANTS		
Anticonvulsants, Other		
BRIVIACT ORAL SOLUTION 10 MG/ML	4	
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG	4	
EPIDIOLEX ORAL SOLUTION 100 MG/ML	4	PA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	2	
levetiracetam oral solution 100 mg/ml	1	
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	1	
ROWEEPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG	2	
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG	4	QL (90 EA per 30 days)
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 250 MG, 500 MG, 750 MG	4	QL (120 EA per 30 days)
Barbiturates		
phenobarbital oral elixir 20 mg/5ml	4	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	2	
primidone oral tablet 250 mg, 50 mg	1	
Benzodiazepines		
clobazam oral suspension 2.5 mg/ml	4	QL (480 ML per 30 days)
clobazam oral tablet 10 mg, 20 mg	4	QL (60 EA per 30 days)
DIASTAT ACUDIAL RECTAL GEL 10 MG, 20 MG	4	
DIASTAT PEDIATRIC RECTAL GEL 2.5 MG	4	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	4	
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	QL (60 EA per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	QL (60 EA per 30 days)
triazolam oral tablet 0.125 mg, 0.25 mg	2	
Calcium Channel Modifying Agents		
CELONTIN ORAL CAPSULE 300 MG	4	
ethosuximide oral capsule 250 mg	2	
ethosuximide oral solution 250 mg/5ml	2	
zonisamide oral capsule 100 mg, 25 mg, 50 mg	1	
Gamma-Aminobutyric Acid (Gaba) Augmenting Agents		
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	2	
divalproex sodium oral capsule delayed release sprinkle 125 mg	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	1	
FYCOMPA ORAL SUSPENSION 0.5 MG/ML	4	ST
FYCOMPA ORAL TABLET 10 MG, 2 MG, 4 MG, 6 MG, 8 MG	4	ST; QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 12 MG	5	ST; QL (30 EA per 30 days)
gabapentin oral capsule 100 mg, 300 mg, 400 mg	2	
gabapentin oral solution 250 mg/5ml	2	
gabapentin oral tablet 600 mg	2	QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	1	QL (180 EA per 30 days)
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	4	
valproic acid oral solution 250 mg/5ml	2	
vigabatrin oral packet 500 mg	5	PA; QL (180 EA per 30 days)
vigabatrin oral tablet 500 mg	5	PA; QL (180 EA per 30 days)
VIGADRONE ORAL PACKET 500 MG	5	PA; QL (180 EA per 30 days)
Glutamate Reducing Agents		
felbamate oral suspension 600 mg/5ml	5	
felbamate oral tablet 400 mg, 600 mg	4	
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	4	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	1	
lamotrigine oral tablet chewable 25 mg, 5 mg	1	
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	4	
topiramate oral capsule sprinkle 15 mg, 25 mg	1	
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	
Sodium Channel Agents		
APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	5	ST; QL (30 EA per 30 days)
APTIOM ORAL TABLET 600 MG	5	ST; QL (60 EA per 30 days)
BANZEL ORAL SUSPENSION 40 MG/ML	5	ST; QL (2760 ML per 30 days)
BANZEL ORAL TABLET 200 MG	5	ST; QL (480 EA per 30 days)
BANZEL ORAL TABLET 400 MG	5	ST; QL (240 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
carbamazepine er oral capsule extended release 12 hour 100 mg, 300 mg	2	
carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg	2	
carbamazepine er oral tablet extended release 12 hour 400 mg	4	
carbamazepine oral suspension 100 mg/5ml	2	
carbamazepine oral tablet 200 mg	2	
carbamazepine oral tablet chewable 100 mg	1	
DILANTIN ORAL CAPSULE 30 MG	4	
EPITOL ORAL TABLET 200 MG	1	
oxcarbazepine oral suspension 300 mg/5ml	4	
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	2	
PEGANONE ORAL TABLET 250 MG	4	
phenytoin oral suspension 125 mg/5ml	1	
phenytoin oral tablet chewable 50 mg	1	
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	1	
VIMPAT ORAL SOLUTION 10 MG/ML	4	
VIMPAT ORAL TABLET 100 MG	4	QL (120 EA per 30 days)
VIMPAT ORAL TABLET 150 MG, 200 MG	4	QL (60 EA per 30 days)
VIMPAT ORAL TABLET 50 MG	4	QL (90 EA per 30 days)
ANTIDEMENTIA AGENTS		
Cholinesterase Inhibitors		
donepezil hcl oral tablet 10 mg, 5 mg	1	
donepezil hcl oral tablet 23 mg	4	
donepezil hcl oral tablet dispersible 10 mg, 5 mg	1	
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	1	
galantamine hydrobromide oral solution 4 mg/ml	4	
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	1	
rivastigmine tartrate oral capsule 1.5 mg	1	
rivastigmine tartrate oral capsule 3 mg, 4.5 mg, 6 mg	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	4	
N-Methyl-D-Aspartate (Nmda) Receptor Antagonist		
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	3	
memantine hcl oral solution 2 mg/ml	2	
memantine hcl oral tablet 10 mg, 5 mg	1	
memantine hcl oral tablet 28 x 5 mg & 21 x 10 mg	2	
NAMENDA XR TITRATION PACK ORAL CAPSULE EXTENDED RELEASE 24 HOUR 7 & 14 & 21 &28 MG	3	QL (56 EA per 365 days)
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG	3	
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG	3	
ANTIDEPRESSANTS		
Antidepressants, Other		
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg	1	QL (120 EA per 30 days)
bupropion hcl er (sr) oral tablet extended release 12 hour 150 mg	1	QL (90 EA per 30 days)
bupropion hcl er (sr) oral tablet extended release 12 hour 200 mg	1	QL (60 EA per 30 days)
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	1	QL (90 EA per 30 days)
bupropion hcl oral tablet 100 mg	1	QL (180 EA per 30 days)
bupropion hcl oral tablet 75 mg	1	QL (120 EA per 30 days)
maprotiline hcl oral tablet 25 mg, 50 mg, 75 mg	1	
mirtazapine oral tablet 15 mg, 30 mg, 45 mg	1	
mirtazapine oral tablet 7.5 mg	1	QL (45 EA per 30 days)
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	1	
nefazodone hcl oral tablet 100 mg, 200 mg, 250 mg	4	
nefazodone hcl oral tablet 150 mg, 50 mg	2	
trazodone hcl oral tablet 100 mg, 150 mg, 50 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
trazodone hcl oral tablet 300 mg	2	
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG	4	ST; QL (30 EA per 30 days)
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG	3	QL (30 EA per 30 days)
VIIBRYD STARTER PACK ORAL KIT 10 & 20 MG	3	QL (30 EA per 30 days)
Monoamine Oxidase Inhibitors		
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR	5	ST; QL (30 EA per 30 days)
MARPLAN ORAL TABLET 10 MG	4	ST
phenelzine sulfate oral tablet 15 mg	1	
tranylcypromine sulfate oral tablet 10 mg	4	
Selective Serotonin Reuptake Inhibitors (Ssris)		
citalopram hydrobromide oral solution 10 mg/5ml	2	
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	1	
escitalopram oxalate oral solution 5 mg/5ml	2	QL (600 ML per 30 days)
escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg	1	
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	1	
fluoxetine hcl oral solution 20 mg/5ml	1	
fluoxetine hcl oral tablet 10 mg, 20 mg	3	
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	1	
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	1	
PAXIL ORAL SUSPENSION 10 MG/5ML	4	QL (900 ML per 30 days)
sertraline hcl oral concentrate 20 mg/ml	2	
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	1	
Serotonin/Norepinephrine Reuptake Inhibitors (Snris)		
desvenlafaxine er oral tablet extended release 24 hour 100 mg	4	QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
desvenlafaxine er oral tablet extended release 24 hour 50 mg	4	QL (30 EA per 30 days)
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg	4	QL (120 EA per 30 days)
desvenlafaxine succinate er oral tablet extended release 24 hour 25 mg, 50 mg	4	QL (30 EA per 30 days)
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	2	QL (60 EA per 30 days)
duloxetine hcl oral capsule delayed release particles 40 mg	4	QL (60 EA per 30 days)
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG	3	QL (30 EA per 30 days)
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG	3	QL (28 EA per 28 days)
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 6-50 mg	4	QL (30 EA per 30 days)
olanzapine-fluoxetine hcl oral capsule 3-25 mg, 6-25 mg	4	QL (90 EA per 30 days)
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg	1	
venlafaxine hcl er oral tablet extended release 24 hour 75 mg	2	
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	1	
Tricyclics		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
amoxapine oral tablet 100 mg, 150 mg, 25 mg, 50 mg	4	ST
clomipramine hcl oral capsule 25 mg, 50 mg, 75 mg	4	ST
desipramine hcl oral tablet 10 mg, 25 mg	1	
desipramine hcl oral tablet 100 mg, 150 mg	4	
desipramine hcl oral tablet 50 mg, 75 mg	2	
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	2	
doxepin hcl oral concentrate 10 mg/ml	2	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
imipramine pamoate oral capsule 100 mg, 125 mg, 150 mg, 75 mg	2	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	1	
nortriptyline hcl oral solution 10 mg/5ml	4	
protriptyline hcl oral tablet 10 mg, 5 mg	4	
trimipramine maleate oral capsule 100 mg, 25 mg, 50 mg	2	
ANTIEMETICS		
Antiemetics, Other		
chlorpromazine hcl oral tablet 10 mg	2	B/D
chlorpromazine hcl oral tablet 25 mg	4	B/D
COMPRO RECTAL SUPPOSITORY 25 MG	2	
meclizine hcl oral tablet 12.5 mg, 25 mg	2	
prochlorperazine maleate oral tablet 10 mg, 5 mg	1	
prochlorperazine rectal suppository 25 mg	2	
promethazine hcl oral syrup 6.25 mg/5ml	2	
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	1	
scopolamine transdermal patch 72 hour 1 mg/3days	4	
TRANSDERM-SCOP (1.5 MG) TRANSDERMAL PATCH 72 HOUR 1 MG/3DAYS	4	
Emetogenic Therapy Adjuncts		
aprepitant oral capsule 125 mg, 40 mg, 80 mg	4	B/D; QL (30 EA per 30 days)
aprepitant oral capsule 80 & 125 mg	4	B/D; QL (12 EA per 30 days)
dronabinol oral capsule 10 mg, 5 mg	4	B/D; QL (60 EA per 30 days)
dronabinol oral capsule 2.5 mg	2	B/D; QL (60 EA per 30 days)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG	4	B/D
granisetron hcl oral tablet 1 mg	2	B/D; QL (60 EA per 30 days)
ondansetron hcl oral solution 4 mg/5ml	4	B/D
ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg	1	B/D
ondansetron oral tablet dispersible 4 mg, 8 mg	1	B/D
SYNDROS ORAL SOLUTION 5 MG/ML	5	B/D; QL (120 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ANTIFUNGALS		
Antifungals		
ABELCET INTRAVENOUS SUSPENSION 5 MG/ML	5	B/D
AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG	5	B/D
amphotericin b intravenous solution reconstituted 50 mg	2	B/D
caspofungin acetate intravenous solution reconstituted 50 mg, 70 mg	5	B/D
CRESEMBA ORAL CAPSULE 186 MG	5	
fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%	4	B/D
fluconazole in sodium chloride intravenous solution 400-0.9 mg/200ml-%	2	B/D
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	2	
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	1	
flucytosine oral capsule 250 mg, 500 mg	5	
griseofulvin microsize oral suspension 125 mg/5ml	4	
griseofulvin microsize oral tablet 500 mg	4	
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	4	
itraconazole oral capsule 100 mg	4	PA
itraconazole oral solution 10 mg/ml	4	PA
ketoconazole oral tablet 200 mg	2	
NOXAFIL ORAL SUSPENSION 40 MG/ML	5	PA; QL (840 ML per 28 days)
NOXAFIL ORAL TABLET DELAYED RELEASE 100 MG	5	PA; QL (93 EA per 30 days)
nystatin oral tablet 500000 unit	1	
terbinafine hcl oral tablet 250 mg	1	
voriconazole intravenous solution reconstituted 200 mg	5	PA
voriconazole oral suspension reconstituted 40 mg/ml	5	PA
voriconazole oral tablet 200 mg	5	PA; QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
voriconazole oral tablet 50 mg	4	PA; QL (120 EA per 30 days)
ANTIGOUT AGENTS		
Antigout Agents		
colchicine oral capsule 0.6 mg	4	
colchicine oral tablet 0.6 mg	4	
colchicine-probenecid oral tablet 0.5-500 mg	1	
febuxostat oral tablet 40 mg, 80 mg	3	
MITIGARE ORAL CAPSULE 0.6 MG	3	
probenecid oral tablet 500 mg	1	
ANTI-INFLAMMATORY AGENTS		
Nonsteroidal Anti-Inflammatory Drugs		
ketorolac tromethamine oral tablet 10 mg	4	QL (20 EA per 30 days)
TIVORBEX ORAL CAPSULE 20 MG, 40 MG	4	
VIVLODEX ORAL CAPSULE 10 MG	4	
ANTIMIGRAINE AGENTS		
Ergot Alkaloids		
dihydroergotamine mesylate nasal solution 4 mg/ml	5	QL (8 ML per 30 days)
ergotamine-caffeine oral tablet 1-100 mg	4	
MIGERGOT RECTAL SUPPOSITORY 2-100 MG	4	QL (20 EA per 28 days)
Serotonin (5-Ht) 1B-1D Receptor Agonists		
almotriptan malate oral tablet 12.5 mg, 6.25 mg	4	QL (12 EA per 30 days)
naratriptan hcl oral tablet 1 mg, 2.5 mg	2	QL (9 EA per 30 days)
rizatriptan benzoate oral tablet 10 mg	1	QL (18 EA per 30 days)
rizatriptan benzoate oral tablet 5 mg	1	QL (24 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 10 mg	2	QL (18 EA per 30 days)
rizatriptan benzoate oral tablet dispersible 5 mg	2	QL (24 EA per 30 days)
sumatriptan nasal solution 20 mg/act, 5 mg/act	4	QL (18 EA per 30 days)
sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg	1	QL (9 EA per 30 days)
sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml	4	QL (5 ML per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	4	QL (8 ML per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml	4	QL (5 ML per 30 days)
sumatriptan succinate subcutaneous solution prefilled syringe 6 mg/0.5ml	4	QL (5 ML per 30 days)
zolmitriptan oral tablet 2.5 mg, 5 mg	2	QL (12 EA per 30 days)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	2	QL (12 EA per 30 days)
ANTIMYASTHENIC AGENTS		
Parasympathomimetics		
guanidine hcl oral tablet 125 mg	3	
pyridostigmine bromide oral solution 60 mg/5ml	4	
pyridostigmine bromide oral tablet 60 mg	1	
ANTIMYCOBACTERIALS		
Antituberculars		
ethambutol hcl oral tablet 100 mg, 400 mg	2	
isoniazid oral syrup 50 mg/5ml	1	
isoniazid oral tablet 100 mg, 300 mg	1	
PASER ORAL PACKET 4 GM	4	
PRIFTIN ORAL TABLET 150 MG	4	
pyrazinamide oral tablet 500 mg	4	
rifabutin oral capsule 150 mg	4	
rifampin intravenous solution reconstituted 600 mg	4	
rifampin oral capsule 150 mg, 300 mg	2	
RIFATER ORAL TABLET 50-120-300 MG	4	
SIRTURO ORAL TABLET 100 MG	5	PA
TRECATOR ORAL TABLET 250 MG	4	
ANTINEOPLASTICS		
Alkylating Agents		
cyclophosphamide oral capsule 25 mg, 50 mg	4	B/D
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	3	
LEUKERAN ORAL TABLET 2 MG	4	
MATULANE ORAL CAPSULE 50 MG	5	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
Antiandrogens		
bicalutamide oral tablet 50 mg	2	
ERLEADA ORAL TABLET 60 MG	5	PA; LA
flutamide oral capsule 125 mg	2	
nilutamide oral tablet 150 mg	5	QL (60 EA per 30 days)
NUBEQA ORAL TABLET 300 MG	5	PA; LA
XTANDI ORAL CAPSULE 40 MG	5	PA; QL (120 EA per 30 days)
Antiangiogenic Agents		
disopyramide phosphate oral capsule 100 mg	4	
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 25 MG, 5 MG	5	PA; LA; QL (28 EA per 28 days)
REVLIMID ORAL CAPSULE 20 MG	5	PA; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 100 MG, 200 MG, 50 MG	5	PA; QL (30 EA per 30 days)
THALOMID ORAL CAPSULE 150 MG	5	PA; QL (60 EA per 30 days)
Antiestrogens/Modifiers		
EMCYT ORAL CAPSULE 140 MG	4	
SOLTAMOX ORAL SOLUTION 10 MG/5ML	4	
tamoxifen citrate oral tablet 10 mg, 20 mg	2	
toremifene citrate oral tablet 60 mg	5	PA; QL (30 EA per 30 days)
Antimetabolites		
hydroxyurea oral capsule 500 mg	2	
PURIXAN ORAL SUSPENSION 2000 MG/100ML	5	
TABLOID ORAL TABLET 40 MG	4	
Antineoplastics		
abiraterone acetate oral tablet 250 mg	5	PA; QL (120 EA per 30 days)
AFINITOR DISPERZ ORAL TABLET SOLUBLE 2 MG, 3 MG	5	PA; QL (30 EA per 30 days)
AFINITOR DISPERZ ORAL TABLET SOLUBLE 5 MG	5	PA; QL (60 EA per 30 days)
AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	5	PA; QL (30 EA per 30 days)
ALECENSA ORAL CAPSULE 150 MG	5	PA
BALVERSA ORAL TABLET 3 MG	5	PA; LA; QL (90 EA per 30 days)
BALVERSA ORAL TABLET 4 MG	5	PA; LA; QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
BALVERSA ORAL TABLET 5 MG	5	PA; LA; QL (30 EA per 30 days)
bexarotene oral capsule 75 mg	5	PA
BOSULIF ORAL TABLET 100 MG	5	PA; QL (120 EA per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PA; QL (30 EA per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	5	PA; LA; QL (180 EA per 30 days)
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG	5	PA
CALQUENCE ORAL CAPSULE 100 MG	5	PA; LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG	5	PA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	5	PA; QL (30 EA per 30 days)
COMETRIQ (100 MG DAILY DOSE) ORAL KIT 1 X 80 & 1 X 20 MG	5	PA; QL (56 EA per 28 days)
COMETRIQ (140 MG DAILY DOSE) ORAL KIT 1 X 80 & 3 X 20 MG	5	PA; QL (112 EA per 28 days)
COMETRIQ (60 MG DAILY DOSE) ORAL KIT 20 MG	5	PA; QL (84 EA per 28 days)
COPIKTRA ORAL CAPSULE 15 MG, 25 MG	5	PA; QL (60 EA per 30 days)
COTELLIC ORAL TABLET 20 MG	5	PA; QL (63 EA per 28 days)
DAURISMO ORAL TABLET 100 MG, 25 MG	5	PA
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	4	B/D
ERIVEDGE ORAL CAPSULE 150 MG	5	PA; QL (28 EA per 28 days)
erlotinib hcl oral tablet 100 mg, 150 mg	5	PA; QL (30 EA per 30 days)
erlotinib hcl oral tablet 25 mg	5	PA; QL (90 EA per 30 days)
FARYDAK ORAL CAPSULE 10 MG	5	PA; QL (60 EA per 30 days)
FARYDAK ORAL CAPSULE 15 MG, 20 MG	5	PA; QL (30 EA per 30 days)
GILOTRIF ORAL TABLET 20 MG, 30 MG, 40 MG	5	PA; QL (30 EA per 30 days)
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG	5	PA; QL (30 EA per 30 days)
ICLUSIG ORAL TABLET 15 MG	5	PA; QL (60 EA per 30 days)
ICLUSIG ORAL TABLET 45 MG	5	PA; QL (30 EA per 30 days)
IDHIFA ORAL TABLET 100 MG	5	PA; QL (30 EA per 30 days)
IDHIFA ORAL TABLET 50 MG	5	PA; QL (60 EA per 30 days)
imatinib mesylate oral tablet 100 mg, 400 mg	5	PA; QL (90 EA per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; QL (120 EA per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
IMBRUVICA ORAL TABLET 140 MG	5	PA; QL (120 EA per 30 days)
IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG	5	PA; QL (30 EA per 30 days)
INLYTA ORAL TABLET 1 MG	5	PA; QL (180 EA per 30 days)
INLYTA ORAL TABLET 5 MG	5	PA; QL (60 EA per 30 days)
INREBIC ORAL CAPSULE 100 MG	5	PA; QL (120 EA per 30 days)
INTRON A INJECTION SOLUTION RECONSTITUTED 18000000 UNIT, 50000000 UNIT	5	PA
IRESSA ORAL TABLET 250 MG	5	PA
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG	5	PA; QL (60 EA per 30 days)
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG	5	PA
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG	5	PA
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG	5	PA
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG	5	PA
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG	5	PA
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG	5	PA
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG	5	PA
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG	5	PA
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	2	
LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG	5	PA
LORBRENA ORAL TABLET 100 MG	5	PA; QL (30 EA per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA; QL (120 EA per 30 days)
LYNPARZA ORAL TABLET 100 MG	5	PA; LA; QL (180 EA per 30 days)
LYNPARZA ORAL TABLET 150 MG	5	PA; LA; QL (120 EA per 30 days)
LYSODREN ORAL TABLET 500 MG	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
MEKINIST ORAL TABLET 0.5 MG	5	PA; LA; QL (120 EA per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PA; LA; QL (30 EA per 30 days)
MEKTOVI ORAL TABLET 15 MG	5	PA; LA; QL (180 EA per 30 days)
NERLYNX ORAL TABLET 40 MG	5	PA; LA; QL (180 EA per 30 days)
NEXAVAR ORAL TABLET 200 MG	5	PA; LA; QL (120 EA per 30 days)
NINLARO ORAL CAPSULE 2.3 MG, 3 MG, 4 MG	5	PA
ODOMZO ORAL CAPSULE 200 MG	5	PA
PIQRAY (200 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
PIQRAY (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 200 & 50 MG	5	PA
PIQRAY (300 MG DAILY DOSE) ORAL TABLET THERAPY PACK 2 X 150 MG	5	PA
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG	5	PA; QL (21 EA per 28 days)
SPRYCEL ORAL TABLET 100 MG, 50 MG, 70 MG, 80 MG	5	PA; QL (60 EA per 30 days)
SPRYCEL ORAL TABLET 140 MG	5	PA; QL (30 EA per 30 days)
SPRYCEL ORAL TABLET 20 MG	5	PA; QL (90 EA per 30 days)
STIVARGA ORAL TABLET 40 MG	5	PA; QL (84 EA per 28 days)
SUTENT ORAL CAPSULE 12.5 MG, 25 MG, 37.5 MG, 50 MG	5	PA; QL (28 EA per 28 days)
SYNRIBO SUBCUTANEOUS SOLUTION RECONSTITUTED 3.5 MG	5	PA
TAFINLAR ORAL CAPSULE 50 MG	5	PA; LA; QL (180 EA per 30 days)
TAFINLAR ORAL CAPSULE 75 MG	5	PA; LA; QL (120 EA per 30 days)
TAGRISSO ORAL TABLET 40 MG, 80 MG	5	PA
TALZENNA ORAL CAPSULE 0.25 MG, 1 MG	5	PA
TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG	5	PA; QL (120 EA per 30 days)
TIBSOVO ORAL TABLET 250 MG	5	PA; LA; QL (60 EA per 30 days)
tolcapone oral tablet 100 mg	5	
tretinoin oral capsule 10 mg	5	
TURALIO ORAL CAPSULE 200 MG	5	PA; LA; QL (120 EA per 30 days)
TYKERB ORAL TABLET 250 MG	5	PA; QL (180 EA per 30 days)
VENCLEXTA ORAL TABLET 10 MG, 50 MG	4	PA; LA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG	3	PA; LA
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG	5	PA; LA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 100 MG	5	PA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PA; QL (180 EA per 30 days)
VITRAKVI ORAL SOLUTION 20 MG/ML	5	PA
VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG	5	PA; QL (30 EA per 30 days)
VOTRIENT ORAL TABLET 200 MG	5	PA; QL (120 EA per 30 days)
XALKORI ORAL CAPSULE 200 MG, 250 MG	5	PA; QL (150 EA per 30 days)
XOSPATA ORAL TABLET 40 MG	5	PA; LA; QL (90 EA per 30 days)
XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA
XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA
XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA
XPOVIO (80 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG	5	PA; LA
YONSA ORAL TABLET 125 MG	5	PA; QL (120 EA per 30 days)
ZELBORAF ORAL TABLET 240 MG	5	PA; QL (240 EA per 30 days)
ZOLINZA ORAL CAPSULE 100 MG	5	PA; QL (120 EA per 30 days)
ZYDELIG ORAL TABLET 100 MG, 150 MG	5	PA; QL (60 EA per 30 days)
ZYKADIA ORAL CAPSULE 150 MG	5	PA; QL (150 EA per 30 days)
ZYKADIA ORAL TABLET 150 MG	5	PA; QL (150 EA per 30 days)
ZYTIGA ORAL TABLET 500 MG	5	PA; QL (120 EA per 30 days)
Aromatase Inhibitors, 3Rd Generation		
anastrozole oral tablet 1 mg	2	
exemestane oral tablet 25 mg	4	
letrozole oral tablet 2.5 mg	2	
Molecular Target Inhibitors		
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA; QL (30 EA per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA; QL (180 EA per 30 days)
ALUNBRIG ORAL TABLET THERAPY PACK 90 & 180 MG	5	PA; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
KISQALI (200 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (400 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI (600 MG DOSE) ORAL TABLET THERAPY PACK 200 MG	5	PA
KISQALI FEMARA (400 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA (600 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
KISQALI FEMARA(200 MG DOSE) ORAL TABLET THERAPY PACK 200 & 2.5 MG	5	PA
RUBRACA ORAL TABLET 200 MG, 250 MG, 300 MG	5	PA
RYDAPT ORAL CAPSULE 25 MG	5	PA; QL (240 EA per 30 days)
ZEJULA ORAL CAPSULE 100 MG	5	PA; QL (90 EA per 30 days)
Treatment Adjuncts		
allopurinol oral tablet 100 mg, 300 mg	1	
MESNEX ORAL TABLET 400 MG	5	
ANTIPARASITICS		
Anthelmintics		
albendazole oral tablet 200 mg	4	
benznidazole oral tablet 100 mg, 12.5 mg	2	
EMVERM ORAL TABLET CHEWABLE 100 MG	4	
ivermectin oral tablet 3 mg	2	
Antiprotozoals		
ALINIA ORAL SUSPENSION RECONSTITUTED 100 MG/5ML	4	
ALINIA ORAL TABLET 500 MG	4	
atovaquone oral suspension 750 mg/5ml	5	
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	2	
chloroquine phosphate oral tablet 250 mg, 500 mg	1	
COARTEM ORAL TABLET 20-120 MG	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
HAVRIX INTRAMUSCULAR SUSPENSION 1440 EL U/ML, 1440 EL U/ML 1 ML	3	
hydroxychloroquine sulfate oral tablet 200 mg	2	
mefloquine hcl oral tablet 250 mg	1	
primaquine phosphate oral tablet 26.3 mg	4	
quinine sulfate oral capsule 324 mg	4	PA; QL (42 EA per 7 days)
ANTIPARKINSON AGENTS		
Anticholinergics		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	1	
trihexyphenidyl hcl oral elixir 0.4 mg/ml	4	
trihexyphenidyl hcl oral solution 0.4 mg/ml	4	
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	1	
Antiparkinson Agents, Other		
amantadine hcl oral capsule 100 mg	2	
amantadine hcl oral syrup 50 mg/5ml	2	
amantadine hcl oral tablet 100 mg	2	
entacapone oral tablet 200 mg	4	
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 137 MG	5	PA; QL (62 EA per 31 days)
GOCOVRI ORAL CAPSULE EXTENDED RELEASE 24 HOUR 68.5 MG	5	PA; QL (31 EA per 31 days)
Dopamine Agonists		
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML	5	PA
bromocriptine mesylate oral capsule 5 mg	4	
bromocriptine mesylate oral tablet 2.5 mg	2	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR	4	
pramipexole dihydrochloride er oral tablet extended release 24 hour 3.75 mg	2	
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	1	
ropinirole hcl er oral tablet extended release 24 hour 12 mg	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	1	
Dopamine Precursors- L-Amino Acid Decarboxylase Inhibitors		
carbidopa oral tablet 25 mg	5	
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	1	
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	1	
carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg	2	
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	4	
Monoamine Oxidase B (Mao-B) Inhibitors		
rasagiline mesylate oral tablet 0.5 mg, 1 mg	2	
selegiline hcl oral capsule 5 mg	3	
selegiline hcl oral tablet 5 mg	3	
ANTIPSYCHOTICS		
1St Generation-Typical		
fluphenazine decanoate injection solution 25 mg/ml	2	
fluphenazine hcl injection solution 2.5 mg/ml	4	
fluphenazine hcl oral concentrate 5 mg/ml	2	
fluphenazine hcl oral elixir 2.5 mg/5ml	2	
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	2	
haloperidol decanoate intramuscular solution 100 mg/ml, 100 mg/ml 1 ml, 50 mg/ml	2	
haloperidol lactate injection solution 5 mg/ml	4	
haloperidol lactate oral concentrate 2 mg/ml	1	
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 5 mg	1	
haloperidol oral tablet 20 mg	2	
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	4	
pimozide oral tablet 1 mg, 2 mg	2	
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	2	
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	2	
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	1	
2Nd Generation-Atypical		
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG	5	
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG	5	
ABILIFY MYCITE ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG	5	
aripiprazole oral solution 1 mg/ml	4	QL (750 ML per 30 days)
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	4	QL (30 EA per 30 days)
aripiprazole oral tablet dispersible 10 mg	4	QL (90 EA per 30 days)
aripiprazole oral tablet dispersible 15 mg	4	QL (60 EA per 30 days)
FANAPT ORAL TABLET 1 MG, 2 MG	4	ST; QL (60 EA per 30 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	5	ST; QL (60 EA per 30 days)
FANAPT ORAL TABLET 4 MG	4	ST; QL (180 EA per 30 days)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG	4	ST; QL (60 EA per 30 days)
GEODON INTRAMUSCULAR SOLUTION RECONSTITUTED 20 MG	4	ST; QL (18 EA per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 1.5 MG, 3 MG, 9 MG	5	ST; QL (30 EA per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 6 MG	5	ST; QL (60 EA per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 78 MG/0.5ML	5	
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 39 MG/0.25ML	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML, 410 MG/1.315ML, 546 MG/1.75ML, 819 MG/2.625ML	5	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG	3	
olanzapine intramuscular solution reconstituted 10 mg	4	QL (60 EA per 30 days)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	2	
olanzapine oral tablet dispersible 10 mg, 5 mg	2	
olanzapine oral tablet dispersible 15 mg, 20 mg	4	
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 9 mg	4	QL (30 EA per 30 days)
paliperidone er oral tablet extended release 24 hour 6 mg	4	QL (60 EA per 30 days)
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG	4	
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg	4	
quetiapine fumarate oral tablet 100 mg, 25 mg, 300 mg, 400 mg, 50 mg	2	QL (60 EA per 30 days)
quetiapine fumarate oral tablet 200 mg	2	QL (30 EA per 30 days)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG	5	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED 12.5 MG	4	
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED 25 MG, 37.5 MG, 50 MG	5	
risperidone oral solution 1 mg/ml	2	QL (480 ML per 30 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	1	
risperidone oral tablet dispersible 0.25 mg, 2 mg, 3 mg, 4 mg	4	QL (60 EA per 30 days)
risperidone oral tablet dispersible 0.5 mg	2	QL (120 EA per 30 days)
risperidone oral tablet dispersible 1 mg	1	QL (60 EA per 30 days)
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	1	QL (60 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG	4	ST; QL (2 EA per 28 days)
Antipsychotic, Other		
chlorpromazine hcl oral tablet 100 mg, 200 mg, 50 mg	4	
NUPLAZID ORAL CAPSULE 34 MG	5	PA; LA
NUPLAZID ORAL TABLET 10 MG	5	PA; LA
perphenazine oral tablet 16 mg, 2 mg	2	
perphenazine oral tablet 4 mg, 8 mg	2	B/D
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	4	
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 2.5 MG, 5 MG	4	QL (60 EA per 30 days)
VRAYLAR ORAL CAPSULE 1.5 MG	5	ST; QL (60 EA per 30 days)
VRAYLAR ORAL CAPSULE 3 MG, 4.5 MG, 6 MG	5	ST; QL (30 EA per 30 days)
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG	4	ST
Treatment-Resistant		
clozapine oral tablet 100 mg	4	QL (180 EA per 30 days)
clozapine oral tablet 200 mg	2	QL (120 EA per 30 days)
clozapine oral tablet 25 mg, 50 mg	1	
clozapine oral tablet dispersible 100 mg, 150 mg	4	QL (180 EA per 30 days)
clozapine oral tablet dispersible 12.5 mg, 200 mg	4	QL (120 EA per 30 days)
clozapine oral tablet dispersible 25 mg	4	QL (90 EA per 30 days)
VERSACLOZ ORAL SUSPENSION 50 MG/ML	5	ST; QL (540 ML per 30 days)
ANTIVIRALS		
Anti-Cytomegalovirus (Cmv) Agents		
valganciclovir hcl oral solution reconstituted 50 mg/ml	4	
valganciclovir hcl oral tablet 450 mg	5	
ZIRGAN OPHTHALMIC GEL 0.15 %	4	
Antihepatitis Agents		
adefovir dipivoxil oral tablet 10 mg	5	
BARACLUDE ORAL SOLUTION 0.05 MG/ML	5	QL (600 ML per 30 days)
entecavir oral tablet 0.5 mg, 1 mg	4	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
EPIVIR HBV ORAL SOLUTION 5 MG/ML	4	
INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML	5	PA
INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT	5	PA
lamivudine oral tablet 100 mg	4	
VEMLIDY ORAL TABLET 25 MG	5	PA
Anti-Hepatitis C (Hcv) Agents, Direct Acting		
EPCLUSA ORAL TABLET 400-100 MG	5	PA
HARVONI ORAL TABLET 90-400 MG	5	PA
ledipasvir-sofosbuvir oral tablet 90-400 mg	5	PA
sofosbuvir-velpatasvir oral tablet 400-100 mg	5	PA
SOVALDI ORAL TABLET 400 MG	5	PA
VOSEVI ORAL TABLET 400-100-100 MG	5	PA
Anti-Hepatitis C (Hcv) Agents, Other		
PEGASYS PROCLICK SUBCUTANEOUS SOLUTION 180 MCG/0.5ML	5	PA
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/0.5ML, 180 MCG/ML	5	PA
RIBASPHERE ORAL CAPSULE 200 MG	2	
ribavirin oral capsule 200 mg	2	
ribavirin oral tablet 200 mg	2	
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG	5	PA; QL (4 EA per 28 days)
Antiherpetic Agents		
acyclovir oral capsule 200 mg	1	
acyclovir oral suspension 200 mg/5ml	4	
acyclovir oral tablet 400 mg, 800 mg	1	
acyclovir sodium intravenous solution 50 mg/ml	1	B/D
famciclovir oral tablet 125 mg, 250 mg, 500 mg	1	
valacyclovir hcl oral tablet 1 gm	1	QL (90 EA per 30 days)
valacyclovir hcl oral tablet 500 mg	1	QL (60 EA per 30 days)
Anti-Hiv Agents, Non-Nucleoside Reverse Transcriptase Inhibitors		
EDURANT ORAL TABLET 25 MG	5	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
efavirenz oral capsule 200 mg, 50 mg	4	QL (480 EA per 30 days)
efavirenz oral tablet 600 mg	4	QL (480 EA per 30 days)
INTELENCE ORAL TABLET 100 MG	5	QL (120 EA per 30 days)
INTELENCE ORAL TABLET 200 MG	5	QL (60 EA per 30 days)
INTELENCE ORAL TABLET 25 MG	4	QL (120 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 100 mg	2	QL (90 EA per 30 days)
nevirapine er oral tablet extended release 24 hour 400 mg	4	QL (30 EA per 30 days)
nevirapine oral suspension 50 mg/5ml	4	QL (1200 ML per 30 days)
nevirapine oral tablet 200 mg	1	QL (60 EA per 30 days)
PIFELTRO ORAL TABLET 100 MG	5	QL (30 EA per 30 days)
RESCRIPTOR ORAL TABLET 200 MG	4	QL (180 EA per 30 days)
Anti-Hiv Agents, Nucleoside And Nucleotide Reverse Transcriptase Inhibitors		
abacavir sulfate oral solution 20 mg/ml	4	QL (960 ML per 30 days)
abacavir sulfate oral tablet 300 mg	4	QL (60 EA per 30 days)
abacavir sulfate-lamivudine oral tablet 600-300 mg	4	QL (30 EA per 30 days)
abacavir-lamivudine-zidovudine oral tablet 300-150-300 mg	5	QL (60 EA per 30 days)
CIMDUO ORAL TABLET 300-300 MG	5	QL (30 EA per 30 days)
didanosine oral capsule delayed release 200 mg	2	QL (60 EA per 30 days)
didanosine oral capsule delayed release 250 mg	2	QL (30 EA per 30 days)
didanosine oral capsule delayed release 400 mg	4	QL (30 EA per 30 days)
EMTRIVA ORAL CAPSULE 200 MG	4	QL (30 EA per 30 days)
EMTRIVA ORAL SOLUTION 10 MG/ML	4	QL (680 ML per 28 days)
lamivudine oral solution 10 mg/ml	2	
lamivudine oral tablet 150 mg	2	QL (60 EA per 30 days)
lamivudine oral tablet 300 mg	2	QL (30 EA per 30 days)
lamivudine-zidovudine oral tablet 150-300 mg	4	QL (60 EA per 30 days)
stavudine oral capsule 15 mg, 20 mg	2	QL (120 EA per 30 days)
stavudine oral capsule 30 mg	2	QL (60 EA per 30 days)
stavudine oral capsule 40 mg	4	QL (60 EA per 30 days)
tenofovir disoproxil fumarate oral tablet 300 mg	4	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
TRUVADA ORAL TABLET 200-300 MG	5	QL (30 EA per 30 days)
VIDEX EC ORAL CAPSULE DELAYED RELEASE 125 MG	4	QL (90 EA per 30 days)
VIDEX ORAL SOLUTION RECONSTITUTED 2 GM, 4 GM	4	QL (1200 ML per 30 days)
VIREAD ORAL POWDER 40 MG/GM	3	QL (240 GM per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	3	QL (30 EA per 30 days)
zidovudine oral capsule 100 mg	2	QL (180 EA per 30 days)
zidovudine oral syrup 50 mg/5ml	2	QL (1680 ML per 28 days)
zidovudine oral tablet 300 mg	1	QL (60 EA per 30 days)
Anti-Hiv Agents, Other		
BIKTARVY ORAL TABLET 50-200-25 MG	5	QL (30 EA per 30 days)
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG	3	QL (60 EA per 30 days)
ISENTRESS HD ORAL TABLET 600 MG	5	QL (60 EA per 30 days)
ISENTRESS ORAL PACKET 100 MG	5	QL (60 EA per 30 days)
ISENTRESS ORAL TABLET 400 MG	5	QL (120 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 100 MG	5	QL (180 EA per 30 days)
ISENTRESS ORAL TABLET CHEWABLE 25 MG	4	QL (180 EA per 30 days)
SELZENTRY ORAL SOLUTION 20 MG/ML	5	QL (1800 ML per 30 days)
SELZENTRY ORAL TABLET 150 MG	5	QL (240 EA per 30 days)
SELZENTRY ORAL TABLET 25 MG	4	QL (120 EA per 30 days)
SELZENTRY ORAL TABLET 300 MG	5	QL (120 EA per 30 days)
SELZENTRY ORAL TABLET 75 MG	4	QL (60 EA per 30 days)
TIVICAY ORAL TABLET 10 MG	4	QL (60 EA per 30 days)
TIVICAY ORAL TABLET 25 MG, 50 MG	5	QL (60 EA per 30 days)
TRIUMEQ ORAL TABLET 600-50-300 MG	5	QL (30 EA per 30 days)
TYBOST ORAL TABLET 150 MG	3	QL (30 EA per 30 days)
Anti-Hiv Agents, Protease Inhibitors		
APTIVUS ORAL CAPSULE 250 MG	5	QL (120 EA per 30 days)
APTIVUS ORAL SOLUTION 100 MG/ML	5	QL (285 ML per 28 days)
atazanavir sulfate oral capsule 150 mg, 200 mg	4	QL (60 EA per 30 days)
atazanavir sulfate oral capsule 300 mg	5	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
CRIXIVAN ORAL CAPSULE 200 MG	4	QL (450 EA per 30 days)
CRIXIVAN ORAL CAPSULE 400 MG	4	QL (270 EA per 30 days)
fosamprenavir calcium oral tablet 700 mg	5	QL (120 EA per 30 days)
INVIRASE ORAL TABLET 500 MG	5	QL (120 EA per 30 days)
KALETRA ORAL TABLET 100-25 MG	3	
KALETRA ORAL TABLET 200-50 MG	3	QL (150 EA per 30 days)
LEXIVA ORAL SUSPENSION 50 MG/ML	4	QL (1575 ML per 28 days)
lopinavir-ritonavir oral solution 400-100 mg/5ml	2	QL (400 ML per 30 days)
NORVIR ORAL PACKET 100 MG	4	QL (360 EA per 30 days)
NORVIR ORAL SOLUTION 80 MG/ML	4	QL (480 ML per 30 days)
PREZISTA ORAL SUSPENSION 100 MG/ML	5	QL (360 ML per 30 days)
PREZISTA ORAL TABLET 150 MG	4	QL (240 EA per 30 days)
PREZISTA ORAL TABLET 600 MG	5	QL (60 EA per 30 days)
PREZISTA ORAL TABLET 75 MG	4	QL (420 EA per 30 days)
PREZISTA ORAL TABLET 800 MG	5	QL (30 EA per 30 days)
REYATAZ ORAL PACKET 50 MG	5	
ritonavir oral tablet 100 mg	4	QL (360 EA per 30 days)
VIRACEPT ORAL TABLET 250 MG	5	QL (300 EA per 30 days)
VIRACEPT ORAL TABLET 625 MG	5	QL (120 EA per 30 days)
Anti-Influenza Agents		
oseltamivir phosphate oral capsule 30 mg, 45 mg	2	
oseltamivir phosphate oral capsule 75 mg	2	QL (84 EA per 365 days)
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	4	
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/BLISTER	3	QL (240 EA per 365 days)
rimantadine hcl oral tablet 100 mg	4	
XOFLUZA ORAL TABLET THERAPY PACK 2 X 20 MG, 2 X 40 MG	4	QL (4 EA per 365 days)
Antiretroviral Combinations		
ATRIPLA ORAL TABLET 600-200-300 MG	5	QL (30 EA per 30 days)
COMPLERA ORAL TABLET 200-25-300 MG	5	QL (30 EA per 30 days)
DELSTRIGO ORAL TABLET 100-300-300 MG	5	QL (30 EA per 30 days)
DESCOVY ORAL TABLET 200-25 MG	5	
DOVATO ORAL TABLET 50-300 MG	5	QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
EVOTAZ ORAL TABLET 300-150 MG	5	QL (30 EA per 30 days)
GENVOYA ORAL TABLET 150-150-200-10 MG	5	QL (30 EA per 30 days)
JULUCA ORAL TABLET 50-25 MG	5	QL (30 EA per 30 days)
ODEFSEY ORAL TABLET 200-25-25 MG	5	
PREZCOBIX ORAL TABLET 800-150 MG	5	QL (30 EA per 30 days)
STRIBILD ORAL TABLET 150-150-200-300 MG	5	QL (30 EA per 30 days)
SYMFI LO ORAL TABLET 400-300-300 MG	5	QL (30 EA per 30 days)
SYMFI ORAL TABLET 600-300-300 MG	5	QL (30 EA per 30 days)
SYMTUZA ORAL TABLET 800-150-200-10 MG	5	QL (30 EA per 30 days)
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG	5	QL (30 EA per 30 days)
ANXIOLYTICS		
Anxiolytics, Other		
buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	1	
hydroxyzine hcl oral syrup 10 mg/5ml	1	
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	1	
hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg	1	
meprobamate oral tablet 200 mg, 400 mg	4	
Benzodiazepines		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML	4	
alprazolam oral tablet 0.25 mg, 0.5 mg	1	QL (120 EA per 30 days)
alprazolam oral tablet 1 mg	1	QL (240 EA per 30 days)
alprazolam oral tablet 2 mg	1	QL (150 EA per 30 days)
chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg	1	QL (120 EA per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet 2 mg	1	QL (300 EA per 30 days)
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet dispersible 2 mg	1	QL (300 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	4	
diazepam oral concentrate 5 mg/ml	1	QL (240 ML per 30 days)
diazepam oral solution 5 mg/5ml	4	QL (1200 ML per 30 days)
diazepam oral tablet 10 mg	1	QL (120 EA per 30 days)
diazepam oral tablet 2 mg	1	QL (600 EA per 30 days)
diazepam oral tablet 5 mg	1	QL (240 EA per 30 days)
lorazepam oral concentrate 2 mg/ml	1	QL (240 ML per 30 days)
lorazepam oral tablet 0.5 mg	1	QL (600 EA per 30 days)
lorazepam oral tablet 1 mg	1	QL (300 EA per 30 days)
lorazepam oral tablet 2 mg	1	QL (150 EA per 30 days)
oxazepam oral capsule 15 mg	1	
BIPOLAR AGENTS		
Mood Stabilizers		
carbamazepine er oral capsule extended release 12 hour 200 mg	2	
lithium carbonate er oral tablet extended release 300 mg, 450 mg	1	
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	1	
lithium carbonate oral tablet 300 mg	1	
lithium oral solution 8 meq/5ml	1	
valproic acid oral capsule 250 mg	2	
BLOOD GLUCOSE REGULATORS		
Antidiabetic Agents, Supply		
ASSURE ID INSULIN SAFETY SYR 29G X 1/2" 1 ML	2	
COMFORT ASSIST INSULIN SYRINGE 29G X 1/2" 1 ML	2	
cvs gauze sterile pad 2"x2"	3	
EXEL COMFORT POINT PEN NEEDLE 29G X 12MM	2	
global alcohol prep ease pad 70 %	3	
OMNIPOD 10 PACK	4	
OMNIPOD 5 PACK	4	
OMNIPOD DASH SYSTEM KIT	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD STARTER KIT	4	
preferred plus insulin syringe 28g x 1/2" 0.5 ml	2	
RELI-ON INSULIN SYRINGE 29G 0.3 ML	2	
Antidiabetic Agents		
acarbose oral tablet 100 mg	2	QL (90 EA per 30 days)
acarbose oral tablet 25 mg	1	QL (150 EA per 30 days)
acarbose oral tablet 50 mg	2	QL (150 EA per 30 days)
CYCLOSET ORAL TABLET 0.8 MG	4	
glimepiride oral tablet 1 mg, 2 mg, 4 mg	1	
glipizide er oral tablet extended release 24 hour 10 mg	1	QL (60 EA per 30 days)
glipizide er oral tablet extended release 24 hour 2.5 mg, 5 mg	1	
glipizide oral tablet 10 mg, 5 mg	1	
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg	2	QL (90 EA per 30 days)
glipizide-metformin hcl oral tablet 5-500 mg	2	QL (120 EA per 30 days)
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	4	
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	4	
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG	3	QL (60 EA per 30 days)
INVOKAMET ORAL TABLET 50-500 MG	3	QL (120 EA per 30 days)
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
INVOKANA ORAL TABLET 100 MG	3	QL (90 EA per 30 days)
INVOKANA ORAL TABLET 300 MG	3	QL (30 EA per 30 days)
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG	3	QL (60 EA per 30 days)
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG	3	QL (30 EA per 30 days)
JARDIANCE ORAL TABLET 10 MG, 25 MG	3	QL (30 EA per 30 days)
KORLYM ORAL TABLET 300 MG	5	PA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	1	
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	1	
nateglinide oral tablet 120 mg, 60 mg	2	QL (90 EA per 30 days)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML	3	QL (1.5 ML per 28 days)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/1.5ML	3	QL (6 ML per 28 days)
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	1	QL (30 EA per 30 days)
repaglinide oral tablet 0.5 mg, 1 mg	2	QL (120 EA per 30 days)
repaglinide oral tablet 2 mg	2	QL (240 EA per 30 days)
repaglinide-metformin hcl oral tablet 1-500 mg	4	QL (90 EA per 30 days)
repaglinide-metformin hcl oral tablet 2-500 mg	4	QL (150 EA per 30 days)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML	3	QL (18 ML per 28 days)
SYNJARDY ORAL TABLET 12.5-1000 MG, 5-1000 MG, 5-500 MG	3	QL (60 EA per 30 days)
SYNJARDY ORAL TABLET 12.5-500 MG	3	QL (120 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 25-1000 MG	3	QL (30 EA per 30 days)
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5-1000 MG, 5-1000 MG	3	QL (60 EA per 30 days)
tolbutamide oral tablet 500 mg	1	QL (180 EA per 30 days)
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML	3	QL (2 ML per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML	3	QL (9 ML per 28 days)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML	3	QL (15 ML per 28 days)
Glycemic Agents		
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG	3	
GLUCAGON EMERGENCY INJECTION KIT 1 MG	3	
PROGLYCEM ORAL SUSPENSION 50 MG/ML	5	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
Insulins		
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
FIASP SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
LEVEMIR FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML	3	
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML	3	
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML	3	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML	3	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML	3	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML	3	
NOVOLOG SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML	3	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML	3	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
BLOOD PRODUCTS-MODIFIERS-VOLUME EXPANDERS		
Anticoagulants		
ELIQUIS ORAL TABLET 2.5 MG, 5 MG	3	
ELIQUIS STARTER PACK ORAL TABLET 5 MG	3	
enoxaparin sodium subcutaneous solution 100 mg/ml, 150 mg/ml	4	QL (60 ML per 28 days)
enoxaparin sodium subcutaneous solution 120 mg/0.8ml, 80 mg/0.8ml	4	QL (48 ML per 28 days)
enoxaparin sodium subcutaneous solution 30 mg/0.3ml	4	QL (18 ML per 28 days)
enoxaparin sodium subcutaneous solution 40 mg/0.4ml	4	QL (24 ML per 28 days)
enoxaparin sodium subcutaneous solution 60 mg/0.6ml	4	QL (36 ML per 28 days)
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 5 mg/0.4ml, 7.5 mg/0.6ml	4	QL (14 ML per 28 days)
fondaparinux sodium subcutaneous solution 2.5 mg/0.5ml	4	QL (7 ML per 28 days)
heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml	2	
JANTOVEN ORAL TABLET 1 MG, 10 MG, 2 MG, 2.5 MG, 3 MG, 4 MG, 5 MG, 6 MG, 7.5 MG	1	
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG	4	
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	1	
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG	3	
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG	3	
Blood Formation Modifiers		
anagrelide hcl oral capsule 0.5 mg	1	
anagrelide hcl oral capsule 1 mg	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML	4	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML	4	PA
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML	4	PA
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG	5	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML	5	PA; QL (14 ML per 30 days)
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5	PA; QL (14 ML per 30 days)
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 20000 UNIT/ML, 4000 UNIT/ML	4	PA; QL (12 ML per 28 days)
PROCRIT INJECTION SOLUTION 2000 UNIT/ML	4	PA; QL (23 ML per 30 days)
PROCRIT INJECTION SOLUTION 3000 UNIT/ML	4	PA; QL (16 ML per 30 days)
PROCRIT INJECTION SOLUTION 40000 UNIT/ML	4	PA; QL (12 ML per 30 days)
PROMACTA ORAL PACKET 12.5 MG	5	QL (360 EA per 30 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	5	QL (60 EA per 30 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	5	QL (30 EA per 30 days)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML	4	PA
tranexamic acid oral tablet 650 mg	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML	5	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML	5	PA
Platelet Modifying Agents		
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	4	
BRILINTA ORAL TABLET 60 MG, 90 MG	3	
CABLIVI INJECTION KIT 11 MG	5	PA; LA; QL (32 EA per 30 days)
cilostazol oral tablet 100 mg, 50 mg	1	
clopidogrel bisulfate oral tablet 75 mg	1	
dipyridamole oral tablet 75 mg	2	
prasugrel hcl oral tablet 10 mg, 5 mg	3	
CARDIOVASCULAR AGENTS		
Alpha-Adrenergic Agonists		
CATAPRES ORAL TABLET 0.3 MG	2	
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	1	
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	2	
guanfacine hcl oral tablet 1 mg, 2 mg	2	
methyldopa oral tablet 250 mg, 500 mg	1	
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	2	
Alpha-Adrenergic Blocking Agents		
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	1	
phenoxybenzamine hcl oral capsule 10 mg	5	
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	2	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	1	
Angiotensin Ii Receptor Antagonists		
aliskiren fumarate oral tablet 150 mg, 300 mg	4	
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	3	
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG	4	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	1	
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	2	
telmisartan oral tablet 20 mg, 40 mg, 80 mg	2	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	2	
Angiotensin-Converting Enzyme (Ace) Inhibitors		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
captopril oral tablet 100 mg, 25 mg	2	
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	1	
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	1	
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	1	
moexipril hcl oral tablet 15 mg, 7.5 mg	2	
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	1	
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	1	
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	1	
trandolapril oral tablet 1 mg, 2 mg, 4 mg	1	
Antiarrhythmics		
amiodarone hcl oral tablet 100 mg, 400 mg	2	
amiodarone hcl oral tablet 200 mg	1	
dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg	4	
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	1	
mexiletine hcl oral capsule 150 mg, 250 mg	2	
mexiletine hcl oral capsule 200 mg	4	
MULTAQ ORAL TABLET 400 MG	3	
PACERONE ORAL TABLET 100 MG, 400 MG	4	
PACERONE ORAL TABLET 200 MG	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg	4	
propafenone hcl oral tablet 150 mg, 300 mg	2	
propafenone hcl oral tablet 225 mg	1	
quinidine sulfate oral tablet 200 mg	1	
quinidine sulfate oral tablet 300 mg	2	
SORINE ORAL TABLET 120 MG, 160 MG, 80 MG	1	
SORINE ORAL TABLET 240 MG	2	
sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 120 mg, 160 mg, 80 mg	1	
sotalol hcl oral tablet 240 mg	2	
Antihypertensive Combinations		
amlodipine besy-benazepril hcl oral capsule 10-40 mg	2	
amlodipine besy-benazepril hcl oral capsule 5-40 mg	1	
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	2	
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	4	
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	4	
irbesartan-hydrochlorothiazide oral tablet 300-12.5 mg	1	
losartan potassium-hctz oral tablet 50-12.5 mg	1	
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	4	
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	2	
propranolol-hctz oral tablet 80-25 mg	1	
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	4	
trandolapril-verapamil hcl er oral tablet extended release 2-180 mg, 2-240 mg	4	
Beta-Adrenergic Blocking Agents		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
acebutolol hcl oral capsule 200 mg, 400 mg	1	
atenolol oral tablet 100 mg, 25 mg, 50 mg	1	
betaxolol hcl oral tablet 10 mg, 20 mg	1	
bisoprolol fumarate oral tablet 10 mg, 5 mg	1	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG	4	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	1	
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	4	
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	1	
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	1	
metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg	1	
nadolol oral tablet 20 mg, 40 mg	1	
nadolol oral tablet 80 mg	4	
pindolol oral tablet 10 mg	2	
pindolol oral tablet 5 mg	4	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	1	
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	1	
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	1	
propranolol-hctz oral tablet 40-25 mg	1	
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	1	
Calcium Channel Blocking Agents		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	1	
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG	1	
diltiazem hcl er beads oral capsule extended release 24 hour 360 mg	3	
diltiazem hcl er beads oral capsule extended release 24 hour 420 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	2	
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	1	
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	1	
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	1	
isradipine oral capsule 2.5 mg, 5 mg	2	
nicardipine hcl oral capsule 20 mg, 30 mg	2	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	1	
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG	1	
verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg	1	
verapamil hcl er oral capsule extended release 24 hour 360 mg	2	
verapamil hcl er oral tablet extended release 120 mg	2	
verapamil hcl er oral tablet extended release 180 mg, 240 mg	1	
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	1	
Cardiovascular Agents, Other		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	1	
amlodipine besy-benazepril hcl oral capsule 10-20 mg	2	
amlodipine besy-benazepril hcl oral capsule 2.5-10 mg, 5-10 mg, 5-20 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	2	
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	1	
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	2	
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	1	
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	2	
captopril oral tablet 12.5 mg, 50 mg	4	
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg	2	
captopril-hydrochlorothiazide oral tablet 50-25 mg	4	
colesevelam hcl oral packet 3.75 gm	2	
CORLANOR ORAL SOLUTION 5 MG/5ML	4	
CORLANOR ORAL TABLET 5 MG, 7.5 MG	4	
DEMSER ORAL CAPSULE 250 MG	5	
DIGITEK ORAL TABLET 125 MCG, 250 MCG	1	
DIGOX ORAL TABLET 125 MCG, 250 MCG	1	
digoxin oral solution 0.05 mg/ml	2	
digoxin oral tablet 125 mcg, 250 mcg	1	
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	1	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG	3	PA
eprosartan mesylate oral tablet 600 mg	3	
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	1	
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg	1	
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	1	
NORTHERA ORAL CAPSULE 100 MG, 200 MG, 300 MG	5	PA; QL (180 EA per 30 days)
pentoxifylline er oral tablet extended release 400 mg	1	
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	1	
ranolazine er oral tablet extended release 12 hour 1000 mg	4	QL (60 EA per 30 days)
ranolazine er oral tablet extended release 12 hour 500 mg	4	QL (120 EA per 30 days)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT	5	PA
spironolactone-hctz oral tablet 25-25 mg	1	
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML	5	PA; LA; QL (4 ML per 28 days)
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	4	
triamterene-hctz oral capsule 37.5-25 mg	1	
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	1	
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	1	
WELCHOL ORAL TABLET 625 MG	3	
Diuretics, Carbonic Anhydrase Inhibitors		
acetazolamide er oral capsule extended release 12 hour 500 mg	2	
acetazolamide oral tablet 125 mg	1	
acetazolamide oral tablet 250 mg	2	
methazolamide oral tablet 25 mg	2	
methazolamide oral tablet 50 mg	4	
Diuretics, Loop		
bumetanide injection solution 0.25 mg/ml	2	
bumetanide oral tablet 0.5 mg, 1 mg, 2 mg	1	
ethacrynic acid oral tablet 25 mg	5	
furosemide injection solution 10 mg/ml, 10 mg/ml (4ml syringe)	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
furosemide oral solution 10 mg/ml, 8 mg/ml	1	
furosemide oral tablet 20 mg, 40 mg, 80 mg	1	
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	1	
Diuretics, Potassium-Sparing		
amiloride hcl oral tablet 5 mg	1	
eplerenone oral tablet 25 mg, 50 mg	4	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	1	
Diuretics, Thiazide		
chlorothiazide oral tablet 250 mg, 500 mg	1	
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide oral capsule 12.5 mg	1	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	1	
indapamide oral tablet 1.25 mg, 2.5 mg	1	
methyclothiazide oral tablet 5 mg	1	
metolazone oral tablet 10 mg	2	
metolazone oral tablet 2.5 mg, 5 mg	1	
Dyslipidemics, Fibric Acid Derivatives		
ANTARA ORAL CAPSULE 30 MG, 90 MG	4	
fenofibrate micronized oral capsule 130 mg	2	QL (30 EA per 30 days)
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	2	
fenofibrate oral capsule 150 mg	2	
fenofibrate oral tablet 145 mg, 160 mg, 40 mg, 48 mg, 54 mg	2	
fenofibric acid oral capsule delayed release 45 mg	1	
gemfibrozil oral tablet 600 mg	1	
Dyslipidemics, Hmg Coa Reductase Inhibitors		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG	3	
lovastatin oral tablet 10 mg, 20 mg, 40 mg	1	
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	2	
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	1	
Dyslipidemics, Other		
cholestyramine light oral powder 4 gm/dose	2	
cholestyramine oral packet 4 gm	2	
colestipol hcl oral packet 5 gm	2	
colestipol hcl oral tablet 1 gm	1	
ezetimibe oral tablet 10 mg	3	
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	4	
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG	5	PA
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	4	
omega-3-acid ethyl esters oral capsule 1 gm	2	
PRALUENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 150 MG/ML, 75 MG/ML	4	PA
PREVALITE ORAL PACKET 4 GM	2	
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML	4	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML	4	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML	4	PA
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM	4	
Vasodilators, Direct-Acting Arterial		
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	1	
minoxidil oral tablet 10 mg, 2.5 mg	1	
Vasodilators, Direct-Acting Arterial-Venous		
isosorbide dinitrate er oral tablet extended release 40 mg	4	
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	1	
isosorbide mononitrate oral tablet 10 mg, 20 mg	1	
NITRO-BID TRANSDERMAL OINTMENT 2 %	3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR	4	
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg	1	
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.4 mg/hr, 0.6 mg/hr	1	
nitroglycerin transdermal patch 24 hour 0.2 mg/hr	2	
nitroglycerin translingual solution 0.4 mg/spray	4	
CENTRAL NERVOUS SYSTEM AGENTS		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine-dextroamphetamine oral tablet 10 mg, 15 mg, 20 mg, 7.5 mg	1	QL (90 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 12.5 mg, 5 mg	2	QL (90 EA per 30 days)
amphetamine-dextroamphetamine oral tablet 30 mg	1	QL (60 EA per 30 days)
dexmethylphenidate hcl oral tablet 10 mg	1	QL (60 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg	2	QL (180 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg	2	QL (120 EA per 30 days)
dextroamphetamine sulfate er oral capsule extended release 24 hour 5 mg	2	QL (360 EA per 30 days)
dextroamphetamine sulfate oral tablet 10 mg	2	QL (180 EA per 30 days)
dextroamphetamine sulfate oral tablet 5 mg	2	QL (150 EA per 30 days)
ZENZEDI ORAL TABLET 10 MG	4	QL (180 EA per 30 days)
ZENZEDI ORAL TABLET 15 MG, 20 MG, 5 MG, 7.5 MG	4	QL (90 EA per 30 days)
ZENZEDI ORAL TABLET 30 MG	4	QL (60 EA per 30 days)
Attention Deficit Hyperactivity Disorder Agents, Non-Amphetamines		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	4	QL (30 EA per 30 days)
dexmethylphenidate hcl oral tablet 2.5 mg	1	QL (90 EA per 30 days)
dexmethylphenidate hcl oral tablet 5 mg	1	QL (120 EA per 30 days)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	2	
METADATE ER ORAL TABLET EXTENDED RELEASE 20 MG	2	QL (90 EA per 30 days)
methylphenidate hcl er (cd) oral capsule extended release 20 mg	2	PA
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 60 mg	2	PA
methylphenidate hcl er oral tablet extended release 10 mg, 20 mg	2	QL (90 EA per 30 days)
methylphenidate hcl er oral tablet extended release 24 hour 27 mg, 36 mg, 54 mg	3	PA
methylphenidate hcl er oral tablet extended release 27 mg, 36 mg, 54 mg, 72 mg	3	PA
methylphenidate hcl oral solution 10 mg/5ml	2	QL (900 ML per 30 days)
methylphenidate hcl oral solution 5 mg/5ml	2	QL (1800 ML per 30 days)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	1	QL (90 EA per 30 days)
methylphenidate hcl oral tablet chewable 10 mg	2	PA; QL (180 EA per 30 days)
methylphenidate hcl oral tablet chewable 2.5 mg, 5 mg	2	PA; QL (90 EA per 30 days)
ZENZEDI ORAL TABLET 2.5 MG	4	QL (90 EA per 30 days)
Central Nervous System, Other		
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	5	PA
FIRDAPSE ORAL TABLET 10 MG	5	PA; QL (240 EA per 30 days)
NUEDEXTA ORAL CAPSULE 20-10 MG	3	PA
riluzole oral tablet 50 mg	4	
TEGSEDI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML	5	PA; LA; QL (6 ML per 28 days)
tetrabenazine oral tablet 12.5 mg, 25 mg	5	PA
TIGLUTIK ORAL SUSPENSION 50 MG/10ML	5	QL (600 ML per 30 days)
Fibromyalgia Agents		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	3	
pregabalin oral solution 20 mg/ml	3	
SAVELLA ORAL TABLET 100 MG	3	
SAVELLA ORAL TABLET 12.5 MG, 25 MG, 50 MG	3	QL (60 EA per 30 days)
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG	3	
Multiple Sclerosis Agents		
AUBAGIO ORAL TABLET 14 MG, 7 MG	5	PA; LA; QL (30 EA per 30 days)
BETASERON SUBCUTANEOUS KIT 0.3 MG	5	PA; QL (15 EA per 30 days)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	5	PA; QL (30 ML per 30 days)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	PA; QL (12 ML per 28 days)
dalfampridine er oral tablet extended release 12 hour 10 mg	5	PA; QL (60 EA per 30 days)
GILENYA ORAL CAPSULE 0.5 MG	5	PA; QL (28 EA per 28 days)
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml	5	PA; QL (30 ML per 30 days)
glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml	5	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML	5	PA; QL (30 ML per 30 days)
GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML	5	PA; QL (12 ML per 28 days)
DENTAL AND ORAL AGENTS		
Dental And Oral Agents		
cevimeline hcl oral capsule 30 mg	2	
chlorhexidine gluconate mouth/throat solution 0.12 %	1	
clotrimazole mouth/throat lozenge 10 mg	1	
lidocaine viscous hcl mouth/throat solution 2 %	1	
nystatin mouth/throat suspension 100000 unit/ml	1	
pilocarpine hcl oral tablet 5 mg, 7.5 mg	2	
triamcinolone acetonide mouth/throat paste 0.1 %	2	
DERMATOLOGICAL AGENTS		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
Antifungals - Topical		
ciclopirox external gel 0.77 %	2	
ciclopirox external shampoo 1 %	2	
ciclopirox external solution 8 %	2	
ciclopirox olamine external cream 0.77 %	1	
ciclopirox olamine external suspension 0.77 %	2	
clotrimazole external cream 1 %	1	
clotrimazole external solution 1 %	1	
clotrimazole-betamethasone external cream 1-0.05 %	2	
clotrimazole-betamethasone external lotion 1-0.05 %	2	
econazole nitrate external cream 1 %	2	
JUBLIA EXTERNAL SOLUTION 10 %	4	
ketoconazole external cream 2 %	2	
ketoconazole external shampoo 2 %	2	
NYAMYC EXTERNAL POWDER 100000 UNIT/GM	1	
nystatin external cream 100000 unit/gm	1	
nystatin external ointment 100000 unit/gm	1	
nystatin external powder 100000 unit/gm	1	
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	2	
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	2	
NYSTOP EXTERNAL POWDER 100000 UNIT/GM	1	
Dermatological Agents		
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG	4	
acitretin oral capsule 10 mg, 25 mg	4	PA
acitretin oral capsule 17.5 mg	5	PA
acyclovir external ointment 5 %	4	
ala-cort external cream 1 %, 2.5 %	1	
alclometasone dipropionate external cream 0.05 %	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
alclometasone dipropionate external ointment 0.05 %	1	
ALTRENO EXTERNAL LOTION 0.05 %	4	PA
amcinonide external ointment 0.1 %	4	
ammonium lactate external cream 12 %	1	
ammonium lactate external lotion 12 %	1	
AMNESTEEM ORAL CAPSULE 10 MG, 20 MG, 40 MG	4	
AVITA EXTERNAL CREAM 0.025 %	2	PA
benzoyl peroxide-erythromycin external gel 5-3 %	4	
betamethasone dipropionate aug external cream 0.05 %	1	
betamethasone dipropionate aug external gel 0.05 %	2	
betamethasone dipropionate aug external lotion 0.05 %	2	
betamethasone dipropionate aug external ointment 0.05 %	2	
betamethasone dipropionate external cream 0.05 %	2	
betamethasone dipropionate external lotion 0.05 %	1	
betamethasone dipropionate external ointment 0.05 %	2	
betamethasone valerate external cream 0.1 %	2	
betamethasone valerate external foam 0.12 %	4	
betamethasone valerate external lotion 0.1 %	2	
betamethasone valerate external ointment 0.1 %	2	
calcipotriene external ointment 0.005 %	4	
calcipotriene external solution 0.005 %	4	
calcipotriene-betameth diprop external ointment 0.005-0.064 %	4	QL (400 GM per 28 days)
CLARAVIS ORAL CAPSULE 20 MG, 30 MG, 40 MG	4	
CLINDACIN-P EXTERNAL SWAB 1 %	1	
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-5 %	4	
clindamycin phosphate external foam 1 %	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
clindamycin phosphate external gel 1 %	2	
clindamycin phosphate external lotion 1 %	2	
clindamycin phosphate external solution 1 %	1	
clindamycin-tretinoin external gel 1.2-0.025 %	4	PA
clobetasol propionate e external cream 0.05 %	2	
clobetasol propionate emulsion external foam 0.05 %	4	
clobetasol propionate external cream 0.05 %	2	
clobetasol propionate external foam 0.05 %	4	
clobetasol propionate external gel 0.05 %	4	
clobetasol propionate external liquid 0.05 %	4	
clobetasol propionate external lotion 0.05 %	4	
clobetasol propionate external ointment 0.05 %	4	
clobetasol propionate external shampoo 0.05 %	4	
clobetasol propionate external solution 0.05 %	2	
COLOCORT RECTAL ENEMA 100 MG/60ML	2	
dapsone external gel 5 %	4	
desonide external cream 0.05 %	2	
desonide external lotion 0.05 %	4	
desonide external ointment 0.05 %	2	
desoximetasone external cream 0.05 %	4	
desoximetasone external cream 0.25 %	2	
desoximetasone external gel 0.05 %	4	
desoximetasone external ointment 0.05 %, 0.25 %	4	
diclofenac epolamine transdermal patch 1.3 %	4	PA
diclofenac sodium transdermal gel 1 %	2	
diclofenac sodium transdermal solution 1.5 %	4	
ery external pad 2 %	2	
erythromycin external gel 2 %	2	
erythromycin external solution 2 %	1	
EUCRISA EXTERNAL OINTMENT 2 %	4	ST
fluocinolone acetonide external cream 0.01 %	2	
fluocinolone acetonide external cream 0.025 %	1	
fluocinolone acetonide external ointment 0.025 %	1	
fluocinolone acetonide external solution 0.01 %	2	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
fluocinonide emulsified base external cream 0.05 %	2	
fluocinonide external cream 0.1 %	4	
fluocinonide external gel 0.05 %	2	
fluocinonide external ointment 0.05 %	2	
fluocinonide external solution 0.05 %	1	
fluorouracil external cream 5 %	2	
fluorouracil external solution 2 %, 5 %	2	
flurandrenolide external cream 0.05 %	2	
flurandrenolide external lotion 0.05 %	2	
fluticasone propionate external cream 0.05 %	1	
fluticasone propionate external lotion 0.05 %	4	
fluticasone propionate external ointment 0.005 %	1	
gentamicin sulfate external cream 0.1 %	2	
gentamicin sulfate external ointment 0.1 %	2	
halobetasol propionate external cream 0.05 %	2	
halobetasol propionate external ointment 0.05 %	2	
hydrocortisone ace-pramoxine rectal cream 1-1 %	1	
hydrocortisone butyrate external cream 0.1 %	2	
hydrocortisone butyrate external ointment 0.1 %	2	
hydrocortisone external cream 1 %, 2.5 %	1	
hydrocortisone external lotion 2.5 %	1	
hydrocortisone external ointment 1 %, 2.5 %	1	
hydrocortisone rectal enema 100 mg/60ml	4	
hydrocortisone valerate external cream 0.2 %	2	
hydrocortisone valerate external ointment 0.2 %	2	
imiquimod external cream 5 %	2	
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	4	
lidocaine external ointment 5 %	4	
lidocaine external patch 5 %	4	PA; QL (90 EA per 30 days)
lidocaine hcl external solution 4 %	1	
lidocaine hcl urethral/mucosal external gel 2 %	1	
lidocaine-prilocaine external cream 2.5-2.5 %	2	
malathion external lotion 0.5 %	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
methoxsalen rapid oral capsule 10 mg	5	
metronidazole external cream 0.75 %	2	
metronidazole external gel 0.75 %	2	
metronidazole external gel 1 %	4	
metronidazole external lotion 0.75 %	2	
mometasone furoate external cream 0.1 %	1	
mometasone furoate external ointment 0.1 %	1	
mometasone furoate external solution 0.1 %	1	
mupirocin calcium external cream 2 %	2	
mupirocin external ointment 2 %	1	
NEUAC EXTERNAL GEL 1.2-5 %	2	
PANRETIN EXTERNAL GEL 0.1 %	5	
permethrin external cream 5 %	3	
PICATO EXTERNAL GEL 0.015 %, 0.05 %	4	
pimecrolimus external cream 1 %	4	ST
podofilox external solution 0.5 %	1	
prednicarbate external cream 0.1 %	4	
prednicarbate external ointment 0.1 %	1	
PROCTO-MED HC RECTAL CREAM 2.5 %	2	
PROCTO-PAK RECTAL CREAM 1 %	1	
PROCTOSOL HC RECTAL CREAM 2.5 %	1	
PROCTOZONE-HC RECTAL CREAM 2.5 %	1	
RECTIV RECTAL OINTMENT 0.4 %	4	
REGRANEX EXTERNAL GEL 0.01 %	5	PA
SANTYL EXTERNAL OINTMENT 250 UNIT/GM	4	
selenium sulfide external lotion 2.5 %	1	
silver sulfadiazine external cream 1 %	1	
SSD EXTERNAL CREAM 1 %	1	
sulfacetamide sodium (acne) external lotion 10 %	2	
tacrolimus external ointment 0.03 %, 0.1 %	4	
TARGRETIN EXTERNAL GEL 1 %	5	PA
tazarotene external cream 0.1 %	4	PA
TAZORAC EXTERNAL CREAM 0.05 %	3	PA
TAZORAC EXTERNAL GEL 0.05 %, 0.1 %	3	PA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
TOLAK EXTERNAL CREAM 4 %	4	
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	3	PA
tretinoin external gel 0.01 %, 0.025 %, 0.05 %	3	PA
tretinoin microsphere external gel 0.1 %	4	PA
triamcinolone acetonide external aerosol solution 0.147 mg/gm	2	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	1	
triamcinolone acetonide external lotion 0.025 %, 0.1 %	1	
triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %	1	
TRIDERM EXTERNAL CREAM 0.1 %	1	
VALCHLOR EXTERNAL GEL 0.016 %	5	PA
ENZYME REPLACEMENT/ MODIFIERS		
Enzyme Replacement/ Modifiers		
CYSTADANE ORAL POWDER	5	
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG	3	
GALAFOLD ORAL CAPSULE 123 MG	5	PA; LA; QL (15 EA per 30 days)
KUVAN ORAL PACKET 100 MG	5	PA; LA
KUVAN ORAL PACKET 500 MG	5	PA
KUVAN ORAL TABLET SOLUBLE 100 MG	5	PA
levocarnitine oral solution 1 gm/10ml	1	
levocarnitine oral tablet 330 mg	2	
XURIDEN ORAL PACKET 2 GM	5	PA; QL (120 EA per 30 days)
GASTROINTESTINAL AGENTS		
Antispasmodics, Gastrointestinal		
dicyclomine hcl oral capsule 10 mg	1	
dicyclomine hcl oral solution 10 mg/5ml	2	
dicyclomine hcl oral tablet 20 mg	1	
glycopyrrolate oral tablet 1 mg, 2 mg	1	
Digestive Enzymes		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000 UNIT, 6000 UNIT	3	
SUCRAID ORAL SOLUTION 8500 UNIT/ML	5	
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-14000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT	3	
Gastrointestinal Agents, Other		
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	4	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	1	
GATTEX SUBCUTANEOUS KIT 5 MG	5	PA
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM	1	
GAVILYTE-G ORAL SOLUTION RECONSTITUTED 236 GM	1	
GAVILYTE-N WITH FLAVOR PACK ORAL SOLUTION RECONSTITUTED 420 GM	1	
loperamide hcl oral capsule 2 mg	1	
metoclopramide hcl oral solution 5 mg/5ml	1	
metoclopramide hcl oral tablet 10 mg, 5 mg	1	
MOVANTIK ORAL TABLET 12.5 MG, 25 MG	4	QL (30 EA per 30 days)
MYTESI ORAL TABLET DELAYED RELEASE 125 MG	3	PA
peg 3350/electrolytes oral solution reconstituted 240 gm	1	
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	1	
peg-3350/electrolytes oral solution reconstituted 236 gm	1	
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 12 MG/0.6ML (0.6ML SYRINGE), 8 MG/0.4ML	4	PA; QL (36 ML per 28 days)
TRILYTE ORAL SOLUTION RECONSTITUTED 420 GM	1	
ursodiol oral capsule 300 mg	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ursodiol oral tablet 250 mg	2	
ursodiol oral tablet 500 mg	4	
Histamine2 (H2) Receptor Antagonists		
cimetidine oral tablet 400 mg	1	
famotidine oral suspension reconstituted 40 mg/5ml	1	
famotidine oral tablet 20 mg, 40 mg	1	
ranitidine hcl oral capsule 150 mg, 300 mg	1	
ranitidine hcl oral syrup 75 mg/5ml	1	
ranitidine hcl oral tablet 150 mg, 300 mg	1	
Irritable Bowel Syndrome Agents		
alosetron hcl oral tablet 0.5 mg, 1 mg	5	QL (60 EA per 30 days)
AMITIZA ORAL CAPSULE 24 MCG	3	QL (60 EA per 30 days)
AMITIZA ORAL CAPSULE 8 MCG	3	QL (90 EA per 30 days)
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM	3	
balsalazide disodium oral capsule 750 mg	2	
LIALDA ORAL TABLET DELAYED RELEASE 1.2 GM	3	
LINZESS ORAL CAPSULE 145 MCG, 290 MCG	3	QL (30 EA per 30 days)
LINZESS ORAL CAPSULE 72 MCG	3	QL (120 EA per 30 days)
mesalamine rectal enema 4 gm	4	
sulfasalazine oral tablet 500 mg	1	
sulfasalazine oral tablet delayed release 500 mg	1	
Laxatives		
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/160ML	4	
constulose oral solution 10 gm/15ml	1	
enulose oral solution 10 gm/15ml	1	
generlac oral solution 10 gm/15ml	1	
lactulose oral packet 10 gm	1	
lactulose oral solution 10 gm/15ml	1	
MOVIPREP ORAL SOLUTION RECONSTITUTED 100 GM	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
PREPOPIK ORAL PACKET 10-3.5-12 MG-GM-GM	3	
SUPREP BOWEL PREP KIT ORAL SOLUTION 17.5-3.13-1.6 GM/177ML	4	
Phosphate Binders		
AURYXIA ORAL TABLET 1 GM 210 MG(FE)	5	PA
calcium acetate (phos binder) oral capsule 667 mg	1	
calcium acetate (phos binder) oral tablet 667 mg	1	
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	3	
sevelamer carbonate oral tablet 800 mg	3	
sevelamer hcl oral tablet 400 mg, 800 mg	3	
Protectants		
CARAFATE ORAL SUSPENSION 1 GM/10ML	4	
misoprostol oral tablet 100 mcg, 200 mcg	1	
sucralfate oral tablet 1 gm	1	
Proton Pump Inhibitors		
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG	3	
esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg	2	
esomeprazole strontium oral capsule delayed release 49.3 mg	4	
lansoprazole oral tablet dispersible 15 mg, 30 mg	4	
omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg	1	
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	1	
rabeprazole sodium oral tablet delayed release 20 mg	1	
GENETIC OR ENZYME DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
Enzyme Replacement/ Modifiers		
CARBAGLU ORAL TABLET 200 MG	5	PA
CERDELGA ORAL CAPSULE 84 MG	5	PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG	5	PA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
CYSTAGON ORAL CAPSULE 150 MG, 50 MG	4	PA
ENDARI ORAL PACKET 5 GM	5	PA; LA; QL (180 EA per 30 days)
miglustat oral capsule 100 mg	5	PA
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG	5	PA
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 20 MG, 5 MG	5	PA
ORFADIN ORAL SUSPENSION 4 MG/ML	5	PA; LA
RAVICTI ORAL LIQUID 1.1 GM/ML	5	PA
sodium phenylbutyrate oral powder 3 gm/tsp	5	PA
sodium phenylbutyrate oral tablet 500 mg	5	PA
GENITOURINARY AGENTS		
Antispasmodics, Urinary		
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	4	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG	3	
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	1	
oxybutynin chloride oral syrup 5 mg/5ml	1	
oxybutynin chloride oral tablet 5 mg	1	
solifenacin succinate oral tablet 10 mg, 5 mg	4	
tolterodine tartrate er oral capsule extended release 24 hour 2 mg	2	
tolterodine tartrate er oral capsule extended release 24 hour 4 mg	4	
tolterodine tartrate oral tablet 1 mg, 2 mg	2	
trospium chloride oral tablet 20 mg	2	
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	1	
dutasteride oral capsule 0.5 mg	2	
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	4	
finasteride oral tablet 5 mg	1	
silodosin oral capsule 4 mg, 8 mg	4	
tamsulosin hcl oral capsule 0.4 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
Genitourinary Agents, Other		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg	1	
bethanechol chloride oral tablet 50 mg	2	
DEPEN TITRATABS ORAL TABLET 250 MG	5	
ELMIRON ORAL CAPSULE 100 MG	4	
Vaginal Products		
clindamycin phosphate vaginal cream 2 %	2	
estradiol vaginal cream 0.1 mg/gm	3	
estradiol vaginal tablet 10 mcg	4	
INTRAROSA VAGINAL INSERT 6.5 MG	4	PA
metronidazole vaginal gel 0.75 %	2	
terconazole vaginal cream 0.4 %, 0.8 %	2	
terconazole vaginal suppository 80 mg	2	
VANDAZOLE VAGINAL GEL 0.75 %	2	
YUVAFEM VAGINAL TABLET 10 MCG	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
Glucocorticoids/Mineralocorticoids		
budesonide er oral tablet extended release 24 hour 9 mg	4	
budesonide oral capsule delayed release particles 3 mg	4	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML	1	
dexamethasone oral elixir 0.5 mg/5ml	2	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	1	
fludrocortisone acetate oral tablet 0.1 mg	1	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	1	
methylprednisolone oral tablet 16 mg, 4 mg, 8 mg	1	
methylprednisolone oral tablet 32 mg	2	
methylprednisolone oral tablet therapy pack 4 mg	1	
prednisolone oral solution 15 mg/5ml	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml, 25 mg/5ml	1	
prednisolone sodium phosphate oral solution 6.7 (5 base) mg/5ml	4	
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	4	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML	1	
prednisone oral solution 5 mg/5ml	4	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	1	
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	1	
UCERIS RECTAL FOAM 2 MG/ACT	4	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
Anabolic Steroids		
ANADROL-50 ORAL TABLET 50 MG	5	
oxandrolone oral tablet 10 mg	4	PA
oxandrolone oral tablet 2.5 mg	3	PA
Androgens		
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR	3	
danazol oral capsule 100 mg, 50 mg	2	
danazol oral capsule 200 mg	4	
methyltestosterone oral capsule 10 mg	5	PA
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	2	
testosterone enanthate intramuscular solution 200 mg/ml	1	
testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	2	
Contraceptives		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ALTAVERA ORAL TABLET 0.15-30 MG-MCG	4	
AMETHIA ORAL TABLET 0.15-0.03 &0.01 MG	1	QL (91 EA per 91 days)
APRI ORAL TABLET 0.15-30 MG-MCG	1	
ARANELLE ORAL TABLET 0.5/1/0.5-35 MG-MCG	4	
AUBRA ORAL TABLET 0.1-20 MG-MCG	1	
AVIANE ORAL TABLET 0.1-20 MG-MCG	1	
BALZIVA ORAL TABLET 0.4-35 MG-MCG	1	
BLISOVI 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	
BLISOVI FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
briellyn oral tablet 0.4-35 mg-mcg	1	
CAMILA ORAL TABLET 0.35 MG	1	
CAMRESE LO ORAL TABLET 0.1-0.02 & 0.01 MG	4	QL (91 EA per 91 days)
CAZIANT ORAL TABLET 0.1/0.125/0.15 - 0.025 MG	4	
CRYSELLE-28 ORAL TABLET 0.3-30 MG-MCG	1	
CYCLAFEM 1/35 ORAL TABLET 1-35 MG-MCG	1	
CYCLAFEM 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	1	
CYRED ORAL TABLET 0.15-30 MG-MCG	1	
DEBLITANE ORAL TABLET 0.35 MG	1	
DELYLA ORAL TABLET 0.1-20 MG-MCG	1	
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML	4	QL (1 ML per 84 days)
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5), 0.15-30 mg-mcg	1	
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg	4	
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
EMOQUETTE ORAL TABLET 0.15-30 MG-MCG	1	
ENPRESSE-28 ORAL TABLET	4	
ENSKYCE ORAL TABLET 0.15-30 MG-MCG	1	
ERRIN ORAL TABLET 0.35 MG	1	
ESTARYLLA ORAL TABLET 0.25-35 MG-MCG	4	
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	1	
FALMINA ORAL TABLET 0.1-20 MG-MCG	1	
FEMYNOR ORAL TABLET 0.25-35 MG-MCG	1	
GIANVI ORAL TABLET 3-0.02 MG	4	
HAILEY 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	
INCASSIA ORAL TABLET 0.35 MG	1	
INTROVALE ORAL TABLET 0.15-0.03 MG	1	
ISIBLOOM ORAL TABLET 0.15-30 MG-MCG	1	
JASMIEL ORAL TABLET 3-0.02 MG	4	
JULEBER ORAL TABLET 0.15-30 MG-MCG	1	
JUNEL 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
JUNEL 1/20 ORAL TABLET 1-20 MG-MCG	4	
JUNEL FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
JUNEL FE 1/20 ORAL TABLET 1-20 MG-MCG	1	
JUNEL FE 24 ORAL TABLET 1-20 MG-MCG(24)	1	
KAITLIB FE ORAL TABLET CHEWABLE 0.8-25 MG-MCG	1	
KARIVA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	4	
KELNOR 1/35 ORAL TABLET 1-35 MG-MCG	1	
KELNOR 1/50 ORAL TABLET 1-50 MG-MCG	1	
KURVELO ORAL TABLET 0.15-30 MG-MCG	4	
LARIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	1	
LARIN 1/20 ORAL TABLET 1-20 MG-MCG	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
LARIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	4	
LARIN FE 1/20 ORAL TABLET 1-20 MG-MCG	1	
LARISSIA ORAL TABLET 0.1-20 MG-MCG	1	
LAYOLIS FE ORAL TABLET CHEWABLE 0.8-25 MG-MCG	4	
LEENA ORAL TABLET 0.5/1/0.5-35 MG-MCG	4	
LESSINA ORAL TABLET 0.1-20 MG-MCG	1	
LEVONEST ORAL TABLET	1	
levonorgest-eth est & eth est oral tablet 42-21-21-7 days	1	
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg	4	QL (91 EA per 91 days)
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 &0.01 mg	1	QL (91 EA per 91 days)
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg	1	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg	1	
levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg	4	
levonorg-eth estrad triphasic oral tablet	1	
LEVORA 0.15/30 (28) ORAL TABLET 0.15-30 MG-MCG	4	
LORYNA ORAL TABLET 3-0.02 MG	1	
LOW-OGESTREL ORAL TABLET 0.3-30 MG-MCG	4	
LUTERA ORAL TABLET 0.1-20 MG-MCG	4	
LYZA ORAL TABLET 0.35 MG	4	
marlissa oral tablet 0.15-30 mg-mcg	4	
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	2	
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	2	
MICROGESTIN 1.5/30 ORAL TABLET 1.5-30 MG-MCG	4	
MICROGESTIN 1/20 ORAL TABLET 1-20 MG-MCG	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
MICROGESTIN FE 1.5/30 ORAL TABLET 1.5-30 MG-MCG	4	
MICROGESTIN FE 1/20 ORAL TABLET 1-20 MG-MCG	4	
MILI ORAL TABLET 0.25-35 MG-MCG	4	
NECON 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	4	
NIKKI ORAL TABLET 3-0.02 MG	1	
NORA-BE ORAL TABLET 0.35 MG	4	
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg(24)	1	
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg	1	
norethindrone oral tablet 0.35 mg	1	
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg	1	
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	4	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg	1	
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	4	
NORLYROC ORAL TABLET 0.35 MG	1	
NORTREL 0.5/35 (28) ORAL TABLET 0.5-35 MG-MCG	1	
NORTREL 1/35 (21) ORAL TABLET 1-35 MG-MCG	1	
NORTREL 1/35 (28) ORAL TABLET 1-35 MG-MCG	4	
NORTREL 7/7/7 ORAL TABLET 0.5/0.75/1-35 MG-MCG	4	
NUVARING VAGINAL RING 0.12-0.015 MG/24HR	4	
OCELLA ORAL TABLET 3-0.03 MG	4	
ORSYTHIA ORAL TABLET 0.1-20 MG-MCG	4	
PIMTREA ORAL TABLET 0.15-0.02/0.01 MG (21/5)	1	
PIRMELLA 1/35 ORAL TABLET 1-35 MG-MCG	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
PORTIA-28 ORAL TABLET 0.15-30 MG-MCG	4	
PREVIFEM ORAL TABLET 0.25-35 MG-MCG	4	
RECLIPSEN ORAL TABLET 0.15-30 MG-MCG	4	
SETLAKIN ORAL TABLET 0.15-0.03 MG	1	
SHAROBEL ORAL TABLET 0.35 MG	1	
SPRINTEC 28 ORAL TABLET 0.25-35 MG-MCG	4	
SRONYX ORAL TABLET 0.1-20 MG-MCG	1	
SYEDA ORAL TABLET 3-0.03 MG	1	
TARINA 24 FE ORAL TABLET 1-20 MG-MCG(24)	1	
TARINA FE 1/20 ORAL TABLET 1-20 MG-MCG	1	
TRI-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	4	
TRI-LEGEST FE ORAL TABLET 1-20/1-30/1-35 MG-MCG	1	
TRI-LO-ESTARYLLA ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	
TRI-LO-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	
TRI-MILI ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	4	
TRI-PREVIFEM ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	4	
TRI-SPRINTEC ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	4	
TRIVORA (28) ORAL TABLET	1	
TRI-VYLIBRA LO ORAL TABLET 0.18/0.215/0.25 MG-25 MCG	1	
TRI-VYLIBRA ORAL TABLET 0.18/0.215/0.25 MG-35 MCG	4	
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG	1	
VIENVA ORAL TABLET 0.1-20 MG-MCG	1	
VYFEMLA ORAL TABLET 0.4-35 MG-MCG	1	
VYLIBRA ORAL TABLET 0.25-35 MG-MCG	4	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
WYMZYA FE ORAL TABLET CHEWABLE 0.4-35 MG-MCG	1	
ZARAH ORAL TABLET 3-0.03 MG	1	
ZOVIA 1/35E (28) ORAL TABLET 1-35 MG-MCG	4	
Estrogens		
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR	4	
ANGELIQ ORAL TABLET 0.25-0.5 MG, 0.5-1 MG	4	
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	1	
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.06 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	2	
estradiol-norethindrone acet oral tablet 0.5-0.1 mg	2	
MENEST ORAL TABLET 0.3 MG, 0.625 MG	4	
norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	2	
OSPHENA ORAL TABLET 60 MG	4	PA
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG	3	
PREMARIN VAGINAL CREAM 0.625 MG/GM	3	
PREMPHASE ORAL TABLET 0.625-5 MG	3	
PREMPRO ORAL TABLET 0.3-1.5 MG, 0.45-1.5 MG, 0.625-2.5 MG, 0.625-5 MG	3	
Progestins		
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	1	
megestrol acetate oral suspension 40 mg/ml	2	PA; HR
megestrol acetate oral suspension 625 mg/5ml	4	PA; HR
megestrol acetate oral tablet 20 mg, 40 mg	1	PA; HR
norethindrone acetate oral tablet 5 mg	3	
progesterone micronized oral capsule 100 mg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
progesterone micronized oral capsule 200 mg	2	
HORMONAL AGENTS, STIMULANT/REPLACEMENT/ MODIFYING (PITUITARY)		
Hormonal Agents, Stimulant/Replacement/ Modifying (Pituitary)		
ACTHAR INJECTION GEL 80 UNIT/ML	5	PA
cabergoline oral tablet 0.5 mg	2	
desmopressin ace spray refrig nasal solution 0.01 %	4	
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	3	
INCRELEX SUBCUTANEOUS SOLUTION 40 MG/4ML	5	PA
NOCDURNA SUBLINGUAL TABLET SUBLINGUAL 27.7 MCG, 55.3 MCG	4	
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML	5	PA
HORMONAL AGENTS, STIMULANT/REPLACEMENT/ MODIFYING (THYROID)		
Hormonal Agents, Stimulant/Replacement/ Modifying (Thyroid)		
LEVO-T ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	1	
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	
liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
SYNTHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	3	
UNITHROID ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 300 MCG, 50 MCG, 75 MCG, 88 MCG	1	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
Hormonal Agents, Suppressant (Pituitary)		
ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG	4	PA
leuprolide acetate injection kit 1 mg/0.2ml	3	PA
LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG, 7.5 MG	5	PA
LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG, 22.5 MG	5	PA
LUPRON DEPOT (4-MONTH) INTRAMUSCULAR KIT 30 MG	5	PA
LUPRON DEPOT (6-MONTH) INTRAMUSCULAR KIT 45 MG	5	PA
octreotide acetate injection solution 100 mcg/ml, 1000 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml	4	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML	5	PA; LA; QL (60 ML per 30 days)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML	5	PA; QL (0.5 ML per 28 days)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 60 MG/0.2ML	5	PA; QL (0.2 ML per 28 days)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 90 MG/0.3ML	5	PA; QL (0.3 ML per 28 days)
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG	5	PA; QL (60 EA per 30 days)
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG, 30 MG	5	PA
SYNAREL NASAL SOLUTION 2 MG/ML	5	PA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 3.75 MG	5	PA
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
Antithyroid Agents		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil oral tablet 50 mg	4	
IMMUNOLOGICAL AGENTS		
Immune Suppressants		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG	4	B/D
azathioprine oral tablet 50 mg	1	B/D
BENLYSTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/ML	5	
BENLYSTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/ML	5	
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	2	B/D
cyclosporine modified oral solution 100 mg/ml	4	B/D
cyclosporine oral capsule 100 mg, 25 mg	4	B/D
ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG	4	B/D
GENGRAF ORAL CAPSULE 100 MG	4	B/D
GENGRAF ORAL CAPSULE 25 MG	2	B/D
GENGRAF ORAL SOLUTION 100 MG/ML	2	B/D
mercaptopurine oral tablet 50 mg	2	
methotrexate oral tablet 2.5 mg	1	B/D
methotrexate sodium (pf) injection solution 50 mg/2ml	2	B/D
methotrexate sodium injection solution 50 mg/2ml	4	B/D
mycophenolate mofetil oral capsule 250 mg	2	B/D
mycophenolate mofetil oral suspension reconstituted 200 mg/ml	5	B/D
mycophenolate mofetil oral tablet 500 mg	2	B/D
mycophenolate sodium oral tablet delayed release 180 mg, 360 mg	4	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
PROGRAF ORAL PACKET 0.2 MG, 1 MG	4	B/D
RAPAMUNE ORAL SOLUTION 1 MG/ML	5	B/D
SANDIMMUNE ORAL SOLUTION 100 MG/ML	4	B/D
sirolimus oral solution 1 mg/ml	5	B/D
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	4	B/D
tacrolimus oral capsule 0.5 mg	2	B/D
tacrolimus oral capsule 1 mg, 5 mg	4	B/D
XATMEP ORAL SOLUTION 2.5 MG/ML	4	B/D
ZORTRESS ORAL TABLET 0.25 MG, 0.75 MG, 1 MG	5	B/D; QL (60 EA per 30 days)
ZORTRESS ORAL TABLET 0.5 MG	5	B/D; QL (120 EA per 30 days)
Immunizing Agents, Passive		
OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML	5	B/D
PANZYGA INTRAVENOUS SOLUTION 1 GM/10ML, 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML	5	B/D
PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML	5	B/D
Immunomodulators		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML	5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML	5	PA; QL (3.6 ML per 28 days)
ACTIMMUNE SUBCUTANEOUS SOLUTION 2000000 UNIT/0.5ML	5	PA; LA
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG	5	PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML	5	PA; QL (8 ML per 28 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML	5	PA; QL (8 ML per 28 days)
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML	5	PA; QL (8 ML per 28 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML	5	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED 25 MG	5	PA; QL (8 EA per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML	5	PA; QL (8 ML per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML, 40 MG/0.8ML (6 PACK)	5	PA; QL (6 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML	5	PA; QL (3 EA per 28 days)
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; QL (2 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML	5	PA; QL (2 EA per 28 days)
HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; QL (6 EA per 28 days)
HUMIRA PEN-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML	5	PA; QL (3 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML	5	PA; QL (4 EA per 28 days)
HUMIRA PEN-PS/UV/ADOL HS START SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML	5	PA; QL (3 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 10 MG/0.2ML, 20 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML	5	PA; QL (2 EA per 28 days)
HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML	5	PA; QL (4 EA per 28 days)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML	5	PA; QL (2.28 ML per 28 days)
leflunomide oral tablet 10 mg, 20 mg	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML	5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML	5	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML	5	PA; QL (1 ML per 28 days)
XELJANZ ORAL TABLET 10 MG, 5 MG	5	PA; QL (60 EA per 30 days)
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG	5	PA; QL (30 EA per 30 days)
Vaccines		
ACTHIB INTRAMUSCULAR SOLUTION RECONSTITUTED	3	
ADACEL INTRAMUSCULAR SUSPENSION 5-2-15.5 (PREFILLED SYRINGE), 5-2-15.5 LF-MCG/0.5	3	
bcg vaccine injection injectable	3	
BEXSERO INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
BOOSTRIX INTRAMUSCULAR SUSPENSION 5-2.5-18.5 , 5-2.5-18.5 (0.5ML SYRINGE)	3	
DAPTACEL INTRAMUSCULAR SUSPENSION 23-15-5	3	
diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml	3	B/D
ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML	3	B/D
GARDASIL 9 INTRAMUSCULAR SUSPENSION	3	
GARDASIL 9 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
HAVRIX INTRAMUSCULAR SUSPENSION 720 EL U/0.5ML, 720 EL U/0.5ML 0.5 ML	3	
HIBERIX INJECTION SOLUTION RECONSTITUTED 10 MCG	3	
IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML	3	B/D
INFANRIX INTRAMUSCULAR SUSPENSION 25-58-10	3	
IPOL INJECTION INJECTABLE	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
IXIARO INTRAMUSCULAR SUSPENSION	3	
KINRIX INTRAMUSCULAR SUSPENSION , INJECTION 0.5 ML	3	
MENACTRA INTRAMUSCULAR INJECTABLE	3	
MENVEO INTRAMUSCULAR SOLUTION RECONSTITUTED	3	
M-M-R II SUBCUTANEOUS INJECTABLE	3	
PEDIARIX INTRAMUSCULAR SUSPENSION	3	
PEDVAX HIB INTRAMUSCULAR SUSPENSION 7.5 MCG/0.5ML	3	
PROQUAD SUBCUTANEOUS SUSPENSION RECONSTITUTED	3	
QUADRACEL INTRAMUSCULAR SUSPENSION	3	
RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED	3	B/D
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML	3	B/D
ROTARIX ORAL SUSPENSION RECONSTITUTED	3	
ROTATEQ ORAL SOLUTION	3	
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML	3	
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML	3	B/D
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU	3	B/D
TRUMENBA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	3	
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML	3	B/D
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML, 25 MCG/0.5ML (0.5ML SYRINGE)	3	
VAQTA INTRAMUSCULAR SUSPENSION 25 UNIT/0.5ML, 25 UNIT/0.5ML 0.5 ML, 50 UNIT/ML, 50 UNIT/ML 1 ML	3	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
VARIVAX SUBCUTANEOUS INJECTABLE 1350 PFU/0.5ML	3	
VARIZIG INTRAMUSCULAR SOLUTION 125 UNIT/1.2ML	3	
YF-VAX SUBCUTANEOUS INJECTABLE	3	
ZOSTAVAX SUBCUTANEOUS SUSPENSION RECONSTITUTED 19400 UNT/0.65ML	3	QL (1 EA per 365 days)
METABOLIC BONE DISEASE AGENTS		
Metabolic Bone Disease Agents		
alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg	1	
alendronate sodium oral tablet 40 mg	1	QL (30 EA per 30 days)
calcitonin (salmon) nasal solution 200 unit/act	1	
calcitriol oral capsule 0.25 mcg, 0.5 mcg	2	B/D
calcitriol oral solution 1 mcg/ml	4	B/D
cinacalcet hcl oral tablet 30 mg	3	PA; QL (60 EA per 30 days)
cinacalcet hcl oral tablet 60 mg	5	PA; QL (60 EA per 30 days)
cinacalcet hcl oral tablet 90 mg	5	PA; QL (120 EA per 30 days)
FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML	5	PA; QL (2.4 ML per 28 days)
ibandronate sodium oral tablet 150 mg	1	QL (1 EA per 30 days)
NATPARA SUBCUTANEOUS CARTRIDGE 100 MCG, 25 MCG, 50 MCG, 75 MCG	5	PA
paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg	4	B/D
PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 60 MG/ML	4	QL (1 ML per 180 days)
raloxifene hcl oral tablet 60 mg	3	QL (30 EA per 30 days)
risedronate sodium oral tablet 150 mg	4	QL (4 EA per 28 days)
risedronate sodium oral tablet 30 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	2	
risedronate sodium oral tablet delayed release 35 mg	2	QL (4 EA per 28 days)
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML	5	PA
XGEVA SUBCUTANEOUS SOLUTION 120 MG/1.7ML	5	PA

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS THERAPEUTIC AGENTS		
Miscellaneous Therapeutic Agents		
V-GO 20 KIT	4	
V-GO 30 KIT	4	
V-GO 40 KIT	4	
OPHTHALMIC AGENTS		
Ophthalmic Prostaglandin And Prostamide Analogs		
latanoprost ophthalmic solution 0.005 %	1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 %	3	
TRAVATAN Z OPHTHALMIC SOLUTION 0.004 %	3	
VYZULTA OPHTHALMIC SOLUTION 0.024 %	4	
Ophthalmic Agents, Other		
atropine sulfate ophthalmic solution 1 %	1	
CYSTARAN OPHTHALMIC SOLUTION 0.44 %	4	
OXERVATE OPHTHALMIC SOLUTION 0.002 %	5	PA
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	1	
RESTASIS OPHTHALMIC EMULSION 0.05 %	3	
XIIDRA OPHTHALMIC SOLUTION 5 %	3	QL (60 EA per 30 days)
Ophthalmic Anti Infectives		
AZASITE OPHTHALMIC SOLUTION 1 %	4	
bacitracin ophthalmic ointment 500 unit/gm	2	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	1	
BESIVANCE OPHTHALMIC SUSPENSION 0.6 %	4	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	4	
BROMSITE OPHTHALMIC SOLUTION 0.075 %	4	
ciprofloxacin hcl ophthalmic solution 0.3 %	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
erythromycin ophthalmic ointment 5 mg/gm	1	
gatifloxacin ophthalmic solution 0.5 %	2	
GENTAK OPHTHALMIC OINTMENT 0.3 %	1	
gentamicin sulfate ophthalmic solution 0.3 %	1	
levofloxacin ophthalmic solution 0.5 %	1	
MOXEZA OPHTHALMIC SOLUTION 0.5 %	3	
moxifloxacin hcl ophthalmic solution 0.5 %	3	
NATACYN OPHTHALMIC SUSPENSION 5 %	4	
neomycin-bacitracin zn-polymyx ophthalmic ointment 5-400-10000	1	
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	1	
ofloxacin ophthalmic solution 0.3 %	1	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	1	
tobramycin ophthalmic solution 0.3 %	1	
trifluridine ophthalmic solution 1 %	2	
Ophthalmic Anti-Allergy Agents		
azelastine hcl ophthalmic solution 0.05 %	1	
BEPREVE OPHTHALMIC SOLUTION 1.5 %	3	
cromolyn sodium ophthalmic solution 4 %	1	
olopatadine hcl ophthalmic solution 0.1 %	2	
olopatadine hcl ophthalmic solution 0.2 %	3	
PAZEO OPHTHALMIC SOLUTION 0.7 %	3	
Ophthalmic Antiglaucoma Agents		
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %	3	
apraclonidine hcl ophthalmic solution 0.5 %	1	
AZOPT OPHTHALMIC SUSPENSION 1 %	3	
betaxolol hcl ophthalmic solution 0.5 %	1	
brimonidine tartrate ophthalmic solution 0.15 %	2	
brimonidine tartrate ophthalmic solution 0.2 %	1	
carteolol hcl ophthalmic solution 1 %	1	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 %	4	
dorzolamide hcl ophthalmic solution 2 %	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
dorzolamide hcl-timolol mal ophthalmic solution 22.3-6.8 mg/ml	1	
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %, 22.3-6.8 mg/ml	1	
levobunolol hcl ophthalmic solution 0.5 %	1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 %	4	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	1	
timolol maleate ophthalmic solution 0.25 %, 0.5 %, 0.5 % (daily)	1	
Ophthalmic Anti-Inflammatories		
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	2	
BLEPHAMIDE S.O.P. OPHTHALMIC OINTMENT 10-0.2 %	4	
dexamethasone sodium phosphate ophthalmic solution 0.1 %	4	
diclofenac sodium ophthalmic solution 0.1 %	1	
DUREZOL OPHTHALMIC EMULSION 0.05 %	3	
fluorometholone ophthalmic suspension 0.1 %	1	
flurbiprofen sodium ophthalmic solution 0.03 %	1	
ILEVRO OPHTHALMIC SUSPENSION 0.3 %	3	
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	1	
LOTEMAX OPHTHALMIC GEL 0.5 %	4	
LOTEMAX OPHTHALMIC OINTMENT 0.5 %	4	
LOTEMAX SM OPHTHALMIC GEL 0.38 %	4	
loteprednol etabonate ophthalmic suspension 0.5 %	4	
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	1	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	1	
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	2	
prednisolone acetate ophthalmic suspension 1 %	1	

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
prednisolone sodium phosphate ophthalmic solution 1 %	1	
PROLENSA OPHTHALMIC SOLUTION 0.07 %	4	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	1	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	2	
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 %	4	
OTIC AGENTS		
Otic Agents		
acetic acid otic solution 2 %	1	
CIPRODEX OTIC SUSPENSION 0.3-0.1 %	4	
ciprofloxacin hcl otic solution 0.2 %	4	
fluocinolone acetonide otic oil 0.01 %	2	
hydrocortisone-acetic acid otic solution 1-2 %	2	
neomycin-polymyxin-hc otic solution 1 %	2	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	2	
ofloxacin otic solution 0.3 %	4	
RESPIRATORY TRACT AGENTS		
Antihistamines		
carbinoxamine maleate oral solution 4 mg/5ml	2	
carbinoxamine maleate oral tablet 4 mg	2	
cetirizine hcl oral solution 1 mg/ml	1	
clemastine fumarate oral tablet 2.68 mg	1	
cyproheptadine hcl oral tablet 4 mg	1	
desloratadine oral tablet 5 mg	1	
desloratadine oral tablet dispersible 2.5 mg, 5 mg	4	
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	2	
levocetirizine dihydrochloride oral tablet 5 mg	2	
Anti-Inflammatories, Inhaled Corticosteroids		

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT	3	QL (30 EA per 30 days)
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/INH	3	QL (1 EA per 30 days)
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/INH, 220 MCG/INH	3	QL (1 EA per 30 days)
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/INH	3	QL (1 EA per 30 days)
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT	3	QL (26 GM per 30 days)
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml	4	B/D
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/BLIST, 250 MCG/BLIST, 50 MCG/BLIST	3	QL (60 EA per 30 days)
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT	3	QL (24 GM per 30 days)
FLOVENT HFA INHALATION AEROSOL 44 MCG/ACT	3	QL (11 GM per 30 days)
flunisolide nasal solution 25 mcg/act (0.025%)	1	QL (50 ML per 30 days)
fluticasone propionate nasal suspension 50 mcg/act	1	
Antileukotrienes		
montelukast sodium oral packet 4 mg	2	
montelukast sodium oral tablet 10 mg	1	
montelukast sodium oral tablet chewable 4 mg, 5 mg	1	
zafirlukast oral tablet 10 mg, 20 mg	2	
zileuton er oral tablet extended release 12 hour 600 mg	4	
Bronchodilators, Anticholinergic		
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT	4	
ipratropium bromide inhalation solution 0.02 %	1	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
ipratropium bromide nasal solution 0.03 %, 0.06 %	1	
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG	3	QL (30 EA per 30 days)
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT	3	QL (4 GM per 30 days)
Bronchodilators, Sympathomimetic		
albuterol sulfate er oral tablet extended release 12 hour 4 mg	2	
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%	1	B/D
albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml	2	B/D
albuterol sulfate oral syrup 2 mg/5ml	1	
albuterol sulfate oral tablet 2 mg, 4 mg	4	
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT	4	QL (4 GM per 20 days)
epinephrine injection solution 0.3 mg/0.3ml	1	
epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml	1	
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML	4	
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML	4	
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/DOSE	3	QL (60 EA per 30 days)
terbutaline sulfate oral tablet 2.5 mg, 5 mg	4	
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT	3	QL (54 GM per 30 days)
Cystic Fibrosis Agents		
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG	5	PA
KALYDECO ORAL TABLET 150 MG	5	PA
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG	5	PA; LA; QL (56 EA per 28 days)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG	5	PA; QL (120 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG	5	PA; LA; QL (56 EA per 28 days)
TOBI PODHALER INHALATION CAPSULE 28 MG	5	PA
Mast Cell Stabilizers		
cromolyn sodium inhalation nebulization solution 20 mg/2ml	3	B/D
cromolyn sodium oral concentrate 100 mg/5ml	4	
Nasal Agents		
azelastine hcl nasal solution 0.1 %	1	QL (30 ML per 25 days)
azelastine hcl nasal solution 0.15 %	2	QL (30 ML per 25 days)
mometasone furoate nasal suspension 50 mcg/act	2	QL (34 GM per 30 days)
olopatadine hcl nasal solution 0.6 %	2	QL (30.5 GM per 30 days)
Phosphodiesterase Inhibitors, Airways Disease		
DALIRESP ORAL TABLET 250 MCG, 500 MCG	3	QL (30 EA per 30 days)
theophylline er oral tablet extended release 12 hour 300 mg	2	
theophylline er oral tablet extended release 24 hour 400 mg, 600 mg	1	
theophylline oral solution 80 mg/15ml	2	
Pulmonary Antihypertensives		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG	5	PA; QL (90 EA per 30 days)
ALYQ ORAL TABLET 20 MG	5	PA
ambrisentan oral tablet 10 mg, 5 mg	5	PA; QL (30 EA per 30 days)
bosentan oral tablet 125 mg, 62.5 mg	5	PA; QL (60 EA per 30 days)
OPSUMIT ORAL TABLET 10 MG	5	PA; QL (90 EA per 30 days)
sildenafil citrate oral tablet 20 mg	2	PA; QL (90 EA per 30 days)
tadalafil (pah) oral tablet 20 mg	5	PA
TRACLEER ORAL TABLET SOLUBLE 32 MG	5	PA; LA; QL (120 EA per 30 days)
UPTRAVI ORAL TABLET 1000 MCG	5	PA; LA; QL (90 EA per 30 days)
UPTRAVI ORAL TABLET 1200 MCG, 1400 MCG, 1600 MCG	5	PA; LA; QL (60 EA per 30 days)
UPTRAVI ORAL TABLET 200 MCG	5	PA; LA; QL (240 EA per 30 days)
UPTRAVI ORAL TABLET 400 MCG	5	PA; LA; QL (320 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
UPTRAVI ORAL TABLET 600 MCG	5	PA; LA; QL (150 EA per 30 days)
UPTRAVI ORAL TABLET 800 MCG	5	PA; LA; QL (120 EA per 30 days)
UPTRAVI ORAL TABLET THERAPY PACK 200 & 800 MCG	5	PA; LA
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML	5	PA; QL (270 ML per 30 days)
Pulmonary Fibrosis Agents		
ESBRIET ORAL CAPSULE 267 MG	5	PA
ESBRIET ORAL TABLET 267 MG, 801 MG	5	PA
OFEV ORAL CAPSULE 100 MG, 150 MG	5	PA
Respiratory Tract Agents, Other		
acetylcysteine inhalation solution 10 %, 20 %	2	B/D
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/DOSE, 250-50 MCG/DOSE, 500-50 MCG/DOSE	3	QL (60 EA per 30 days)
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT	3	QL (12 GM per 30 days)
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/INH	3	QL (60 EA per 30 days)
BETHKIS INHALATION NEBULIZATION SOLUTION 300 MG/4ML	3	B/D
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/INH, 200-25 MCG/INH	3	QL (60 EA per 30 days)
fluticasone-salmeterol inhalation aerosol powder breath activated 113-14 mcg/act, 232-14 mcg/act, 55-14 mcg/act	3	QL (1 EA per 30 days)
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	1	B/D
PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5	PA
PULMOZYME INHALATION SOLUTION 1 MG/ML	5	PA
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT	3	QL (4 GM per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
tobramycin inhalation nebulization solution 300 mg/5ml	5	B/D
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/INH	3	ST; QL (60 EA per 30 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML	5	PA
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG	5	PA
ZEMAIRA INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG	5	PA
SKELETAL MUSCLE RELAXANTS		
Skeletal Muscle Relaxants		
baclofen oral tablet 10 mg, 20 mg, 5 mg	1	
carisoprodol oral tablet 250 mg	4	QL (120 EA per 30 days)
carisoprodol oral tablet 350 mg	1	QL (120 EA per 30 days)
carisoprodol-aspirin oral tablet 200-325 mg	4	QL (240 EA per 30 days)
carisoprodol-aspirin-codeine oral tablet 200-325-16 mg	4	QL (240 EA per 30 days)
chlorzoxazone oral tablet 500 mg	1	
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	2	QL (90 EA per 30 days)
metaxalone oral tablet 800 mg	4	
methocarbamol oral tablet 500 mg, 750 mg	1	
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	1	
tizanidine hcl oral tablet 2 mg, 4 mg	1	
SLEEP DISORDER AGENTS		
Gaba Receptor Modulators		
eszopiclone oral tablet 2 mg, 3 mg	2	
flurazepam hcl oral capsule 15 mg, 30 mg	2	
zaleplon oral capsule 10 mg, 5 mg	1	QL (30 EA per 30 days)
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	2	QL (30 EA per 30 days)
zolpidem tartrate oral tablet 10 mg, 5 mg	1	QL (30 EA per 30 days)
Sleep Disorders, Other		
armodafinil oral tablet 150 mg, 200 mg, 250 mg	4	PA; QL (30 EA per 30 days)

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
armodafinil oral tablet 50 mg	3	PA; QL (30 EA per 30 days)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	4	
HETLIOZ ORAL CAPSULE 20 MG	5	PA; QL (30 EA per 30 days)
modafinil oral tablet 100 mg	4	PA; QL (90 EA per 30 days)
modafinil oral tablet 200 mg	4	PA; QL (60 EA per 30 days)
SILENOR ORAL TABLET 3 MG, 6 MG	4	
temazepam oral capsule 15 mg, 30 mg	1	QL (30 EA per 30 days)
temazepam oral capsule 22.5 mg	4	QL (30 EA per 30 days)
temazepam oral capsule 7.5 mg	2	QL (120 EA per 30 days)
XYREM ORAL SOLUTION 500 MG/ML	5	PA; LA; QL (540 ML per 30 days)
THERAPEUTIC NUTRIENTS-MINERALS- ELECTROLYTES		
Electrolyte-Mineral Modifiers		
CHEMET ORAL CAPSULE 100 MG	4	
deferasirox oral tablet soluble 125 mg, 250 mg, 500 mg	5	PA
FERRIPROX ORAL SOLUTION 100 MG/ML	5	PA
FERRIPROX ORAL TABLET 500 MG	5	PA
JADENU ORAL TABLET 180 MG, 360 MG, 90 MG	5	PA
JADENU SPRINKLE ORAL PACKET 180 MG, 360 MG, 90 MG	5	PA
KIONEX ORAL SUSPENSION 15 GM/60ML	1	
SAMSCA ORAL TABLET 15 MG, 30 MG	5	QL (60 EA per 30 days)
sodium polystyrene sulfonate oral powder	1	
sodium polystyrene sulfonate oral suspension 15 gm/60ml	1	
SPS ORAL SUSPENSION 15 GM/60ML	1	
trientine hcl oral capsule 250 mg	5	PA
Electrolyte-Mineral Replacement		
dextrose intravenous solution 10 %	2	B/D
dextrose intravenous solution 5 %	4	B/D
dextrose-nacl intravenous solution 10-0.2 %, 5-0.2 %, 5-0.45 %, 5-0.9 %	4	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
dextrose-nacl intravenous solution 10-0.45 %, 2.5-0.45 %, 5-0.225 %, 5-0.33 %	2	B/D
IONOSOL-MB IN D5W INTRAVENOUS SOLUTION	4	B/D
ISOLYTE-P IN D5W INTRAVENOUS SOLUTION	4	B/D
ISOLYTE-S INTRAVENOUS SOLUTION	4	B/D
kcl in dextrose-nacl intravenous solution 10-5-0.45 meq/l-%-%, 20-5-0.33 meq/l-%-%, 20-5-0.45 meq/l-%-%	4	B/D
kcl in dextrose-nacl intravenous solution 20-5-0.2 meq/l-%-%, 20-5-0.9 meq/l-%-%, 30-5-0.45 meq/l-%-%, 40-5-0.45 meq/l-%-%, 40-5-0.9 meq/l-%-%	2	B/D
KLOR-CON 10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M10 ORAL TABLET EXTENDED RELEASE 10 MEQ	2	
KLOR-CON M15 ORAL TABLET EXTENDED RELEASE 15 MEQ	3	
KLOR-CON M20 ORAL TABLET EXTENDED RELEASE 20 MEQ	2	
KLOR-CON ORAL TABLET EXTENDED RELEASE 8 MEQ	2	
KLOR-CON SPRINKLE ORAL CAPSULE EXTENDED RELEASE 8 MEQ	2	
K-TAB ORAL TABLET EXTENDED RELEASE 8 MEQ	1	
magnesium sulfate injection solution 50 %, 50 % (10ml syringe)	4	
NORMOSOL-M IN D5W INTRAVENOUS SOLUTION	4	B/D
NORMOSOL-R IN D5W INTRAVENOUS SOLUTION	4	B/D
NORMOSOL-R PH 7.4 INTRAVENOUS SOLUTION	4	B/D
PLASMA-LYTE 148 INTRAVENOUS SOLUTION	4	B/D
PLASMA-LYTE A INTRAVENOUS SOLUTION	4	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
potassium chloride crys er oral tablet extended release 10 meq, 20 meq	2	
potassium chloride er oral capsule extended release 10 meq, 8 meq	2	
potassium chloride er oral tablet extended release 10 meq, 20 meq, 8 meq	2	
potassium chloride in dextrose intravenous solution 20-5 meq/l-%	2	B/D
potassium chloride in dextrose intravenous solution 40-5 meq/l-%	4	B/D
potassium chloride in nacl intravenous solution 20-0.45 meq/l-%, 20-0.9 meq/l-%, 40-0.9 meq/l-%	2	B/D
potassium chloride intravenous solution 2 meq/ml, 2 meq/ml (20 ml)	4	
potassium chloride intravenous solution 20 meq/100ml	2	
potassium chloride oral solution 20 meq/15ml (10%), 40 meq/15ml (20%)	4	
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	4	
prenatal oral tablet 27-1 mg	1	
sodium chloride intravenous solution 0.45 %, 0.9 %	4	
sodium chloride intravenous solution 3 %, 5 %	2	
sodium chloride irrigation solution 0.9 %	1	
TPN ELECTROLYTES INTRAVENOUS SOLUTION	4	B/D
Nutrients		
AMINOSYN II INTRAVENOUS SOLUTION 10 %	4	B/D
AMINOSYN-PF INTRAVENOUS SOLUTION 10 %, 7 %	4	B/D
CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %	2	B/D
CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %	4	B/D
CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %	4	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %	4	B/D
FREAMINE HBC INTRAVENOUS SOLUTION 6.9 %	4	B/D
HEPATAMINE INTRAVENOUS SOLUTION 8 %	4	B/D
INTRALIPID INTRAVENOUS EMULSION 20 %, 30 %	4	B/D
NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %	4	B/D
nutrilipid intravenous emulsion 20 %	4	B/D
PREMASOL INTRAVENOUS SOLUTION 10 %	4	B/D
PREMASOL INTRAVENOUS SOLUTION 6 %	2	B/D
PROCALAMINE INTRAVENOUS SOLUTION 3 %	4	B/D
PROSOL INTRAVENOUS SOLUTION 20 %	4	B/D
TRAVASOL INTRAVENOUS SOLUTION 10 %	4	B/D
TROPHAMINE INTRAVENOUS SOLUTION 10 %	4	B/D

You can find information on what the symbols and abbreviations on this table mean by going to page vi of the Introduction and reviewing the chart for the **EnvisionRxPlus** 2020 Formulary. We have made no changes to this formulary since 10/02/2019.

INDEX

A
abacavir sulfate 34
abacavir sulfate-lamivudine ... 34
abacavir-lamivudine-zidovudine 34
ABELCET 19
ABILIFY MAINTENA 30
ABILIFY MYCITE 30
abiraterone acetate 22
ABSORICA 56
acamprosate calcium 4
acarbose 39
acebutolol hcl 47
acetaminophen-codeine 2
acetaminophen-codeine #3 2
acetazolamide 50
acetazolamide er 50
acetic acid 85
acetylcysteine 89
acitretin 56
ACTEMRA 77
ACTEMRA ACTPEN 77
ACTHAR 74
ACTHIB 79
ACTIMMUNE 77
acyclovir 33, 56
acyclovir sodium 33
ADACEL 79
adefovir dipivoxil 32
ADEMPAS 88
ADVAIR DISKUS 89
ADVAIR HFA 89
AFINITOR 22
AFINITOR DISPERZ 22
ala-cort 56
albendazole 27
albuterol sulfate 87
albuterol sulfate er 87
alclometasone dipropionate... 56, 57
ALECENSA 22
alendronate sodium 81
alfuzosin hcl er 65
ALINIA 27
aliskiren fumarate 44
allopurinol 27
almotriptan malate 20
ALORA 73
alosetron hcl 63
ALPHAGAN P 83
alprazolam 37
ALPRAZOLAM INTENSOL 37
ALTAVERA 68
ALTRENO 57
ALUNBRIG 26
ALYQ 88
amantadine hcl 28
AMBISOME 19
ambrisentan 88
amcinonide 57
AMETHIA 68
amikacin sulfate 5
amiloride hcl 51
amiloride-hydrochlorothiazide48
AMINOSYN II 93
AMINOSYN-PF 93
amiodarone hcl 45
AMITIZA 63
amitriptyline hcl 17
amlodipine besy-benazepril hcl 46, 48
amlodipine besylate 47
amlodipine besylate-valsartan 46
amlodipine-atorvastatin 49
amlodipine-olmesartan 46
amlodipine-valsartan-hctz 46
ammonium lactate 57
AMNESTEEM 57
amoxapine 17
amoxicillin 8
amoxicillin-pot clavulanate .. 8, 9
amoxicillin-pot clavulanate er .. 8
amphetamine-dextroamphetamine 53
amphotericin b 19
ampicillin 9
ampicillin sodium 9
ampicillin-sulbactam sodium ... 9
ANADROL-50 67
anagrelide hcl 42
anastrozole 26
ANDRODERM 67
ANGELIQ 73
ANORO ELLIPTA 89
ANTARA 51
APOKYN 28
apraclonidine hcl 83
aprepitant 18
APRI 68
APRISO 63
APTIOM 13
APTIVUS 35
ARANELLE 68
ARANESP (ALBUMIN FREE) 43
ARCALYST 77
ARIKAYCE 5
aripiprazole 30
armodafinil 90, 91
ARNUITY ELLIPTA 86
ASMANEX (120 METERED DOSES) 86
ASMANEX (30 METERED DOSES) 86
ASMANEX (60 METERED DOSES) 86
ASMANEX HFA 86
aspirin-dipyridamole er 44
ASSURE ID INSULIN SAFETY SYR 38
ASTAGRAF XL 76
atazanavir sulfate 35
atenolol 47
atenolol-chlorthalidone 49
atomoxetine hcl 54
atorvastatin calcium 51
atovaquone 27
atovaquone-proguanil hcl 27
ATRIPLA 36
atropine sulfate 82
ATROVENT HFA 86
AUBAGIO 55
AUBRA 68
AURYXIA 64
AUSTEDO 54
AVIANE 68
AVITA 57
AZACTAM 8
AZASITE 82
azathioprine 76
azelastine hcl 83, 88
azithromycin 10
AZOPT 83
aztreonam 8

B
bacitracin 82
bacitracin-polymyxin b 82
bacitra-neomycin-polymyxin-hc 84
baclofen 90
balsalazide disodium 63
BALVERSA 22, 23
BALZIVA 68
BANZEL 13
BARACLUDE 32
bcg vaccine 79
BELSOMRA 91
benazepril hcl 45
benazepril-hydrochlorothiazide 49
BENLYSTA 76
benznidazole 27
benzoyl peroxide-erythromycin 57
benztropine mesylate 28
BEPREVE 83
BESIVANCE 82
betamethasone dipropionate... 57
betamethasone dipropionate aug 57
betamethasone valerate 57
BETASERON 55
betaxolol hcl 47, 83
bethanechol chloride 66
BETHKIS 89
bexarotene 23
BEXSERO 79
bicalutamide 22
BICILLIN L-A 9
BIKTARVY 35
bisoprolol fumarate 47
bisoprolol-hydrochlorothiazide 49
BLEPHAMIDE S.O.P. 84
BLISOVI 24 FE 68
BLISOVI FE 1.5/30 68
BOOSTRIX 79
bosentan 88
BOSULIF 23
BRAFTOVI 23
BREO ELLIPTA 89
briellyn 68
BRILINTA 44
brimonidine tartrate 83
BRIVIACT 11
bromfenac sodium (once-daily) 82
bromocriptine mesylate 28
BROMSITE 82
budesonide 66, 86
budesonide er 66
bumetanide 50
BUPAP 2
buprenorphine hcl 4
buprenorphine hcl-naloxone hcl 4
bupropion hcl 15
bupropion hcl er (smoking det) 4
bupropion hcl er (sr) 15
bupropion hcl er (xl) 15
buspirone hcl 37
butalbital-acetaminophen 2
butalbital-apap-caff-cod 2
butalbital-apap-caffeine 3
butalbital-asa-caff-codeine 3
butalbital-aspirin-caffeine 3
BYSTOLIC 47
C
cabergoline 74
CABLIVI 44
CABOMETYX 23
calcipotriene 57
calcipotriene-betameth diprop 57
calcitonin (salmon) 81
calcitriol 81
calcium acetate (phos binder). 64
CALQUENCE 23
CAMILA 68
CAMRESE LO 68
candesartan cilexetil 44
candesartan cilexetil-hctz 49
CAPRELSA 23
captopril 45, 49
captopril-hydrochlorothiazide 49
CARAFATE 64
CARBAGLU 64
carbamazepine 14
carbamazepine er 14, 38
carbidopa 29
carbidopa-levodopa 29
carbidopa-levodopa er 29
carbidopa-levodopa-entacapone 29
carbinoxamine maleate 85
carisoprodol 90
carisoprodol-aspirin 90
carisoprodol-aspirin-codeine .. 90
carteolol hcl 83
CARTIA XT 47
carvedilol 47
carvedilol phosphate er 47
caspofungin acetate 19
CATAPRES 44
CAYSTON 8
CAZIANT 68
cefaclor 6
cefaclor er 6
cefadroxil 6, 7
cefazolin sodium 7
cefdinir 7
cefepime hcl 7
cefixime 7
cefoxitin sodium 7
cefpodoxime proxetil 7
cefprozil 7
ceftazidime 7
ceftriaxone sodium 7
cefuroxime axetil 7
cefuroxime sodium 8
celecoxib 1
CELONTIN 12
cephalexin 8
CERDELGA 64
cetirizine hcl 85
cevimeline hcl 55
CHANTIX 4
CHANTIX CONTINUING MONTH PAK 4
CHANTIX STARTING MONTH PAK 5
CHEMET 91
chlordiazepoxide hcl 37
chlorhexidine gluconate 55
chloroquine phosphate 27
chlorothiazide 51
chlorpromazine hcl 18, 32
chlorthalidone 51
chlorzoxazone 90
CHOLBAM 64
cholestyramine 52
cholestyramine light 52
ciclopirox 56
ciclopirox olamine 56
cilostazol 44

CIMDUO 34
cimetidine 63
cinacalcet hcl 81
CIPRODEX 85
ciprofloxacin 10
ciprofloxacin hcl 10, 82, 85
ciprofloxacin in d5w 10
citalopram hydrobromide 16
CLARAVIS 57
clarithromycin 10
clarithromycin er 10
clemastine fumarate 85
CLENPIQ 63
CLINDACIN-P 57
clindamycin hcl 5
clindamycin palmitate hcl 5
clindamycin phos-benzoyl perox 57
clindamycin phosphate 5, 57, 58, 66
clindamycin phosphate in d5w 5
clindamycin-tretinoin 58
CLINIMIX/DEXTROSE (4.25/10) 93
CLINIMIX/DEXTROSE (4.25/5) 93
CLINIMIX/DEXTROSE (5/15) 93
CLINIMIX/DEXTROSE (5/20) 94
clobazam 12
clobetasol propionate 58
clobetasol propionate e 58
clobetasol propionate emulsion 58
clomipramine hcl 17
clonazepam 37
clonidine 44
clonidine hcl 44
clopidogrel bisulfate 44
clorazepate dipotassium 38
clotrimazole 55, 56
clotrimazole-betamethasone .. 56
clozapine 32
COARTEM 27
codeine sulfate 3
colchicine 20
colchicine-probenecid 20
colesevelam hcl 49
colestipol hcl 52
colistimethate sodium (cba) 5
COLOCORT 58
COMBIGAN 83
COMBIVENT RESPIMAT ... 87
COMETRIQ (100 MG DAILY DOSE) 23
COMETRIQ (140 MG DAILY DOSE) 23
COMETRIQ (60 MG DAILY DOSE) 23
COMFORT ASSIST INSULIN SYRINGE 38
COMPLERA 36
COMPRO 18
constulose 63
COPAXONE 55
COPIKTRA 23
CORLANOR 49
COSENTYX (300 MG DOSE) 77
COSENTYX SENSOREADY (300 MG) 77
COTELLIC 23
CREON 62
CRESEMBA 19
CRIXIVAN 36
cromolyn sodium 83, 88
CRYSELLE-28 68
cvs gauze sterile 38
CYCLAFEM 1/35 68
CYCLAFEM 7/7/7 68
cyclobenzaprine hcl 90
cyclophosphamide 21
CYCLOSET 39
cyclosporine 76
cyclosporine modified 76
cyproheptadine hcl 85
CYRED 68
CYSTADANE 61
CYSTAGON 65
CYSTARAN 82

D

dalfampridine er 55
DALIRESP 88
danazol 67
dapsone 5, 58
DAPTACEL 79
daptomycin 5
darifenacin hydrobromide er .. 65
DAURISMO 23
DEBLITANE 68
deferasirox 91
DELSTRIGO 36
DELYLA 68
DEMSER 49
DEPEN TITRATABS 66
DEPO-PROVERA 23
DEPO-SUBQ PROVERA 104 68
DESCOVY 36
desipramine hcl 17
desloratadine 85
desmopressin ace spray refrig. 74
desmopressin acetate 74
desogestrel-ethinyl estradiol ... 68
desonide 58
desoximetasone 58
desvenlafaxine er 16, 17
desvenlafaxine succinate er 17
dexamethasone 66
DEXAMETHASONE INTENSOL 66
dexamethasone sodium phosphate 84
DEXILANT 64
dexmethylphenidate hcl ... 53, 54
dextroamphetamine sulfate 53
dextroamphetamine sulfate er. 53
dextrose 91
dextrose-nacl 91, 92
DIASTAT ACUDIAL 12
DIASTAT PEDIATRIC 12
diazepam 12, 38
diclofenac epolamine 58
diclofenac potassium 1
diclofenac sodium 1, 58, 84
diclofenac sodium er 1
dicloxacillin sodium 9
dicyclomine hcl 61
didanosine 34
diflunisal 1
DIGITEK 49
DIGOX 49
digoxin 49
dihydroergotamine mesylate ... 20
DILANTIN 14
diltiazem hcl 48
diltiazem hcl er 48
diltiazem hcl er beads 47
diltiazem hcl er coated beads .. 48

dilt-xr 48
diphenoxylate-atropine..... 62
diphtheria-tetanus toxoids dt.. 79
dipyridamole 44
disopyramide phosphate..... 22
disulfiram 4
divalproex sodium 12, 13
divalproex sodium er 12
dofetilide 45
donepezil hcl 14
dorzolamide hcl 83
dorzolamide hcl-timolol mal.. 84
dorzolamide hcl-timolol mal pf 84
DOVATO 36
doxazosin mesylate..... 44
doxepin hcl 17
DOXY 100 11
doxycycline hyclate 11
doxycycline monohydrate 11
dronabinol 18
drospiren-eth estrad-levomefol 68
drospirenone-ethinyl estradiol 68
DROXIA 61
duloxetine hcl..... 17
DUREZOL 84
dutasteride 65
dutasteride-tamsulosin hcl..... 65
E
econazole nitrate 56
EDARBYCLOR 44
EDURANT..... 33
efavirenz..... 34
ELIGARD 75
ELIQUIS 42
ELIQUIS STARTER PACK.. 42
ELMIRON 66
EMCYT 22
EMEND..... 18
EMOQUETTE..... 69
EMSAM 16
EMTRIVA 34
EMVERM 27
enalapril maleate..... 45
enalapril-hydrochlorothiazide 49
ENBREL 78
ENBREL MINI..... 77
ENBREL SURECLICK..... 78
ENDARI..... 65
ENDOCET 3
ENGERIX-B 79
enoxaparin sodium..... 42
ENPRESSE-28..... 69
ENSKYCE..... 69
entacapone 28
entecavir..... 32
ENTRESTO..... 49
enulose 63
ENVARSUS XR..... 76
EPCLUSA 33
EPIDIOLEX..... 11
epinephrine 87
EPIPEN 2-PAK..... 87
EPIPEN JR 2-PAK 87
EPITOL 14
EPIVIR HBV..... 33
eplerenone..... 51
EPOGEN 43
eprosartan mesylate..... 49
ergotamine-caffeine 20
ERIVEDGE 23
ERLEADA 22
erlotinib hcl..... 23
ERRIN 69
ertapenem sodium 8
ery 58
ERY-TAB 10
ERYTHROCIN LACTOBIONATE..... 10
ERYTHROCIN STEARATE. 10
erythromycin 58, 83
erythromycin base..... 10
erythromycin ethylsuccinate .. 10
ESBRIET 89
escitalopram oxalate 16
esomeprazole magnesium..... 64
esomeprazole strontium..... 64
ESTARYLLA..... 69
estradiol 66, 73
estradiol-norethindrone acet... 73
eszopiclone 90
ethacrynic acid 50
ethambutol hcl 21
ethosuximide 12
ethynodiol diac-eth estradiol .. 69
etodolac..... 1
etodolac er 1
EUCRISA 58
EVOTAZ 37
EXEL COMFORT POINT PEN NEEDLE 38
exemestane 26
ezetimibe 52
ezetimibe-simvastatin.....52
F
FALMINA 69
famciclovir 33
famotidine 63
FANAPT 30
FANAPT TITRATION PACK 30
FARYDAK 23
febuxostat 20
felbamate 13
felodipine er 48
FEMYNOR 69
fenofibrate 51
fenofibrate micronized 51
fenofibric acid 51
fentanyl.....2
fentanyl citrate 2
FERRIPROX 91
FETZIMA 17
FETZIMA TITRATION 17
FIASP 41
FIASP FLEXTOUCH 41
finasteride.....65
FIRDAPSE.....54
FIRVANQ.....5
flecainide acetate 45
FLOVENT DISKUS 86
FLOVENT HFA 86
fluconazole 19
fluconazole in sodium chloride 19
flucytosine.....19
fludrocortisone acetate 66
flunisolide 86
fluocinolone acetonide 58, 85
fluocinonide 59
fluocinonide emulsified base ..59
fluorometholone.....84
fluorouracil.....59
fluoxetine hcl 16
fluphenazine decanoate 29
fluphenazine hcl.....29
flurandrenolide.....59
flurazepam hcl 90
flurbiprofen 1

flurbiprofen sodium 84
flutamide 22
fluticasone propionate 59, 86
fluticasone-salmeterol 89
fluvoxamine maleate 16
fondaparinux sodium 42
FORTEO 81
fosamprenavir calcium 36
fosinopril sodium 45
fosinopril sodium-hctz..... 49
FREAMINE HBC..... 94
furosemide..... 50, 51
FUZEON 35
FYCOMPA 13
G
gabapentin 13
GALAFOLD 61
galantamine hydrobromide 14
galantamine hydrobromide er 14
GARDASIL 9 79
gatifloxacin..... 83
GATTEX..... 62
GAVILYTE-C 62
GAVILYTE-G 62
GAVILYTE-N WITH FLAVOR PACK 62
gemfibrozil 51
generlac 63
GENGRAF 76
GENTAK 83
gentamicin in saline 5
gentamicin sulfate..... 5, 59, 83
GENVOYA..... 37
GEODON 30
GIANVI..... 69
GILENYA 55
GILOTRIF 23
glatiramer acetate..... 55
GLATOPA 55
GLEOSTINE..... 21
glimepiride 39
glipizide..... 39
glipizide er..... 39
glipizide-metformin hcl..... 39
global alcohol prep ease 38
GLUCAGEN HYPOKIT 40
GLUCAGON EMERGENCY 40
glyburide 39
glyburide micronized..... 39
glycopyrrolate 61
GOCOVRI 28
granisetron hcl 18
GRANIX..... 43
griseofulvin microsize 19
griseofulvin ultramicrosize..... 19
guanfacine hcl 44
guanfacine hcl er 54
guanidine hcl 21
H
HAILEY 24 FE 69
halobetasol propionate 59
haloperidol 29
haloperidol decanoate 29
haloperidol lactate 29
HARVONI..... 33
HAVRIX.....28, 79
heparin sodium (porcine)..... 42
HEPATAMINE..... 94
HETLIOZ 91
HIBERIX..... 79
HUMIRA 78
HUMIRA PEDIATRIC CROHNS START..... 78
HUMIRA PEN 78
HUMIRA PEN-CD/UC/HS STARTER 78
HUMIRA PEN-PS/UV/ADOL HS START 78
hydralazine hcl 52
hydrochlorothiazide 51
hydrocodone-acetaminophen ... 3
hydrocodone-ibuprofen 3
hydrocortisone.....59, 66
hydrocortisone ace-pramoxine59
hydrocortisone butyrate 59
hydrocortisone valerate..... 59
hydrocortisone-acetic acid..... 85
hydromorphone hcl 3
hydromorphone hcl er..... 3
hydromorphone hcl pf..... 3
hydroxychloroquine sulfate 28
hydroxyurea..... 22
hydroxyzine hcl..... 37
hydroxyzine pamoate..... 37
I
ibandronate sodium..... 81
IBRANCE..... 23
IBU..... 1
ibuprofen..... 1
ICLUSIG 23
IDHIFA 23
ILEVRO 84
imatinib mesylate.....23
IMBRUVICA 23, 24
imipenem-cilastatin 8
imipramine hcl 17
imipramine pamoate 18
imiquimod 59
IMOVAX RABIES 79
INCASSIA 69
INCRELEX.....74
indapamide.....51
indomethacin.....1
INFANRIX 79
INLYTA.....24
INREBIC.....24
INTELENCE 34
INTRALIPID 94
INTRAROSA 66
INTRON A..... 24, 33
INTROVALE 69
INVEGA 30
INVEGA SUSTENNA.....30
INVEGA TRINZA 31
INVIRASE.....36
INVOKAMET 39
INVOKAMET XR 39
INVOKANA.....39
IONOSOL-MB IN D5W.....92
IPOL 79
ipratropium bromide..... 86, 87
ipratropium-albuterol 89
irbesartan 44
irbesartan-hydrochlorothiazide 46, 49
IRESSA 24
ISENTRESS.....35
ISENTRESS HD 35
ISIBLOOM 69
ISOLYTE-P IN D5W.....92
ISOLYTE-S 92
isoniazid 21
isosorbide dinitrate 52
isosorbide dinitrate er 52
isosorbide mononitrate 53
isosorbide mononitrate er.....53
isotretinoin 59
isradipine 48
itraconazole 19
ivermectin 27

IXIARO 80
J
JADENU 91
JADENU SPRINKLE 91
JAKAFI 24
JANTOVEN 42
JANUMET 39
JANUMET XR 39
JANUVIA 39
JARDIANCE 39
JASMIEL 69
JUBLIA 56
JULEBER 69
JULUCA 37
JUNEL 1.5/30 69
JUNEL 1/20 69
JUNEL FE 1.5/30 69
JUNEL FE 1/20 69
JUNEL FE 24 69
JUXTAPID 52
K
KAITLIB FE 69
KALETRA 36
KALYDECO 87
KARIVA 69
kcl in dextrose-nacl 92
KELNOR 1/35 69
KELNOR 1/50 69
ketoconazole 19, 56
ketoprofen 1
ketorolac tromethamine 20, 84
KEVZARA 78
KINRIX 80
KIONEX 91
KISQALI (200 MG DOSE) ... 27
KISQALI (400 MG DOSE) ... 27
KISQALI (600 MG DOSE) ... 27
KISQALI FEMARA (400 MG DOSE) 27
KISQALI FEMARA (600 MG DOSE) 27
KISQALI FEMARA(200 MG DOSE) 27
KLOR-CON 92
KLOR-CON 10 92
KLOR-CON M10 92
KLOR-CON M15 92
KLOR-CON M20 92
KLOR-CON SPRINKLE 92
KORLYM 39
K-TAB 92
KURVELO 69
KUVAN 61
L
labetalol hcl 47
lactulose 63
lamivudine 33, 34
lamivudine-zidovudine 34
lamotrigine 13
lamotrigine er 13
lansoprazole 64
LANTUS 41
LANTUS SOLOSTAR 41
LARIN 1.5/30 69
LARIN 1/20 69
LARIN FE 1.5/30 70
LARIN FE 1/20 70
LARISSIA 70
latanoprost 82
LATUDA 31
LAYOLIS FE 70
ledipasvir-sofosbuvir 33
LEENA 70
leflunomide 78
LENVIMA (10 MG DAILY DOSE) 24
LENVIMA (12 MG DAILY DOSE) 24
LENVIMA (14 MG DAILY DOSE) 24
LENVIMA (18 MG DAILY DOSE) 24
LENVIMA (20 MG DAILY DOSE) 24
LENVIMA (24 MG DAILY DOSE) 24
LENVIMA (4 MG DAILY DOSE) 24
LENVIMA (8 MG DAILY DOSE) 24
LESSINA 70
letrozole 26
leucovorin calcium 24
LEUKERAN 21
LEUKINE 43
leuprolide acetate 75
LEVEMIR 41
LEVEMIR FLEXTOUCH 41
levetiracetam 12
levetiracetam er 12
levobunolol hcl 84
levocarnitine 61
levocetirizine dihydrochloride 85
levofloxacin 11, 83
levofloxacin in d5w 11
LEVONEST 70
levonorgest-eth est & eth est ... 70
levonorgest-eth estrad 91-day . 70
levonorgestrel-ethinyl estrad ... 70
levonorg-eth estrad triphasic ... 70
LEVORA 0.15/30 (28) 70
LEVO-T 74
levothyroxine sodium 74
LEVOXYL 74
LEXIVA 36
LIALDA 63
lidocaine 59
lidocaine hcl 59
lidocaine hcl urethral/mucosal 59
lidocaine viscous hcl 55
lidocaine-prilocaine 59
linezolid 6
LINZESS 63
liothyronine sodium 74
lisinopril 45
lisinopril-hydrochlorothiazide 49
lithium 38
lithium carbonate 38
lithium carbonate er 38
LIVALO 51
LONSURF 24
loperamide hcl 62
lopinavir-ritonavir 36
lorazepam 38
LORBRENA 24
LORCET 3
LORCET HD 3
LORYNA 70
losartan potassium 45
losartan potassium-hctz 46, 49
LOTEMAX 84
LOTEMAX SM 84
loteprednol etabonate 84
lovastatin 51
LOW-OGESTREL 70
loxapine succinate 29
LUMIGAN 82
LUPRON DEPOT (1-MONTH) 75

LUPRON DEPOT (3-MONTH) 75
LUPRON DEPOT (4-MONTH) 75
LUPRON DEPOT (6-MONTH) 75
LUTERA 70
LYNPARZA 24
LYSODREN 24
LYZA 70
M
magnesium sulfate 92
malathion 59
maprotiline hcl 15
marlissa 70
MARPLAN 16
MATULANE 21
meclizine hcl 18
medroxyprogesterone acetate 70, 73
mefloquine hcl 28
megestrol acetate 73
MEKINIST 25
MEKTOVI 25
meloxicam 1
memantine hcl 15
memantine hcl er 15
MENACTRA 80
MENEST 73
MENVEO 80
meprobamate 37
mercaptopurine 76
meropenem 8
mesalamine 63
MESNEX 27
METADATE ER 54
metaxalone 90
metformin hcl 40
metformin hcl er 40
methadone hcl 2, 3
methazolamide 50
methenamine hippurate 6
methimazole 76
methocarbamol 90
methotrexate 76
methotrexate sodium 76
methotrexate sodium (pf) 76
methoxsalen rapid 60
methyclothiazide 51
methyldopa 44
methylphenidate hcl 54
methylphenidate hcl er 54
methylphenidate hcl er (cd) 54
methylphenidate hcl er (la) 54
methylprednisolone 66
methyltestosterone 67
metoclopramide hcl 62
metolazone 51
metoprolol succinate er 47
metoprolol tartrate 47
metoprolol-hydrochlorothiazide 50
metronidazole 6, 60, 66
metronidazole in nacl 6
mexiletine hcl 45
MICROGESTIN 1.5/30 70
MICROGESTIN 1/20 70
MICROGESTIN FE 1.5/30 71
MICROGESTIN FE 1/20 71
midodrine hcl 44
MIGERGOT 20
miglustat 65
MILI 71
minocycline hcl 11
minoxidil 52
mirtazapine 15
misoprostol 64
MITIGARE 20
M-M-R II 80
modafinil 91
moexipril hcl 45
molindone hcl 30
mometasone furoate 60, 88
montelukast sodium 86
morphine sulfate 2, 3
morphine sulfate (concentrate) . 2
morphine sulfate er 2
MOVANTIK 62
MOVIPREP 63
MOXEZA 83
moxifloxacin hcl 83
MULTAQ 45
mupirocin 60
mupirocin calcium 60
MYALEPT 65
mycophenolate mofetil 76
mycophenolate sodium 76
MYRBETRIQ 65
MYTESI 62
N
nabumetone 1
nadolol 47
nafcillin sodium 9
naloxone hcl 4
naltrexone hcl 4
NAMENDA XR TITRATION PACK 15
NAMZARIC 15
naproxen 1
naproxen dr 1
naproxen sodium 1
naproxen sodium er 1
naratriptan hcl 20
NARCAN 4
NATACYN 83
nateglinide 40
NATPARA 81
NEBUPENT 6
NECON 0.5/35 (28) 71
nefazodone hcl 15
neomycin sulfate 5
neomycin-bacitracin zn-polymyx 83
neomycin-polymyxin-dexameth 84
neomycin-polymyxin-gramicidin 83
neomycin-polymyxin-hc .. 84, 85
NEPHRAMINE 94
NERLYNX 25
NEUAC 60
NEULASTA 43
NEUPOGEN 43
NEUPRO 28
nevirapine 34
nevirapine er 34
NEXAVAR 25
niacin er (antihyperlipidemic) . 52
nicardipine hcl 48
NICOTROL 5
nifedipine er 48
nifedipine er osmotic release .. 48
NIKKI 71
nilutamide 22
NINLARO 25
NITRO-BID 53
NITRO-DUR 53
nitrofurantoin 6
nitrofurantoin macrocrystal 6

nitrofurantoin monohyd macro 6
nitroglycerin 53
NOCDURNA 74
NORA-BE 71
NORDITROPIN FLEXPRO .. 74
norethin ace-eth estrad-fe 71
norethindrone 71
norethindrone acetate 73
norethindrone acet-ethinyl est 71
norethindrone-eth estradiol 73
norethin-eth estradiol-fe 71
norgestimate-eth estradiol 71
norgestim-eth estrad triphasic 71
NORLYROC 71
NORMOSOL-M IN D5W 92
NORMOSOL-R IN D5W 92
NORMOSOL-R PH 7.4 92
NORTHERA 50
NORTREL 0.5/35 (28) 71
NORTREL 1/35 (21) 71
NORTREL 1/35 (28) 71
NORTREL 7/7/7 71
nortriptyline hcl 18
NORVIR 36
NOVOLIN 70/30 41
NOVOLIN N 41
NOVOLIN R 41
NOVOLOG 41
NOVOLOG FLEXPEN 41
NOVOLOG MIX 70/30 41
NOVOLOG MIX 70/30 FLEXPEN 41
NOVOLOG PENFILL 41
NOXAFIL 19
NUBEQA 22
NUEDEXTA 54
NUPLAZID 32
nutrilipid 94
NUVARING 71
NYAMYC 56
nystatin 19, 55, 56
nystatin-triamcinolone 56
NYSTOP 56
O
OCELLA 71
OCTAGAM 77
octreotide acetate 75
ODEFSEY 37
ODOMZO 25
OFEV 89
ofloxacin 11, 83, 85
olanzapine 31
olanzapine-fluoxetine hcl 17
olmesartan medoxomil 45
olmesartan medoxomil-hctz ... 46
olmesartan-amlodipine-hctz ... 46
olopatadine hcl 83, 88
omega-3-acid ethyl esters 52
omeprazole 64
OMNIPOD 10 PACK 38
OMNIPOD 5 PACK 38
OMNIPOD DASH SYSTEM. 38
OMNIPOD STARTER 39
ondansetron 18
ondansetron hcl 18
OPSUMIT 88
ORFADIN 65
ORKAMBI 87
orphenadrine citrate er 90
ORSYTHIA 71
oseltamivir phosphate 36
OSPHENA 73
oxacillin sodium 9
oxandrolone 67
oxaprozin 1
oxazepam 38
oxcarbazepine 14
OXERVATE 82
oxybutynin chloride 65
oxybutynin chloride er 65
oxycodone hcl 3
oxycodone-acetaminophen 4
oxycodone-aspirin 4
oxycodone-ibuprofen 4
OXYCONTIN 2
oxymorphone hcl 4
OZEMPIC (0.25 OR 0.5 MG/DOSE) 40
OZEMPIC (1 MG/DOSE) 40
P
PACERONE 45
paliperidone er 31
PANRETIN 60
pantoprazole sodium 64
PANZYGA 77
paricalcitol 81
paromomycin sulfate 5
paroxetine hcl 16
PASER 21
PAXIL 16
PAZEO 83
PEDIARIX 80
PEDVAX HIB 80
peg 3350/electrolytes 62
peg 3350-kcl-na bicarb-nacl ... 62
peg-3350/electrolytes 62
PEGANONE 14
PEGASYS 33
PEGASYS PROCLICK 33
penicillin g pot in dextrose 9
penicillin g potassium 9
penicillin g procaine 9
penicillin g sodium 9
penicillin v potassium 9
PENTAM 6
pentoxifylline er 50
perindopril erbumine 45
permethrin 60
perphenazine 32
perphenazine-amitriptyline 32
PERSERIS 31
phenelzine sulfate 16
phenobarbital 12
phenoxybenzamine hcl 44
phenytoin 14
phenytoin sodium extended 14
PICATO 60
PIFELTRO 34
pilocarpine hcl 55, 82
pimecrolimus 60
pimozide 30
PIMTREA 71
pindolol 47
pioglitazone hcl 40
piperacillin sod-tazobactam so 10
PIQRAY (200 MG DAILY DOSE) 25
PIQRAY (250 MG DAILY DOSE) 25
PIQRAY (300 MG DAILY DOSE) 25
PIRMELLA 1/35 71
piroxicam 1
PLASMA-LYTE 148 92
PLASMA-LYTE A 92
podofilox 60
polymyxin b sulfate 5
polymyxin b-trimethoprim 83
POMALYST 25
PORTIA-28 72

potassium chloride 93
potassium chloride crys er..... 93
potassium chloride er..... 93
potassium chloride in dextrose 93
potassium chloride in nacl..... 93
potassium citrate er..... 93
PRADAXA 42
PRALUENT..... 52
pramipexole dihydrochloride . 28
pramipexole dihydrochloride er 28
prasugrel hcl..... 44
pravastatin sodium..... 51
prazosin hcl 44
prednicarbate..... 60
prednisolone..... 66
prednisolone acetate 84
prednisolone sodium phosphate 67, 85
prednisone 67
PREDNISONE INTENSOL .. 67
preferred plus insulin syringe 39
pregabalin..... 55
PREMARIN 73
PREMASOL 94
PREMPHASE..... 73
PREMPRO 73
prenatal 93
PREPOPIK..... 64
PREVALITE..... 52
PREVIFEM..... 72
PREZCOBIX 37
PREZISTA..... 36
PRIFTIN..... 21
primaquine phosphate..... 28
primidone 12
PRIVIGEN 77
probenecid..... 20
PROCALAMINE 94
prochlorperazine 18
prochlorperazine maleate 18
PROCRIT 43
PROCTO-MED HC..... 60
PROCTO-PAK 60
PROCTOSOL HC 60
PROCTOZONE-HC..... 60
progesterone micronized .. 73, 74
PROGLYCEM..... 40
PROGRAF 77
PROLASTIN-C..... 89
PROLENSA 85
PROLIA..... 81
PROMACTA..... 43
promethazine hcl 18
propafenone hcl..... 46
propafenone hcl er..... 46
propranolol hcl 47
propranolol hcl er 47
propranolol-hctz 46, 47
propylthiouracil 76
PROQUAD..... 80
PROSOL..... 94
protriptyline hcl..... 18
PULMOZYME 89
PURIXAN 22
pyrazinamide 21
pyridostigmine bromide..... 21
Q
QUADRACEL 80
quetiapine fumarate..... 31
quetiapine fumarate er 31
quinapril hcl..... 45
quinapril-hydrochlorothiazide 50
quinidine sulfate..... 46
quinine sulfate 28
R
RABAVERT 80
rabeprazole sodium 64
raloxifene hcl..... 81
ramipril 45
ranitidine hcl..... 63
ranolazine er 50
RAPAMUNE 77
rasagiline mesylate..... 29
RAVICTI..... 65
RECLIPSEN..... 72
RECOMBIVAX HB 80
RECTIV..... 60
REGRANEX 60
RELENZA DISKHALER 36
RELI-ON INSULIN SYRINGE 39
RELISTOR..... 62
repaglinide 40
repaglinide-metformin hcl 40
REPATHA..... 52
REPATHA PUSHTRONEX SYSTEM 52
REPATHA SURECLICK 52
RESCRIPTOR 34
RESTASIS 82
RETACRIT 43
REVLIMID 22
REXULTI 31
REYATAZ.....36
RIBASPHERE.....33
ribavirin.....33
rifabutin.....21
rifampin.....21
RIFATER.....21
riluzole.....54
rimantadine hcl 36
risedronate sodium 81
RISPERDAL CONSTA.....31
risperidone.....31
ritonavir.....36
rivastigmine 15
rivastigmine tartrate.....14
rizatriptan benzoate 20
ropinirole hcl.....29
ropinirole hcl er 28
rosuvastatin calcium.....52
ROTARIX.....80
ROTATEQ.....80
ROWEEPRA XR.....12
RUBRACA 27
RUCONEST 50
RYDAPT.....27
S
SAMSCA 91
SANDIMMUNE.....77
SANTYL.....60
SAPHRIS 32
SAVELLA 55
SAVELLA TITRATION PACK 55
scopolamine 18
selegiline hcl 29
selenium sulfide.....60
SELZENTRY 35
SEREVENT DISKUS.....87
sertraline hcl.....16
SETLAKIN 72
sevelamer carbonate 64
sevelamer hcl 64
SHAROBEL 72
SHINGRIX 80
SIGNIFOR 75
sildenafil citrate 88

SILENOR 91
silodosin 65
silver sulfadiazine 60
SIMBRINZA..... 84
simvastatin 52
sirolimus 77
SIRTURO..... 21
SIVEXTRO 6
sodium chloride 93
sodium phenylbutyrate 65
sodium polystyrene sulfonate 91
sofosbuvir-velpatasvir 33
solifenacin succinate..... 65
SOLIQUA 40
SOLTAMOX 22
SOMATULINE DEPOT 75
SOMAVERT..... 75
SORINE 46
sotalol hcl 46
sotalol hcl (af) 46
SOVALDI 33
SPIRIVA HANDIHALER 87
SPIRIVA RESPIMAT..... 87
spironolactone 51
spironolactone-hctz..... 50
SPRINTEC 28..... 72
SPRITAM 12
SPRYCEL 25
SPS 91
SRONYX 72
SSD..... 60
stavudine 34
STELARA..... 79
STIOLTO RESPIMAT 89
STIVARGA 25
STRIBILD..... 37
SUBOXONE..... 4
SUCRAID 62
sucralfate 64
sulfacetamide sodium 11
sulfacetamide sodium (acne).. 60
sulfacetamide-prednisolone ... 85
sulfadiazine 11
sulfamethoxazole-trimethoprim 11
sulfasalazine 63
sulindac..... 1
sumatriptan 20
sumatriptan succinate 20, 21
sumatriptan succinate refill 20
SUPREP BOWEL PREP KIT 64
SUTENT 25
SYEDA 72
SYLATRON..... 33
SYMDEKO 88
SYMFI 37
SYMFI LO 37
SYMPAZAN 12
SYMTUZA..... 37
SYNAREL..... 75
SYNDROS 18
SYNJARDY 40
SYNJARDY XR 40
SYNRIBO..... 25
SYNTHROID..... 75
T
TABLOID..... 22
tacrolimus 60, 77
tadalafil (pah) 88
TAFINLAR 25
TAGRISSO 25
TAKHZYRO 50
TALZENNA..... 25
tamoxifen citrate 22
tamsulosin hcl..... 65
TARGRETIN 60
TARINA 24 FE 72
TARINA FE 1/20..... 72
TASIGNA..... 25
tazarotene..... 60
TAZORAC 60
TAZTIA XT 48
TDVAX 80
TEFLARO 8
TEGSEDI 54
telmisartan 45
telmisartan-amlodipine 46
telmisartan-hctz 50
temazepam..... 91
TENIVAC..... 80
tenofovir disoproxil fumarate. 34
terazosin hcl..... 44
terbinafine hcl..... 19
terbutaline sulfate..... 87
terconazole..... 66
testosterone 67
testosterone cypionate..... 67
testosterone enanthate 67
tetrabenazine..... 54
tetracycline hcl 11
THALOMID 22
theophylline 88
theophylline er 88
thioridazine hcl 30
thiothixene.....30
tiagabine hcl 13
TIBSOVO 25
tigecycline 6
TIGLUTIK.....54
timolol maleate 47, 84
tinidazole 6
TIVICAY 35
TIVORBEX 20
tizanidine hcl.....90
TOBI PODHALER 88
tobramycin 83, 90
tobramycin sulfate 5
tobramycin-dexamethasone 85
TOLAK 61
tolbutamide 40
tolcapone 25
tolterodine tartrate 65
tolterodine tartrate er 65
topiramate 13
toremifene citrate.....22
torsemide 51
TOUJEO MAX SOLOSTAR .41
TOUJEO SOLOSTAR 41
TPN ELECTROLYTES.....93
TRACLEER.....88
tramadol hcl 4
tramadol hcl er 2
tramadol hcl er (biphasic) 2
tramadol-acetaminophen 4
trandolapril.....45
trandolapril-verapamil hcl er ..46
tranexamic acid.....43
TRANSDERM-SCOP (1.5 MG) 18
tranylcypromine sulfate.....16
TRAVASOL 94
TRAVATAN Z.....82
trazodone hcl..... 15, 16
TRECATOR 21
TRELEGY ELLIPTA 90
TRELSTAR MIXJECT.....76
TRESIBA 41
TRESIBA FLEXTOUCH 41
tretinoin 25, 61
tretinoin microsphere.....61

triamcinolone acetonide ... 55, 61
triamterene-hctz ... 50
triazolam ... 12
TRIDERM ... 61
trientine hcl ... 91
TRI-ESTARYLLA ... 72
trifluoperazine hcl ... 30
trifluridine ... 83
trihexyphenidyl hcl ... 28
TRI-LEGEST FE ... 72
TRI-LO-ESTARYLLA ... 72
TRI-LO-SPRINTEC ... 72
TRILYTE ... 62
trimethoprim ... 6
TRI-MILI ... 72
trimipramine maleate ... 18
TRINTELLIX ... 16
TRI-PREVIFEM ... 72
TRI-SPRINTEC ... 72
TRIUMEQ ... 35
TRIVORA (28) ... 72
TRI-VYLIBRA ... 72
TRI-VYLIBRA LO ... 72
TROPHAMINE ... 94
trospium chloride ... 65
TRULICITY ... 40
TRUMENBA ... 80
TRUVADA ... 35, 37
TURALIO ... 25
TWINRIX ... 80
TYBOST ... 35
TYKERB ... 25
TYMLOS ... 81
TYPHIM VI ... 80
U
UCERIS ... 67
UDENYCA ... 44
UNITHROID ... 75
UPTRAVI ... 88, 89
ursodiol ... 62, 63
V
valacyclovir hcl ... 33
VALCHLOR ... 61
valganciclovir hcl ... 32
valproic acid ... 13, 38
valsartan ... 45
valsartan-hydrochlorothiazide 50
vancomycin hcl ... 6
VANDAZOLE ... 66
VAQTA ... 80
VARIVAX ... 81
VARIZIG ... 81
VASCEPA ... 52
VELIVET ... 72
VEMLIDY ... 33
VENCLEXTA ... 25, 26
VENCLEXTA STARTING PACK ... 26
venlafaxine hcl ... 17
venlafaxine hcl er ... 17
VENTAVIS ... 89
VENTOLIN HFA ... 87
verapamil hcl ... 48
verapamil hcl er ... 48
VERSACLOZ ... 32
VERZENIO ... 26
V-GO 20 ... 82
V-GO 30 ... 82
V-GO 40 ... 82
VICODIN ES ... 4
VICTOZA ... 40
VIDEX ... 35
VIDEX EC ... 35
VIENVA ... 72
vigabatrin ... 13
VIGADRONE ... 13
VIIBRYD ... 16
VIIBRYD STARTER PACK ... 16
VIMPAT ... 14
VIRACEPT ... 36
VIREAD ... 35
VITRAKVI ... 26
VIVITROL ... 4
VIVLODEX ... 2, 20
VIZIMPRO ... 26
voriconazole ... 19, 20
VOSEVI ... 33
VOTRIENT ... 26
VRAYLAR ... 32
VYFEMLA ... 72
VYLIBRA ... 72
VYZULTA ... 82
W
warfarin sodium ... 42
WELCHOL ... 50
WYMZYA FE ... 73
X
XALKORI ... 26
XARELTO ... 42
XARELTO STARTER PACK ... 42
XATMEP ... 77
XELJANZ ... 79
XELJANZ XR ... 79
XGEVA ... 81
XIFAXAN ... 6
XIIDRA ... 82
XOFLUZA ... 36
XOLAIR ... 90
XOSPATA ... 26
XPOVIO (100 MG ONCE WEEKLY) ... 26
XPOVIO (60 MG ONCE WEEKLY) ... 26
XPOVIO (80 MG ONCE WEEKLY) ... 26
XPOVIO (80 MG TWICE WEEKLY) ... 26
XTANDI ... 22
XULTOPHY ... 40
XURIDEN ... 61
XYREM ... 91
Y
YF-VAX ... 81
YONSA ... 26
YUVAFEM ... 66
Z
zafirlukast ... 86
zaleplon ... 90
ZARAH ... 73
ZARXIO ... 44
ZEJULA ... 27
ZELBORAF ... 26
ZEMAIRA ... 90
ZENPEP ... 62
ZENZEDI ... 53, 54
ZERBAXA ... 8
zidovudine ... 35
zileuton er ... 86
ziprasidone hcl ... 31
ZIRGAN ... 32
ZOLINZA ... 26
zolmitriptan ... 21
zolpidem tartrate ... 90
zolpidem tartrate er ... 90
zonisamide ... 12
ZORTRESS ... 77
ZORVOLEX ... 2
ZOSTAVAX ... 81

ZOVIA 1/35E (28)..... 73
ZYDELIG 26
ZYKADIA..... 26
ZYLET..... 85
ZYPREXA RELPREVV.....32
ZYTIGA.....26

This abridged formulary was updated on 10/21/2019. This is not a complete list of drugs covered by our plan. For a complete listing or other questions, please contact **EnvisionRxPlus Employer Group Retiree PDP** Member Services at 1-844-293-4760 or, for TTY users, 711, 24 hours a day, 7 days a week, or visit www.envisionrxplus.com.