




# Updates to your prescription benefits

Effective January 1, 2023

## Advantage 3-Tier PDL update summary

Within the Prescription Drug List (PDL), prescription drugs are grouped by tier. The tier indicates the amount you pay when you fill a prescription. Please reference the chart below as you review the following updates to the PDL.

|   |  |   |
|---|--|---|
| <br><b>Tier 1</b><br>Lowest-cost medications | <br><b>Tier 2</b><br>Mid-range cost | <br><b>Tier 3</b><br>Highest-cost |
|---|--|---|

## Prescription drugs with new benefit coverage

The following drugs were previously not covered under most benefit plans and are now eligible for coverage.

| Therapeutic Use            | Medication Name   | Tier Placement |
|----------------------------|---|----------------|
| Acne                       | dapsone 5% Gel (generic Aczone)   | Tier 3         |
| Acne                       | dapsone 7.5% Gel (generic Aczone)                                       | Tier 3         |
| Cholesterol/Lipid lowering | colesevelam hydrochloride (generic Welchol)                             | Tier 2         |
| Hereditary angioedema      | icatibant acetate (generic Firazyr) <sup>1</sup>                        | Tier 2         |
| Pain                       | hydrocodone bitartrate extended-release (generic Hysingla) <sup>1</sup> | Tier 3         |
| Pain                       | morphine sulfate extended-release (generic Kadian) <sup>1</sup>         | Tier 3         |

## Prescription drugs moving to a higher tier

The following medications are moving to a higher tier. Medications may move from a lower tier to a higher tier when they are more costly and have available lower-cost options.

| Therapeutic Use | Medication Name         | Tier Placement   | Alternative Treatment Option(s)          |
|-----------------|-------------------------|------------------|--|
| Infections      | Vandazole               | Tier 2 to Tier 3 | metronidazole (generic MetroGel-Vaginal) |
| Pain            | Xtampza ER <sup>1</sup> | Tier 2 to Tier 3 | morphine sulfate (generic MS Contin)     |

## Prescription drugs excluded from benefit coverage<sup>2, 3</sup>

We evaluate prescription drugs based on their total value, including how a drug works and how much it costs. When several drugs work in the same way, we may choose to exclude the higher-cost option. Effective January 1, 2023, the drugs listed below may be excluded from coverage or you may need to get a Prior Authorization. Sign into your online account to check which drugs your plan covers and if there are any actions you need to take.

| Therapeutic Use            | Medication Name                          | Alternative Treatment Option(s)   |
|----------------------------|--|---|
| Acne                       | Aczone 5% topical gel (brand only)       | dapsone topical gel (generic Aczone), OTC Differin Gel                        |
| Acne                       | Aczone 7.5% topical gel (brand only)     | dapsone topical gel (generic Aczone), OTC Differin Gel                        |
| Acne                       | Twynéo <sup>4</sup>                      | OTC benzoyl peroxide + OTC Differin gel or tretinoin cream (generic Retin A)  |
| Cancer                     | Eulexin (brand only) <sup>4</sup>        | bicalutamide (generic Casodex)  |
| Cancer                     | Nilandron                                | bicalutamide (generic Casodex)  |
| Cancer                     | nilutamide (generic Nilandron)           | bicalutamide (generic Casodex)  |
| Cholesterol/Lipid lowering | Welchol (brand only)                     | colesevelam (generic Welchol)   |
| Cushing's disease          | Recorlev <sup>1,4</sup>                  | ketoconazole (generic Nizoral)  |
| Diuretic                   | Soanz <sup>4</sup>                       | toremide (generic Demadex)  |
| Elevated phosphate levels  | Auryxia                                  | sevelamer (generic Renagel), Velphoro   |
| Elevated phosphate levels  | Renagel (brand only)                     | sevelamer (generic Renagel)   |
| Elevated phosphate levels  | Renvela (brand only) packet <sup>1</sup> | sevelamer carbonate (generic Renvela)   |
| Excessive secretions       | Dartisla ODT <sup>4</sup>                | glycopyrrolate tablet (generic Robinul)                                       |
| Hepatitis B                | Vemlidy <sup>1</sup>                     | entecavir (generic Baraclude), tenofovir disoproxil fumarate (generic Viread) |
| Hereditary angioedema      | Firazyr (brand only) <sup>1</sup>        | icatibant acetate (generic Firazyr) <sup>1</sup>                              |
| Infections                 | Alinia tablets (brand only)              | nitazoxanide (generic Alinia)   |

| Therapeutic Use              | Medication Name                               | Alternative Treatment Option(s)                                      |
|------------------------------|---|--|
| <b>Mental health</b>         | Citalopram hydrobromide capsules <sup>4</sup> | citalopram (generic Celexa)  |
| <b>Pain</b>                  | Dilaudid (brand only)                         | hydromorphone (generic Dilaudid)                                     |
| <b>Pain</b>                  | MS Contin (brand only) <sup>1</sup>           | morphine sulfate (generic MS Contin)                                 |
| <b>Pain and inflammation</b> | Anaprox DS (brand only) <sup>4</sup>          | naproxen (generic Naprosyn, generic Anaprox DS), OTC naproxen        |
| <b>Pain and inflammation</b> | Seglentis <sup>4</sup>                        | celecoxib capsules (generic Celebrex) plus tramadol (generic Ultram) |
| <b>Parkinson's disease</b>   | Dhivy <sup>4</sup>                            | carbidopa/levodopa (generic Sinemet)                                 |

<sup>1</sup> Step Therapy or Prior Authorization may be required prior to coverage.

<sup>2</sup> Exclusion includes brand, generic and authorized generic products unless otherwise noted.

<sup>3</sup> For benefits that do not exclude, Step Therapy or Prior Authorization may be required.

<sup>4</sup> Newly released medication which was excluded from coverage at the time of launch and will continue to be excluded from our pharmacy benefit.

# Advantage 3-Tier PDL clinical programs update summary

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective January 1, 2023.

## MN Medical Necessity

Medical Necessity is a type of Prior Authorization that evaluates the clinical appropriateness of a medication, such as condition being treated, type of medication, frequency of use, and duration of therapy. The following medications will now require Medical Necessity for coverage.

| Therapeutic Use | Medication Name |
|-----------------|-----------------|
| Hepatitis B     | Vemlidy         |

## ST Step Therapy<sup>5</sup>

The medications below have a new or revised Step Therapy program. You must try one or more other medications before the medication below may be covered.

| Therapeutic Use | Medication Name      | Step 1 Medication  |
|-----------------|----------------------|--------------------|
| Blood clots     | Savaysa <sup>6</sup> | Eliquis or Xarelto |

<sup>5</sup> Referred to as First Start in New Jersey.

<sup>6</sup> Includes continuation of therapy, existing members not impacted.

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**Phone:** Toll free **1-800-368-1019**, **1-800-537-7697** (TDD)  
**Mail:** U.S. Dept. of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, D.C. 20201

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