Optum Rx®

Focused utilization management program

Effective Jan. 1, 2026

Focused Specialty

Focused specialty prior authorization with quantity limits program

The following medications require a prior authorization (PA) for coverage. This means we need more information from your doctor to see if you can get coverage for your medication.

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Growth hormones	Preferred Agents: (Tier 2) NORDITROPIN, OMNITROPE (Tier 3) NGENLA, SKYTROFA Non-preferred Agents: GENOTROPIN, HUMATROPE, NUTROPIN AQ, SAIZEN, SOGROYA, ZOMACTON	None	None
Hepatitis C	Preferred Agents: EPCLUSA, HARVONI, MAVYRET, VOSEVI Non-preferred Agents#: LEDIPASVIR-SOFOSBUVIR[G], SOFOSBUVIR-VELPATASVIR[G], SOVALDI, ZEPATIER	EPCLUSA PELLET PACK 150-37.5 MG	1 pack per day
		EPCLUSA PELLET PACK 200-50 MG	2 packs per day
		EPCLUSA, SOFOSBUVIR-VELPATASVIR[G] TAB	1 tablet per day
		HARVONI PELLET PACK 33.75-150 MG	1 pack per day
		HARVONI PELLET PACK 45-200 MG	2 packs per day
		HARVONI TAB 45-200 MG	2 tablets per day
		HARVONI, LEDIPASVIR-SOFOSBUVIR[G] TAB 90-400 MG	1 tablet per day
		MAVYRET	3 tablets per day
		MAVYRET PELLET PACK 50-20 MG	5 packs per day
		SOVALDI PELLET PACK 150 MG	1 pack per day
		SOVALDI PELLET PACK 200 MG	2 packs per day
		SOVALDI TAB	1 tablet per day
		SOVALDI TAB 200 MG	2 tablets per day
		VOSEVI	1 tablet per day
		ZEPATIER	1 tablet per day

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Immunomodulators	Preferred Agents: (Tier 2) AMJEVITA (preferred NDCs), AVSOLA, CIMZIA, ENBREL, INFLECTRA, OMVOH, OTEZLA, RINVOQ, RINVOQ LQ, SIMPONI, SIMPONI ARIA, SKYRIZI, SOTYKTU, TALTZ, TREMFYA, VELSIPITY, WEZLANA, XELJANZ, XELJANZ XR, YESINTEK (Tier 3) ACTEMRA*, BIMZELX*, ENTYVIO SQ*, LITFULO, OLUMIANT*, ORENCIA* Non-preferred Agents#: ABRILADA, ADALIMUMAB-AACF, ADALIMUMAB-AATY, ADALIMUMAB-ADAZ, ADALIMUMAB-ADBM, ADALIMUMAB-FKJP, ADALIMUMAB-RYVK, COSENTYX, CYLTEZO, HADLIMA, HULIO, HUMIRA, HYRIMOZ, IDACIO, ILUMYA, IMULDOSA, INFLIXIMAB, KEVZARA, KINERET, LEQSELVI, OTULFI, PYZCHIVA, REMICADE, RENFLEXIS, SELARSDI, SILIQ, SIMLANDI, STELARA, STEQEYMA, TOFIDENCE, TYENNE, USTEKINUMAB, USTEKINUMAB-AEKN, USTEKINUMAB-TTWE, YUFLYMA, YUSIMRY, ZYMFENTRA	ABRILADA INJ 20 MG/0.4 ML	4 syringes per 28 days
		ABRILADA INJ 40 MG/0.8 ML	4 syringes per 28 days
		ACTEMRA INJ 162 MG/0.9 ML	4 syringes per 28 days
		AMJEVITA INJ 10 MG/0.2 ML	2 syringes per 28 days
		AMJEVITA INJ 20 MG/0.2 ML	4 syringes per 28 days
		AMJEVITA INJ 20 MG/0.4 ML	4 syringes per 28 days
		AMJEVITA INJ 40 MG/0.4 ML	4 syringes per 28 days
		AMJEVITA INJ 40 MG/0.8 ML	4 syringes per 28 days
		AMJEVITA INJ 80 MG/0.8 ML	2 syringes per 28 days
		BIMZELX INJ	1 syringe per 28 days
		CIMZIA KIT 200 MG	4 syringes per 28 days
		CIMZIA PREFL KIT 200 MG/ML	4 syringes per 28 days
		COSENTYX INJ 75 MG/0.5 ML	1 syringe per 28 days
		COSENTYX INJ 150 MG/ML	1 syringe per 28 days
		COSENTYX INJ 300 DOSE	2 syringes per 28 days
		COSENTYX PEN INJ 150 MG/ML	1 syringe per 28 days
		COSENTYX PEN INJ 300 DOSE	2 syringes per 28 days
		COSENTYX UNO INJ 300 MG/2 ML	1 syringe per 28 days
		CYLTEZO, ADALIMUMAB-ADBM[G] INJ 10 MG/0.2 ML	2 syringes per 28 days
		CYLTEZO, ADALIMUMAB-ADBM[G] INJ 20 MG/0.4 ML	4 syringes per 28 days
		CYLTEZO, ADALIMUMAB-ADBM[G] INJ 40 MG/0.4 ML	4 syringes per 28 days
		CYLTEZO, ADALIMUMAB-ADBM[G] INJ 40 MG/0.8 ML	4 syringes per 28 days
		ENBREL INJ 25 MG/0.5 ML	8 vials/syringes per 28 days
		ENBREL INJ 50 MG/ML	4 syringes per 28 days
		ENBREL MINI INJ 50 MG/ML	4 cartridges per 28 days
		ENBREL SRCLK INJ 50 MG/ML	4 syringes per 28 days
		ENTYVIO INJ 108 MG/0.68 ML	2 syringes per 28 days
		HADLIMA INJ 40 MG/0.4 ML	4 syringes per 28 days
		HADLIMA INJ 40 MG/0.8 ML	4 syringes per 28 days
		HADLIMA PUSH INJ 40 MG/0.4 ML	4 syringes per 28 days
		HADLIMA PUSH INJ 40 MG/0.8 ML	4 syringes per 28 days
		HULIO, ADALIMUMAB-FKJP[G] INJ 20 MG/0.4 ML	4 syringes per 28 days
		HULIO, ADALIMUMAB-FKJP[G] INJ 40 MG/0.8 ML	4 syringes per 28 days
		HUMIRA INJ 10 MG/0.1 ML	2 syringes per 28 days
		HUMIRA INJ 20 MG/0.2 ML	4 syringes per 28 days
		HUMIRA INJ 40 MG/0.4 ML	4 syringes per 28 days

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Immunomo-dulators continued		HUMIRA INJ 40 MG/0.8 ML	4 syringes per 28 days
		HUMIRA PEN INJ 40 MG/0.4 ML	4 syringes per 28 days
		HUMIRA PEN INJ 40 MG/0.8 ML	4 syringes per 28 days
		HUMIRA PEN INJ 80 MG/0.8 ML	2 syringes per 28 days
		HUMIRA STARTER PACK	1 starter kit per 365 days
		HYRIMOZ, ADALIMUMAB-ADAZ[G] INJ 10 MG/0.1 ML	2 syringes per 28 days
		HYRIMOZ, ADALIMUMAB-ADAZ[G] INJ 20 MG/0.2 ML	4 syringes per 28 days
		HYRIMOZ, ADALIMUMAB-ADAZ[G] INJ 40 MG/0.4 ML	4 syringes per 28 days
		HYRIMOZ INJ 40 MG/0.8 ML	4 syringes per 28 days
		HYRIMOZ INJ 80 MG/0.8 ML	2 syringes per 28 days
		HYRIMOZ STARTER PACK	1 starter kit per 365 days
		IDACIO, ADALIMUMAB-AACF[G] INJ 40 MG/0.8 ML	4 syringes per 28 days
		ILUMYA INJ 100 MG/ML	1 syringe per 84 days
		IMULDOSA INJ 45 MG/0.5 ML	1 syringe per 56 days
		IMULDOSA INJ 90 MG/ML	1 syringe per 56 days
		KEVZARA INJ 150 MG/1.14 ML	2 syringes per 28 days
		KEVZARA INJ 200 MG/1.14 ML	2 syringes per 28 days
		LEQSELVI TAB	2 tablets per day
		LITFULO CAP	1 capsule per day
		OLUMIANT TAB	1 tablet per day
		OMVOH INJ 100 MG/ML	2 syringes per 28 days
		OMVOH INJ 100/200 MG/ML	1 package per 28 days
		OMVOH IV SOLN 300 MG/15 ML	45 mL per 365 days
		ORENCIA INJ 50 MG/0.4 ML	4 syringes per 28 days
		ORENCIA INJ 87.5 MG/0.7 ML	4 syringes per 28 days
		ORENCIA INJ 125 MG/ML	4 syringes per 28 days
		OTEZLA STARTER PACK	1 starter pack per 365 days
		OTEZLA TAB	2 tablets per day
		OTULFI INJ 45 MG/0.5 ML	1 syringe per 56 days
		OTULFI INJ 90 MG/ML	1 syringe per 56 days
		PYZCHIVA, USTEKINUMAB-TTWE[G] INJ 45 MG/0.5 ML	1 syringe per 56 days
		PYZCHIVA, USTEKINUMAB-TTWE[G] INJ 90 MG/ML	1 syringe per 56 days
		RINVOQ LQ SOLN 1 MG/ML	12 mL per day
		RINVOQ TAB	1 tablet per day
		SELARSDI, USTEKINUMAB-AEKN[G] INJ 45 MG/0.5 ML	1 syringe per 56 days

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Immunomodulators continued		SELARSDI, USTEKINUMAB-AEKN[G] INJ 90 MG/ML	1 syringe per 56 days
		SILIQ INJ 210 MG/1.5 ML	2 syringes per 28 days
		SIMLANDI INJ 20 MG/0.2 ML	4 syringes per 28 days
		SIMLANDI, ADALIMUMAB-RYVK[G] INJ 40 MG/0.4 ML	4 syringes per 28 days
		SIMLANDI INJ 80 MG/0.8 ML	2 syringes per 28 days
		SIMPONI INJ 50 MG/0.5 ML	1 syringe per 28 days
		SIMPONI INJ 100 MG/ML	1 syringe per 28 days
		SKYRIZI INJ 150 MG/ML	1 syringe per 84 days
		SKYRIZI INJ 180 MG/1.2 ML	1 syringe per 56 days
		SKYRIZI INJ 360 MG/2.4 ML	1 syringe per 56 days
		SKYRIZI PEN INJ 150 MG/ML	1 syringe per 84 days
		SOTYKTU TAB	1 tablet per day
		STELARA, USTEKINUMAB[G] INJ 45 MG/0.5 ML	1 vial/syringe per 56 days
		STELARA, USTEKINUMAB[G] INJ 90 MG/ML	1 syringe per 56 days
		STEQEYMA INJ 45 MG/0.5 ML	1 syringe per 56 days
		STEQEYMA INJ 90 MG/ML	1 syringe per 56 days
		TALTZ INJ	1 syringe per 28 days
		TREMFYA INJ 100 MG/ML	1 syringe per 56 days
		TREMFYA INJ 200 MG/2 ML	1 syringe per 28 days
		TYENNE INJ 162 MG/0.9 ML	4 syringes per 28 days
		VELSIPITY TAB	1 tablet per day
		WEZLANA INJ 45 MG/0.5 ML	1 vial/syringe per 56 days
		WEZLANA INJ 90 MG/ML	1 syringe per 56 days
		XELJANZ SOLN	10 mL per day
		XELJANZ TAB	2 tablets per day
		XELJANZ XR TAB	1 tablet per day
		YESINTEK INJ 45 MG/0.5 ML	1 syringe per 56 days
		YESINTEK INJ 90 MG/ML	1 syringe per 56 days
		YUFLYMA, ADALIMUMAB-AATY[G] INJ 20 MG/0.2 ML	4 syringes per 28 days
		YUFLYMA, ADALIMUMAB-AATY[G] INJ 40 MG/0.4 ML	4 syringes per 28 days
		YUFLYMA, ADALIMUMAB-AATY[G] INJ 80 MG/0.8 ML	2 syringes per 28 days
		YUSIMRY INJ 40 MG/0.8 ML	4 syringes per 28 days
		ZYMFENTRA INJ 120 MG/ML	2 syringes per 28 days

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Multiple Sclerosis	Preferred Agents: (Tier 1) fingolimod, glatopa, glatiramer, dimethyl fumarate, teriflunomide (Tier 2) AVONEX, BAFIERTAM, BETASERON, KESIMPTA, VUMERITY (Tier 3) MAVENCLAD*, MAYZENT, REBIF*, ZEPOSIA Non-preferred Agents#: AUBAGIO, BRIUMVI, COPAXONE, EXTAVIA, GILENYA, LEMTRADA, OCREVUS, OCREVUS ZUNOVO, PLEGRIDY, PONVORY, TASCENSO ODT, TECFIDERA, TYSABRI	AUBAGIO TAB teriflunomide tab	1 tablet per day
		AVONEX INJ 30 MCG/0.5 ML	1 kit per 28 days
		BAFIERTAM CAP	4 capsules per day
		BETASERON, EXTAVIA INJ	1 package per 28 days
		COPAXONE INJ 20 MG/ML glatiramer inj 20 mg/mL glatopa inj 20 mg/mL	1 syringe per day
		COPAXONE INJ 40 MG/ML glatiramer inj 40 mg/mL glatopa inj 40 mg/mL	12 syringes per 28 days
		GILENYA CAP fingolimod cap	1 capsule per day
		KESIMPTA INJ 20 MG/0.4 ML	1 syringe per month
		LEMTRADA INJ	3.6 mL per 365 days
		MAVENCLAD	20 day supply per lifetime
		MAYZENT STARTER PACK	2 starter packs per 365 days
		MAYZENT TAB 0.25 MG	4 tablets per day
		MAYZENT TAB 1 MG	1 tablet per day
		MAYZENT TAB 2 MG	1 tablet per day
		OCREVUS ZUNOVO	1 syringe per 180 days
		PLEGRIDY INJ	2 syringes per 28 days
		PLEGRIDY STARTER PACK	2 starter packs per 365 days
		PONVORY STARTER PACK	2 starter packs per 365 days
		PONVORY TAB	1 tablet per day
		REBIF INJ	12 syringes per 28 days
		REBIF TITRATION PACK	1 starter pack per 365 days
		TASCENSO ODT	1 tablet per day
		TECFIDERA CAP dimethyl fumarate cap	2 capsules per day
		TECFIDERA STARTER PACK dimethyl fumarate starter pack	2 starter packs per 365 days
		TYSABRI INJ	1 injection per 28 days
		VUMERITY CAP	4 capsules per day
		ZEPOSIA CAP	1 capsule per day
		ZEPOSIA STARTER PACK	2 starter packs per 365 days

Focused non-specialty prior authorization with quantity limits program

The following medications require a prior authorization (PA) for coverage. This means we need more information from your doctor to see if you can get coverage for your medication.

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Basal Insulin	Preferred Agents[N]: BASAGLAR, LANTUS, REZVOGLAR, TOUJEO, TRESIBA Non-preferred Agents: INSULIN DEGLUDEC[G] (Tresiba ABA) INSULIN GLARGINE[G] (Lantus and Toujeo ABA)	None	None
Constipation Agents	Preferred Agents[N]: lactulose, polyethylene glycol, LINZESS* Non-preferred Agents: IBSRELA	IBSRELA	2 tablets per day
Continuous Blood Glucose System - Receiver, Sensor, Transmitter	Preferred Agents: DEXCOM, FREESTYLE LIBRE Non-Preferred Agents: All other brands	None	None
Chronic Dry Eye	Preferred Agents: (Tier 1) generic cyclosporine (Tier 2) RESTASIS, MIEBO, XIIDRA Non-preferred Agents: CEQUA, TRYPTYR, TYRVAYA, VEVYE	CEQUA	2 vials per day
		MIEBO	3 mL per 30 days
		RESTASIS	2 vials per day or 1 bottle per 30 days
		TRYPTYR	2 vials per day
		TYRVAYA	2 bottles per 30 days
		VEVYE	1 bottle per 30 days
		XIIDRA	2 vials per day
Glucagon-Like Peptide-1 Agonist	Preferred Agents: BYDUREON BCISE, BYETTA, liraglutide, MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY Non-preferred Agents: EXENATIDE, VICTOZA	BYDUREON BCISE	4 syringes per 28 days
		BYETTA EXENATIDE	1 syringe per 30 days
		MOUNJARO	4 syringes per 28 days
		OZEMPIC	1 syringe per 28 days
		RYBELSUS	1 tablet per day
		RYBELSUS 3 mg	2 starter packs per 365 days
		TRULICITY	4 syringes per 28 days
		VICTOZA liraglutide	3 syringes per 30 days

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Long-Acting Opioids	Preferred Agents: buprenorphine patch, fentanyl patch, hydrocodone ER, hydromorphone ER, methadone, morphine ER, oxymorphone ER, BELBUCA, HYSINGLA ER, OXYCONTIN, XTAMPZA ER Non-preferred Agents: BUTRANS, MS CONTIN, NUCYNTA ER, OXYCODONE ER[G]	BELBUCA FILM	2 films per day
		BUTRANS PATCH buprenorphine patch	4 patches per 28 days
		fentanyl patch	15 patches per 30 days
		fentanyl patch 75 mcg/hr	1 patch per day
		fentanyl patch 100 mcg/hr	1 patch per day
		hydrocodone ER cap	2 capsules per day
		hydrocodone ER cap 50 MG	4 capsules per day
		hydromorphone ER tab	2 tablets per day
		HYSINGLA ER TAB hydrocodone ER tab	1 tablet per day
		morphine ER beads cap	1 capsule per day
		morphine ER beads cap 120 mg	2 capsules per day
		morphine ER cap	2 capsules per day
		MS CONTIN ER TAB morphine sulfate ER tab	3 tablets per day
		NUCYNTA ER	2 tablets per day
		OXYCONTIN TAB OXYCODONE ER[G] TAB	4 tablets per day
		oxymorphone ER tab	4 tablets per day
		XTAMPZA ER CAP	4 capsules per day
Migraine CGRP - Non-injectable	Preferred Agents: (Tier 2) NURTEC ODT, UBRELVY (Tier 3) ZAVZPRET Non-preferred Agents: REYVOW	NURTEC ODT	16 tablets per 30 days
		QULIPTA	1 tablet per day
		REYVOW	4 tablets per 30 days
		UBRELVY	16 tablets per 30 days
		ZAVZPRET	6 devices per 30 days
Migraine CGRP - SubQ	Preferred Agents: (Tier 2) AIMOVIG, EMGALITY Non-preferred Agents: AJOVY	AIMOVIG 70 MG/ML	2 syringes per 28 days
		AIMOVIG 140 MG/ML	1 syringe per 28 days
		AJOVY	3 syringes per 84 days
		EMGALITY 100 MG/ML	3 syringes per 28 days
		EMGALITY 120 MG/ML	1 syringe per 28 days
Pulmonary Anti-Inflammatory Inhalers	Preferred Agents[N]: ARNUITY ELLIPTA, QVAR REDIHALER Non-preferred Agents: FLUTICASONE ELLIPTA[G]	FLUTICASONE ELLIPTA[G]	1 inhaler per 30 days

Therapeutic use	Targeted drugs	Drugs with Quantity limit	Quantity limit
Pulmonary Anti-Inflammatory/ Long-Acting Beta Agonist Combination Inhalers	Preferred Agents[N]: ADVAIR HFA, ANORO, BREO ELLIPTA Non-preferred Agents: FLUTICASONE-SALMETEROL HFA[G] FLUTICASONE-VILANTEROL[G] UMECLIDINIUM-VILANTEROL[G]	FLUTICASONE-SALMETEROL HFA[G]	1 inhaler per 30 days
		FLUTICASONE-VILANTEROL[G]	1 package per 30 days
		UMECLIDINIUM-VILANTEROL[G]	1 package per 30 days
Rapid-Acting Insulin	Preferred Agents[N]: ADMELOG, APIDRA, FIASP, HUMALOG, INSULIN LISPRO[G], INSULIN LISPRO JR[G], INSULIN LISPRO PROTAMINE/INSULIN LISPRO[G], LYUMJEV, NOVOLOG Non-preferred Agents: INSULIN ASPART[G], INSULIN ASPART PROTAMINE/INSULIN ASPART[G], NOVOLOG RELION, NOVOLOG RELION FLEXPEN, NOVOLOG RELION 70/30, NOVOLOG MIX FLEX RELION	None	None
Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors & Combinations	Preferred Agents[N]: FARXIGA, GLYXAMBI, JARDIANCE, SYNJARDY, SYNJARDY XR, TRIJARDY XR, XIGDUO XR Non-preferred Agents: DAPAGLIFLOZIN (Farxiga ABA), DAPAGLIFLOZIN/ METFORMIN (Xigduo XR ABA)	None	None

Focused non-specialty step therapy with quantity limits program

The following medications have been added to a step therapy program. This means you must try a lower-cost medication (step 1) before a higher-cost medication (targeted drug) is covered.

Therapeutic use	Step 1 medication	Targeted drugs	Quantity limit
Basal Insulin	Any three of the following: BASAGLAR, LANTUS, REZVOGLAR, TOUJEO, TRESIBA	BASAGLAR TEMPO SEMGLEE GLARGIN-YFGN[G] (Semglee ABA)	None
Blood Glucose Meters & Strips	CONTOUR and one of the following FREESTYLE or PRECISION	All other brands	300 strips per 30 days
Constipation Agents	Any one of the following: lactulose, polyethylene glycol	LINZESS	1 capsule per day
		MOVANTIK	1 tablet per day
		prucalopride	1 tablet per day
		SYMPROIC	1 tablet per day
	Any one of the following: lactulose, polyethylene glycol AND Any one of the following: LINZESS*, MOVANTIK*, SYMPROIC*	AMITIZA	2 capsules per day
	Any one of the following: lactulose, polyethylene glycol AND Any one of the following: MOVANTIK*, SYMPROIC* AND lubiprostone	RELISTOR TABLET	3 tablets per day
		RELISTOR INJECTION	1 syringe per day
	Any one of the following: lactulose, polyethylene glycol AND LINZESS* AND prucalopride*	MOTEGRITY	1 tablet per day
	Any one of the following: lactulose, polyethylene glycol AND LINZESS* AND lubiprostone	TRULANCE	1 tablet per day

Therapeutic use	Step 1 medication	Targeted drugs	Quantity limit
Dipeptidyl Peptidase-4 Inhibitors & Combinations	Any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin AND Any one of the following: JANUMET, JANUMET XR, JANUVIA AND Any one of the following: JENTADUETO, JENTADUETO XR, TRADJENTA	ALOGLIPTIN[G] ALOGLIPTIN-METFORMIN[G] ALOGLIPTIN-PIOGLITAZONE[G] KAZANO KOMBIGLYZE XR NESINA ONGLYZA OSENI SITAGLIPTIN[G] SITAGLIPTIN-METFORMIN[G] ZITUVIMET ZITUVIMET XR ZITUVIO	None
Inflammatory Bowel Disease	APRISO	DELZICOL LIALDA	None
	Both of the following: mesalamine and APRISO	PENTASA	None
Pancreatic Enzymes	Both of the following: CREON and ZENPEP	PANCREAZE PERTZYE VIOKACE	None
Pulmonary Anti-Inflammatory Inhalers	Both of the following: ARNUITY ELLIPTA, QVAR REDIHALER	ALVESCO	2 inhalers per 30 days
		ARMONAIR DIGIHALER	1 inhaler per 30 days
		ASMANEX/ASMANEX HFA	1 inhaler per 30 days
		FLUTICASONE DISKUS[G]	60 blisters per 30 days
		FLUTICASONE DISKUS 250 MCG/ACT[G]	240 blisters per 30 days
		FLUTICASONE HFA[G]	2 inhalers per 30 days
		PULMICORT FLEXHALER	2 packages per 30 days
	Any one of the following: generic tiotropium inhalation caps or SPIRIVA RESPIMAT	INCRUSE ELLIPTA	1 inhaler per 30 days
		TUDORZA PRESSAIR	1 inhaler per 30 days
	Generic tiotropium inhalation caps	SPIRIVA HANDIHALER 18 MCG	1 package per 30 days
Pulmonary Anti-Inflammatory/ Long-Acting Beta Agonist Combination Inhalers	Any two of the following: ADVAIR HFA, BREO ELLIPTA, budesonide-formoterol inhaler	ADVAIR DISKUS	1 diskus per 30 days
		AIRDUO DIGIHALER	1 inhaler per 30 days
		AIRDUO RESPICLICK, FLUTICASONE/SALMETEROL[G]	1 inhaler per 30 days
		DULERA	1 inhaler per 30 days
		SYMBICORT	1 inhaler per 30 days
	Both of the preferred brands: ANORO ELLIPTA and STIOLTO RESPIMAT	BEVESPI AEROSPHERE	1 inhaler per 30 days
		DUAKLIR PRESSAIR	1 device per 30 days

Therapeutic use	Step 1 medication	Targeted drugs	Quantity limit
Rapid-Acting Insulin	Any two of the following: ADMELOG, APIDRA, FIASP, HUMALOG/BRAND LISPRO, LYUMJEV, NOVOLOG	HUMALOG TEMPO LYUMJEV TEMPO MERILOG	None
Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors & Combinations	Any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin AND Any one of the following: FARXIGA, XIGDUO XR AND Any one of the following: GLYXAMBI, JARDIANCE, SYNJARDY, SYNJARDY XR, TRIJARDY XR	BRENZAVVY BEXAGLIFLOZIN[G] INVOKAMET INVOKAMET XR INVOKANA QTERN SEGLUROMET STEGLATRO STEGLUJAN	None
	Both of the followings: FARXIGA and JARDIANCE	INPEFA	None
Topical Acne Treatment	Any one of the following: EPIDUO FORTE, clindamycin/benzoyl peroxide gel 1.2/3.75%, TWYNEO	ACANYA BENZAMYCIN ONEXTON ZIANA	None

Notice of Availability of Language Assistance Services and Alternate Formats

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ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas y comunicaciones en otros formatos como letra grande, sin cargo, a su disposición. Llame al número gratuito que figura en su tarjeta de identificación de miembro. TTY: **711**

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ចំណាំ៖ ប្រសិនបើអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាឥតគិតថ្លៃ
និងការទំនាក់ទំនងឥតគិតថ្លៃក្នុងទម្រង់ផ្សេងទៀត ដូចជាពុម្ពអក្សរធំ មានសម្រាប់អ្នក។
ទូរសព្ទមកលេខឥតគិតថ្លៃនៅលើបណ្ណសម្គាល់សមាជិករបស់អ្នក។

请注意：如果您说**中文 (Chinese)**，我们可以为您提供免费语言协助服务以及大字印刷本等其他格式的免费通信。请致电您的会员身份卡上的免付费电话号码。

請注意：如果您說**中文 (Chinese)**，您可以獲得免費語言協助服務和大字體等其他格式的免費通訊。請致電您的會員身份卡上的免付費電話號碼。

ATTENTION: Si vous parlez **français (French)**, des services d’assistance linguistique et des communications dans d’autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le numéro gratuit figurant sur votre carte de membre.

ATANSYON: Si w pale **Kreyòl Ayisyen (Haitian Creole)**, gen sèvis lang gratis ak kominikasyon nan lòt fòma lo disponib, tankou sa ki enprime ak gwo lèt. Rele nimewo gratis ki sou kat idantifikasyon manm ou an.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie die gebührenfreie Nummer auf Ihrer Mitgliedskarte an.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते हैं, तो आपके लिए मुफ्त भाषा सहायता सेवाएँ और अन्य प्रारूपों में मुफ्त संचार, जैसे कि बड़े प्रिंट, उपलब्ध हैं। अपने सदस्य पहचान पत्र पर दिए गए टोल-फ्री नंबर पर कॉल करें।

LUS TSEEM CEEB: Yog tias koj hais **lus Hmoob (Hmong)**, muaj cov kev pab cuam txhais lus thiab muaj kev sib txuas lus pab dawb ua lwm hom ntawv, xws li luam ua ntawv loj rau koj. Thov hu rau tus xov tooj hu dawb ntawm koj daim npav ID.

ATENSION: No agsasaoka iti **Ilocano (Ilocano)**, magun-odmo dagiti libre a serbisio ti tulong iti pagsasao ken libre a komunikasion iti dadduma a pormat, kas iti dadakkel a letra. Tawagan ti awan-bayadna a numero a masarakan iti kard a pakabigbigam kas miembro.

ATTENZIONE: se parla **italiano (Italian)**, può usufruire di servizi di assistenza linguistica gratuiti e comunicazioni gratuite in altri formati, come ad esempio la stampa a caratteri grandi. Chiami il numero verde riportato sul Suo tesserino identificativo.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスや、拡大文字など他の形式での無料のコミュニケーションをご利用いただけます。会員証に記載されているフリーダイアルにお電話ください。

알림 사항: **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 대형 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 회원 ID 카드에 나와 있는 무료 전화번호로 전화해 주십시오.

BAA'ÁKONÍNÍZIN: **Diné (Navajo)** saad bee yáníłti'go, t'áá jíík'eh saad bee áka'e'eyeed bee áka'anída'wo'í dóó náánáł łahgo át'éego bee hadadilyaa bee ahxił hane'í, díí nitsaago bee ak'eda'ashchínígíí, náhóló. Bee atah nil'íní ninaaltsoos nitł'izí bee nééhoziní bąąh t'áá hiik'eh bee hane'í námboo bee hodíilnih.

توجه: اگر به زبان **فارسی (Farsi)** صحبت می‌کنید، خدمات رایگان کمک زبانی و ارتباطات رایگان در قالب‌های دیگر، مانند چاپ بزرگ، در دسترس شما هستند. با شماره رایگان مندرج روی کارت شناسایی عضویت‌تان تماس بگیرید.

UWAGA: Dla osób mówiących po **polsku (Polish)** dostępne są bezpłatne usługi pomocy językowej i bezpłatne komunikaty w innych formatach, takich jak duży druk. Prosimy zadzwonić pod bezpłatny numer podany na karcie identyfikacyjnej.

ATENÇÃO: se você fala **português (Portuguese)**, tem à sua disposição serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como caracteres grandes. Ligue para o número gratuito que se encontra no seu cartão de identificação de membro.

ВНИМАНИЕ! Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например напечатанные
крупным шрифтом. Звоните по бесплатному номеру телефона, указанному на вашей идентификационной карте участника.

FIIRO GAAR AH: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Ka wac lambarka wicitaanka bilaashka ah kaarkaaga aqoonsiga xubinta.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tawagan ang walang bayad na numero na nasa iyong ID card ng miyembro.

LƯU Ý: Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Gọi đến số điện thoại miễn phí có trên thẻ định danh thành viên của quý vị.

Optum Rx®

Brand-name medications are shown in UPPERCASE (for example, CLOBEX) and generic medications in lowercase (for example, clobetasol).

G Authorized Brand Alternative.

Those taking non-preferred medications in the Hepatitis C, Immunomodulators and Multiple Sclerosis categories can stay on the current therapy if used correctly.

N These preferred products do not require prior authorization for coverage.

* These preferred products may need additional step therapy requirements.

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