

Aetna Health Exchange Plan - California - OA Managed Choice, PPO

Visit www.aetna.com/formulary for the most up-to-date information. For a summary of your coverage or benefits plan log in to your secure member site at www.aetna.com. Or call the toll-free number on your member ID card.

The formulary is updated the first week of each month. The formulary is subject to change. Previous versions are no longer in effect.

The Medical plan names to which this document applies to in the state of California are listed below:

Plan Name

Savings Plus OA Managed Choice® POS HDHP
Savings Plus OA Managed Choice® POS
OA Managed Choice® POS
OA Managed Choice® POS HDHP
Open Choice® PPO

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health of California Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products. Pharmacy benefits are administered by an affiliated pharmacy benefit manager, CVS Caremark. Aetna is part of the CVS Health family of companies.

2025 Pharmacy Drug Guide

Aetna Health Exchange Plan - California PPO

Table of Contents

INFORMATIONAL SECTION.....	4
ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION.....	18
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS.....	24
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER.....	36
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS.....	42
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS.....	51
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES.....	73
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS.....	98
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS.....	104
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS.....	106
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM.....	108
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS.....	112
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS.....	113
OTHER.....	116
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS.....	117
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS.....	123

Definitions

Brand name drug means a drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.

Coinsurance means a percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.

Copayment means a fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.

Deductible means the amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

Drug Tier means a group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.

Enrollee is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

Exception request means a request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.

Exigent circumstances means when you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.

Formulary or **prescription drug list** means the list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.

Generic drug means a drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in bolded italicized lowercase letters.

Medically Necessary means health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.

Medically necessary treatment of mental health and substance use disorders means a service or product addressing the specific needs of that patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, condition or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms that are:

- In accordance with generally accepted standards of mental health disorder and substance use disorder care
- Clinically appropriate, in terms of type, frequency, extent, site and duration
- Not primarily for the economic benefit for us or the convenience of the patient, physician, or other health care provider

Refer to your Summary of Benefits for additional information about your coverage for medically necessary services to treat a mental health and/or substance use disorder.

For a summary of your coverage or benefits plan log in to your secure member site at www.aetna.com. Or call the toll-free number on your member ID card.

Non-formulary drug means a prescription drug that is not listed on this formulary.

Oral Anti-Cancer drugs Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Out-of-pocket costs means your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.

Prescribing provider means a health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.

Prescription means an oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual. **Prescription drug** means a drug that by law requires a prescription.

Preventive Health drugs Affordable Care Act (ACA) preventive health drugs, including contraceptive drugs and devices are covered at no cost with a prescription from your prescribing provider when obtained at an in-network pharmacy. Certain limitations may apply.

Prior Authorization means a decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.

Step therapy means a specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.

Subscriber means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

How to use this guide

Your guide includes a list of commonly used drugs covered on your pharmacy plan. The amount you pay depends on the drug your health care provider prescribes. It's either a flat fee or a percentage of the prescription's price after you meet your deductible, if applicable. Preferred generic drugs cost less. Preferred brand drugs will have a higher cost.

Refer to the Summary of Benefits for differences and information about the prescription drugs covered under your Outpatient prescription drugs and medical benefit in your plan.

A prescription drug may be located by looking up the therapeutic category and class to which the drug belongs or the brand or generic name of the drug in the alphabetical index; and

If a generic equivalent for a brand name drug is not available on the market or is not covered, the drug will not be separately listed by its generic name.

- A drug is listed alphabetically by its brand and generic names in the therapeutic category and class to which it belongs;
- The generic name for a brand name drug is included after the brand name in parentheses and all lowercase bolded italicized letters. (For example: COREG (***carvedilol***))
- If a generic equivalent for a brand name drug is both available and covered, the generic drug will be listed separately from the brand name drug in all lowercase bolded italicized letters; and (For example: ***carvedilol***)
- If a generic drug is marketed under a proprietary, trademark-protected brand name, the brand name will be listed after the generic name in parentheses and regular typeface with the first letter of each word capitalized. (For example: ***desogestrel-ethinyl estradiol*** (Azurette)).
- Inclusion of a prescription drug on the formulary does not guarantee that your prescribing provider will prescribe the drug for a particular medical condition.
- Therapeutic categories and classes are based on the Medispan therapeutic classification system.

Your plan includes

- Brand and generic drugs that are hand-picked for their quality and effectiveness
- You can fill prescriptions at any participating (network) pharmacy unless it is a prescription for a specialty drug,

or your plan requires maintenance drugs to be dispensed by certain pharmacies. Aetna contracts with a wide network of retail pharmacies. To find a network pharmacy, visit www.aetna.com.

- A specialty pharmacy fills specialty drug prescriptions (ones that are injected, infused or taken by mouth) — and provides services that include personal support, helpful resources and training, and free secure home delivery
- A home delivery pharmacy that delivers maintenance drugs to your home or wherever you choose (for drugs that are taken regularly to treat conditions like diabetes or asthma)

What you can expect to pay

With your pharmacy plan, the amount you pay depends on the drug your health care provider prescribes. It's either a flat fee or a percentage of the drug's/medicine price. If a pharmacy's retail price for a prescription drug is less than your total cost share amount, you will not be required to pay more than the retail drug price.

Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands.

Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth.

Covered services are based on the drugs listed in the drug guide. We exclude prescription drugs not in the drug guide unless we approve a medical exception. If it is medically necessary for you to use a prescription drug that is not in this drug guide, you or your prescribing provider must request a medical exception.

You're covered for all types of medicine — some more expensive, and some less.

- **Tier 1:** Most generic and low-cost preferred brand
- **Tier 2:** Preferred brand and non-preferred generic
- **Tier 3:** Non-preferred brand
- **Tier 4:** Specialty

Your pharmacy plan may not have all the coverage levels listed above so check your plan documents to see how much you will pay, for example your copayments and maximum dollar amounts.

Oral Anti-Cancer drugs are covered at a \$0 cost share for drugs on the oral anti-cancer drug list unless you have an integrated medical/pharmacy deductible that needs to be met. Once you meet your deductible, you would pay \$0 for oral anti-cancer drugs on the drug list.

For your exact coverage and cost, and to learn more about your plan

Visit the website that's on your member ID card. Then log in to your account, where you can:

- Find out the coverage and estimate of cost for specific drugs
- View your deductibles and plan limits
- Order medications
- Check your pharmacy order status
- Get a member ID card
- View your claims, Explanation of Benefits and more

Have more questions about your pharmacy benefits?

We're here to help. There are several ways you can learn more about your benefits:

- Check your Plan Design and Benefits Summary in your enrollment kit.
- Call the toll-free number on your member ID card.
- Review our pharmacy frequently asked questions (FAQs) and answers. Just visit the website that's on your member ID card to search for the "Pharmacy FAQ".

Specialty Pharmacy Network

An in-network specialty pharmacy can fill your prescriptions for specialty drugs. These are the types of drugs that may be injected, infused or taken by mouth. They often need special storage and handling. And they need to be delivered quickly. A nurse or pharmacist may monitor your treatment, if needed. With this type of pharmacy, you can get this medicine sent right to our mailbox.

How to get started with a specialty pharmacy

Ordering your prescriptions through our specialty pharmacy is easy. And we typically offer a 30-day medicine supply.

- **To transfer your prescription**, just call us toll-free at [1-866-353-1892](tel:1-866-353-1892) (TTY: 711).
- **For a new prescription**, your prescribing provider can send it to us in one of four ways:
 - 1. Electronically:** Through e-prescribe
 - 2. Fax: 1-800-323-2445**
 - 3. Phone: [1-800-237-2767](tel:1-800-237-2767) (TTY: 711)**

If you mail in your own prescription, please send it with a completed Patient Profile Form. To find this form, just visit the website that's on your member ID card, to search for the "Patient Profile Form".

CVS Caremark Mail Service Pharmacy™

You can have maintenance drugs sent right to your home or anywhere else you choose with CVS Caremark Mail Service Pharmacy. These are drugs that are taken regularly for chronic conditions like diabetes or asthma. Depending on your plan, you can get up to a 90-day supply of medicine for less cost. It's fast and convenient, and standard shipping is always free.

Get started right away

You can submit your order using one of these options:

- 1. Online** — Visit your secure member website and sign in to your account. There you can add or remove your prescriptions.
- 2. Phone** — Call us toll-free, 24/7 at [1-888-792-3862](tel:1-888-792-3862) (TTY: [711](tel:1-877-833-2779)). If you need the help of a telephone device for the hard of hearing, call [1-877-833-2779](tel:1-877-833-2779) (TTY: [711](tel:1-877-833-2779)).
- 3. Mail** — Get a new prescription from your prescribing provider. Then mail it to us with a completed order form. You can find the form on your secure member website. The mailing address is on the form.

Your prescribing provider can submit your order using one of these options:

- 1. Online** — They can submit your prescriptions using the e-prescribe services on our provider website.
- 2. Fax** — They can fax your prescription to [1-877-270-3317](tel:1-877-270-3317). Make sure they include your member ID number, date of birth and mailing address on the fax cover sheet. Only a prescribing provider may fax a prescription.

Frequently asked questions

How can I save on prescriptions?

Here are some tips to pay less out of pocket for your prescription drugs:

- Ask your prescribing provider to consider prescribing drugs that are on the Pharmacy Drug Guide (formulary).
- Ask your prescribing provider to consider prescribing generic drugs instead of brand-name drugs.
- Our home delivery service may save you money. For more information, visit the website on your member ID card and log in to your account.

What are generic drugs?

Generic drugs are proven to be just as safe and effective as brand-name drugs. They contain the same active ingredients in the same amounts as the brand-name drugs and work the same way. So they have the same risks and benefits as brand-name drugs. However, they typically cost less.

When appropriate, your prescribing provider may decide to prescribe a generic drug or allow the pharmacist to substitute a generic drug.

What is precertification/prior authorization (PA)?

Prior authorization is one way that we can help you and your prescribing provider find safe, appropriate drugs and keep costs down. Prior authorization means that you or your prescribing provider need to get approval from the plan before certain drugs will be covered. Generally, Prior authorization applies to drugs that:

- Are often taken in the wrong way
- Should only be used for certain conditions
- Often cost more than other drugs that are proven to be just as effective

Keep in mind that your prescribing provider must contact us to request approval of coverage for these drugs.

What is step therapy (ST)?

Some drugs require step therapy. This means that you must try one or more prerequisite drug(s) before a step therapy drug is covered.

The prerequisite drugs have U.S. Food and Drug Administration (FDA) approval and may cost less. They treat the same condition as the step therapy drug.

If you don't try the appropriate prerequisite drug(s) first, you may need to pay full cost for the step-therapy drug.

What are quantity limits (QL)?

Quantity limits help your prescribing provider and pharmacist make sure that you use your drug correctly and safely. We use medical guidelines and FDA-approved recommendations from drug makers to set these coverage limits. The quantity limit program includes:

- **Dose efficiency edits** — Limits prescription coverage to one dose per day for drugs that have approval for once-daily dosing
- **Maximum daily dose** — If a prescription is lower than the minimum or higher than the maximum allowed dose, a message is sent to the pharmacy
- **Quantity limits over time** — Limits prescription coverage to a specific number of units over a specific amount of time

What if I need a drug that requires an exception to the prior authorization, step therapy or quantity limits requirements? Or what if I need a drug that's not covered under my plan?

In certain cases, you or your prescribing provider can request a medical exception to the prior authorization, step therapy or quantity limits requirement or for a drug that's not covered on your plan. Coverage determinations will be made within 72 hours of receiving non-urgent requests. You can ask for your request to be expedited. Expedited coverage decisions are made within 24 hours.

We'll then contact you or your prescribing provider with our decision. All medically necessary outpatient prescription drugs will be covered. If a medical exception is approved, you only need to pay the copay after the deductible. This amount is based on your pharmacy plan design.

Medical exceptions which are approved for non-urgent requests will cover the duration of the prescription, including refills. Approved medical exceptions for exigent circumstances will provide coverage, including refills, for the duration of the exigency.

If your request is denied you have the right to file an appeal using the process described in the notification letter.

If a determination is not made for a prior authorization or step therapy exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed approved and we may not deny the request thereafter.

In accordance with state law, we will cover a drug if we previously approved coverage of the drug for a member's medical condition and the prescribing provider continues to prescribe the drug for the medical condition, provided the drug is appropriately prescribed and safe and effective for treating the member's medical condition.

How can your prescribing provider request a medical exception?

The following options will provide detail to help request a medical exception.

- Submit their request through our secure provider website on www.availity.com.
- Call the Pharmacy prior authorization unit:
Non-Specialty **1-800-294-5979 (TTY: 711)** or
Specialty **1-866-814-5506 (TTY: 711)**.
- Fax the completed request form to:
Non-Specialty **1-888-836-0730** or
Specialty **1-866-249-6155**.
- Mail the completed request form to:
Medical Exception to Pharmacy Prior Authorization Unit
1300 East Campbell Road
Richardson, TX 75081

Can the formulary change during the year?

The formulary can change throughout the year. Some reasons why they can change include:

- New drugs are approved.
- Existing drugs are removed from the market.
- Prescription drugs may become available over the counter (without a prescription). Over-the-counter drugs are not generally covered in a formulary.
- Brand-name drugs lose patent protection and generic versions become available. When this happens, the generic drug will be covered in place of the brand-name drug. The brand-name drug is likely to become non-formulary or covered at a higher cost. See the "what are generic drugs?" section above for more information.
- A change in drug or dosage form.
- A drug changes tiers which results in higher cost sharing.
- Prescription drugs have changes in utilization management restrictions (e.g., prior authorization, step therapy and quantity limits).

What is a medical benefit drug versus a drug covered under the Outpatient Prescription Drug Benefit?

A medical benefit drug is a drug that is generally not self-administered and requires administration by health care provider. The Outpatient Prescription Drug Benefit includes FDA-approved drugs that are self-administered, commonly oral or self-injectable drugs, not otherwise excluded from coverage.

Refer to your Summary of Benefits for differences and information about the prescription drugs covered under your Outpatient prescription drugs and medical benefit in your plan.

For a summary of your coverage or benefits plan log in to your secure member site at www.aetna.com. Or call the toll-free number on your member ID card.

Is equipment and supplies for treatment of diabetes covered?

Your prescription drug benefit also includes coverage for equipment and supplies for treatment of diabetes. Please see the "Diabetic Supplies" section of this formulary for the items and supplies covered by your plan.

• **Pharmacy and Therapeutics (P&T) committee**

The services of an independent National Pharmacy and Therapeutics Committee (“P&T Committee”) are utilized to approve safe and clinically effective drug therapies.

The P&T Committee is an external advisory body of clinical professionals from across the United States. The P&T Committee’s voting members include physicians, pharmacists, a pharmacoeconomist and a medical ethicist, all of whom have a broad background of clinical and academic expertise regarding prescription drugs.

Voting members of the P&T Committee are not employees of CVS Caremark and must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

How do you find a pharmacy?

You can find a pharmacy in two ways:

- **Online:** By logging onto your secure member website at [Aetna.com](https://www.aetna.com).
- **By phone:** Call the toll-free number on your ID card. During regular business hours, a representative can assist you. Our automated telephone assistant can give you this information 24 hours a day.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call **1-888-802-3862 (TTY: 711)**.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable California and Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on race, color, national origin, ancestry, religion, sex, marital status, age, gender, gender identity, sexual orientation or disability, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator
P.O. Box 24030, Fresno, CA 93779
1-800-648-7817 (TTY: 711), Fax: 860-262-7705
CRCoordinator@aetna.com.

You can also file a complaint with the California Department of Insurance at **www.insurance.ca.gov**, or at: Consumer Services Division, 300 Spring Street South Tower, Los Angeles CA 90013, or at **1-800-927-HELP (4357) (TTY: 711), TDD: 1-800-482-4TDD (4833) (TTY: 711)**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019 (TTY: 711), 1-800-537-7697 (TDD) (TTY: 711)**.

Hawaiian	No ka wala'au 'ana me ka lawelawe 'olelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤန့ၢ်ကိၣ်တၢ်မၤစၢၤအတၢ်ဖံးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အိၣ်အကီၢ်,ကိးဘၣ်လီၤတၢ်စိနီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂံၢ် (ID) အလီၤန့ၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بو دەسپێرێ ئاگهیشتن بە خزمەتگوزاری زمان بەبێ تێچوون بو تو، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتێ خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Nan bōk jipañ kōn kajin ilo an ejjelōk wōṇean ñan kwe, kwōn kallok nōm̄ba eo ilo kaat in ID eo am̄.
Micronesia-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowol doo búáh ílínígóó naaltsoos bee atah níłjigo nanitinígíí bee néého'dólzínígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke cìn wëu kor keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tō në ID kard duɔn de tīt de nyin de panakim kōu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.

Remember to visit the website on your member ID card. Then sign in to your account for the most up-to-date information.

Please note that if your prescription drug benefits plan changes, the information here may no longer apply.

Medications on the Aetna Drug Guide, precertification, step-therapy and quantity limits lists are subject to change.

Health benefits and health insurance plans are offered, administered and/or underwritten by Aetna Health Inc., Aetna Health Insurance Company of New York, Aetna Health Assurance Pennsylvania Inc., Aetna Health Insurance company and/or Aetna Life Insurance Company (Aetna). In Florida, by Aetna Health Inc. and/or Aetna Life Insurance Company. In Utah and Wyoming by Aetna Health of Utah Inc. and Aetna Life Insurance Company. In Maryland, by Aetna Health Inc., 151 Farmington Avenue, Hartford, CT 06156. Pharmacy benefits are administered through an affiliated pharmacy benefit manager, CVS Caremark. Aetna is part of the CVS Health family of companies.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. To check coverage and copay information for a specific medicine, log into your member website. For questions, please call the toll-free number on the back of your member ID card.

The drugs on the Pharmacy Drug Guide (formulary), Formulary Exclusions, Precertification, and Quantity Limit Lists are subject to change. The quantity limits and step therapy drug coverage review programs are not available in all service areas. However, these programs are available to self-funded plans.

Information is subject to change. In accordance with state law or insurer policies, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in Louisiana, New York, Texas, and in most circumstances Connecticut and Vermont, until the plans' renewal date.

In accordance with state law, certain fully insured commercial California members (except Federal Employee Health Benefit Plan members) who obtained approval from an Aetna plan for coverage of drugs that are later added to the Preauthorization or Step Therapy Lists or removed from the Pharmacy Drug Guide will continue to have those drugs covered, for as long as the treating in-network provider continues prescribing them, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Aetna reserves the right to periodically request clinical information from your provider to assess your medical condition and the appropriateness of your ongoing treatment. Failure to provide clinical information could result in subsequent denial of coverage for this medication.

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

In accordance with state law, commercial fully insured (including HMO) members in Connecticut, Louisiana, New Mexico and Texas (except Federal Employee Health Benefit Plan members) who are receiving coverage for drugs that are added or removed from the Pharmacy Drug Guide and Specialty Drug List will continue to have those drugs covered at the same benefit level until their plan's renewal date. In Texas, preauthorization approval is known as "preservice utilization review." It is not "verification" as defined by Texas law. Preauthorization means a determination that healthcare services proposed to be provided to a patient are medically necessary and appropriate.

In certain states, including Arkansas, Colorado, Connecticut, Delaware, Georgia, Illinois, Louisiana, Maryland, Minnesota, North Dakota, Pennsylvania and Texas, step therapy programs do not apply to fully insured members utilizing prescription drugs for the treatment of stage-four advanced, metastatic cancer.

This document contains trademarks or registered trademarks of CVS Pharmacy, Inc. or one of its affiliates; it may also contain references to products that are trademarks or registered trademarks of entities not affiliated with CVS Health.

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

List of Abbreviations

Tier 1: Most generic and low-cost preferred brand

Tier 2: Preferred Brand and Non-Preferred Generic

Tier 3: Non-Preferred Brands

Tier 4: Specialty

AL: Age Limit

DCN: Drug Coverage Note

OAC: Oral Anti-Cancer Drugs

PA: Prior Authorization

PH: Preventive Health

QL: Quantity Limit

QLR: QL Restriction based on Age

ST: Step Therapy

Below is a list of drug name formatting patterns that may appear in the following pages.

List of Patterns

lowercase bold italics: Generic drugs

UPPERCASE: Brand name drugs

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Aetna Health Exchange Plan - California PPO

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANALGESICS - DRUGS TO TREAT PAIN AND INFLAMMATION		
COX-2 INHIBITORS		
<i>celecoxib oral capsule 100 mg, 200 mg, 50 mg</i>	Tier 1	
GOUT		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	Tier 1	
<i>colchicine oral tablet 0.6 mg</i>	Tier 1	
<i>colchicine-probenecid oral tablet 0.5-500 mg</i>	Tier 1	
<i>febuxostat oral tablet 40 mg, 80 mg</i>	Tier 1	ST
<i>probenecid oral tablet 500 mg</i>	Tier 1	
NSAIDS		
<i>diclofenac potassium oral tablet 50 mg</i>	Tier 1	
<i>diclofenac sodium er oral tablet extended release 24 hour 100 mg</i>	Tier 1	
<i>diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg</i>	Tier 1	
<i>etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg</i>	Tier 1	
<i>etodolac oral capsule 200 mg, 300 mg</i>	Tier 1	
<i>etodolac oral tablet 400 mg, 500 mg</i>	Tier 1	
<i>fenoprofen calcium oral tablet 600 mg</i>	Tier 1	
<i>flurbiprofen oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>ibuprofen oral suspension 100 mg/5ml</i>	Tier 1	
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	Tier 1	
<i>ketorolac tromethamine oral tablet 10 mg</i>	Tier 1	QL (20 TABLETS per 30 days)
<i>meclofenamate sodium oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>mefenamic acid oral capsule 250 mg</i>	Tier 1	
<i>meloxicam oral tablet 15 mg, 7.5 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nabumetone oral tablet 500 mg, 750 mg</i>	Tier 1	DCN (Listing does not include certain NDCs)
<i>naproxen oral tablet 250 mg, 375 mg, 500 mg</i>	Tier 1	
<i>oxaprozin oral tablet 600 mg</i>	Tier 1	
<i>piroxicam oral capsule 10 mg, 20 mg</i>	Tier 1	
<i>sulindac oral tablet 150 mg, 200 mg</i>	Tier 1	
NSAIDS, COMBINATIONS		
<i>diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg</i>	Tier 1	
OPIOID ANALGESICS		
<i>acetaminophen-codeine oral solution 300-30 mg/12.5ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (2700 ML per 30 DAYS)
<i>butorphanol tartrate nasal solution 10 mg/ml</i>	Tier 1	QL (2 BOTTLES per 30 days)
<i>codeine sulfate oral tablet 30 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (42 TABLETS per 30 days)
<i>codeine sulfate oral tablet 60 mg</i>	Tier 3	ST; DCN (Subject to initial limit); QL (42 TABLETS per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 10-325 Mg)	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 2.5-325 Mg, 5-325 Mg)	Tier 1	ST; DCN (Subject to initial limit); QL (360 TABLETS per 30 days)
<i>oxycodone-acetaminophen</i> (Endocet Oral Tablet 7.5-325 Mg)	Tier 1	ST; DCN (Subject to initial limit); QL (240 TABLETS per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg</i>	Tier 1	PA; QL (120 LOZENGES per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	Tier 1	PA; ST
<i>fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr</i>	Tier 1	ST; QL (10 PATCHES per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	ST; QL (60 CAPSULES per 30 days)
<i>hydrocodone bitartrate er oral capsule extended release 12 hour 50 mg</i>	Tier 1	PA; ST
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg</i>	Tier 1	PA; ST
<i>hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	ST; QL (30 TABLETS per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (2700 ML per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 7.5-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (240 TABLETS per 30 DAYS)
<i>hydrocodone-acetaminophen oral tablet 5-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (240 TABLETS per 30 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (50 TABLETS per 30 days)
<i>hydromorphone hcl er oral tablet extended release 24 hour 12 mg, 16 mg, 8 mg</i>	Tier 1	ST; QL (30 TABLETS per 30 days)
<i>hydromorphone hcl er oral tablet extended release 24 hour 32 mg</i>	Tier 1	PA; ST
<i>hydromorphone hcl oral tablet 2 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>hydromorphone hcl oral tablet 4 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (120 TABLETS per 30 days)
<i>hydromorphone hcl oral tablet 8 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (60 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levorphanol tartrate oral tablet 2 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (120 TABLETS per 30 days)
<i>levorphanol tartrate oral tablet 3 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (60 TABLETS per 30 days)
<i>methadone hcl</i> (Methadone Hcl Intensol Oral Concentrate 10 Mg/ML)	Tier 1	ST; QL (45 ML per 30 days)
<i>methadone hcl oral concentrate 10 mg/ml</i>	Tier 1	QL (30 ML per 30 days)
<i>methadone hcl oral solution 10 mg/5ml</i>	Tier 1	ST; QL (225 ML per 30 days)
<i>methadone hcl oral solution 5 mg/5ml</i>	Tier 1	ST; QL (450 ML per 30 days)
<i>methadone hcl oral tablet 10 mg</i>	Tier 1	ST; QL (30 TABLETS per 30 days)
<i>methadone hcl oral tablet 5 mg</i>	Tier 1	ST; QL (90 TABLETS per 30 days)
<i>methadone hcl oral tablet soluble 40 mg</i>	Tier 1	QL (9 TABLETS per 30 days)
<i>methadone hcl</i> (Methadose Oral Tablet Soluble 40 Mg)	Tier 1	QL (9 TABLETS per 30 days)
<i>morphine sulfate (concentrate) oral solution 100 mg/5ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (135 ML per 30 days)
<i>morphine sulfate er oral tablet extended release 100 mg, 200 mg, 60 mg</i>	Tier 1	PA; ST
<i>morphine sulfate er oral tablet extended release 15 mg, 30 mg</i>	Tier 1	ST; QL (90 TABLETS per 30 days)
<i>morphine sulfate oral solution 10 mg/5ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (900 ML per 30 days)
<i>morphine sulfate oral solution 20 mg/5ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (675 ML per 30 days)
<i>morphine sulfate oral tablet 15 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>morphine sulfate oral tablet 30 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (90 TABLETS per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg, 20 mg</i>	Tier 1	ST; QL (60 TABLETS per 30 days)
<i>oxycodone hcl er oral tablet er 12 hour abuse-deterrent 40 mg, 80 mg</i>	Tier 1	PA; ST
<i>oxycodone hcl oral capsule 5 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 CAPSULES per 30 days)
<i>oxycodone hcl oral concentrate 100 mg/5ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (90 ML per 30 days)
<i>oxycodone hcl oral solution 5 mg/5ml</i>	Tier 1	ST; DCN (Subject to initial limit); QL (900 ML per 30 days)
<i>oxycodone hcl oral tablet 10 mg, 5 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>oxycodone hcl oral tablet 15 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (120 TABLETS per 30 days)
<i>oxycodone hcl oral tablet 20 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (90 TABLETS per 30 days)
<i>oxycodone hcl oral tablet 30 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (60 TABLETS per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (360 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxycodone-acetaminophen oral tablet 7.5-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (240 TABLETS per 30 days)
<i>oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 15 mg, 5 mg, 7.5 mg</i>	Tier 1	ST; QL (60 TABLETS per 30 days)
<i>oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg</i>	Tier 1	PA; ST
<i>oxymorphone hcl oral tablet 10 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (90 TABLETS per 30 days)
<i>oxymorphone hcl oral tablet 5 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>tramadol hcl er oral tablet extended release 24 hour 100 mg</i>	Tier 1	ST; QL (30 TABLETS per 30 days)
<i>tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg</i>	Tier 1	PA; ST
<i>tramadol hcl oral tablet 50 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 TABLETS per 30 days)
<i>tramadol-acetaminophen oral tablet 37.5-325 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (40 TABLETS per 30 days)
OPIOID ANALGESICS - DRUGS TO TREAT PAIN		
<i>acetaminophen-codeine oral tablet 300-15 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (400 tablets per 30 days)
<i>acetaminophen-codeine oral tablet 300-30 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (360 tablets per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	Tier 1	ST; DCN (Subject to initial limit); QL (180 tablets per 30 days)
OPIOID PARTIAL AGONISTS		
<i>buprenorphine transdermal patch weekly 10 mcg/hr, 5 mcg/hr, 7.5 mcg/hr</i>	Tier 1	ST; QL (4 PATCHES per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>buprenorphine transdermal patch weekly 15 mcg/hr, 20 mcg/hr</i>	Tier 1	PA; ST
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (<i>buprenorphine</i>)	Tier 4	
SALICYLATES		
<i>aspirin adult low strength oral tablet delayed release 81 mg</i>	Tier 1	DCN (\$0 copay for members at risk for preeclampsia, otherwise not covered); PH; QL (100 TABLETS per 30 days)
<i>diflunisal oral tablet 500 mg</i>	Tier 1	
<i>goodsense aspirin oral tablet chewable 81 mg</i>	Tier 1	DCN (\$0 copay for members at risk for preeclampsia, otherwise not covered); PH; QL (100 TABLETS per 30 days)
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
ANTHELMINTICS - DRUGS FOR WORM INFECTION		
<i>albendazole oral tablet 200 mg</i>	Tier 1	QL (336 TABLETS per 365 DAYS)
<i>benznidazole oral tablet 100 mg, 12.5 mg</i>	Tier 3	
EMVERM ORAL TABLET CHEWABLE 100 MG (<i>mebendazole</i>)	Tier 3	QL (12 TABLETS per 365 DAYS)
<i>ivermectin oral tablet 3 mg</i>	Tier 1	
<i>praziquantel oral tablet 600 mg</i>	Tier 1	QL (24 TABLETS per 365 DAYS)
ANTI-BACTERIALS - MISCELLANEOUS		
<i>fosfomycin tromethamine oral packet 3 gm</i>	Tier 1	
<i>neomycin sulfate oral tablet 500 mg</i>	Tier 1	
<i>paromomycin sulfate oral capsule 250 mg</i>	Tier 1	
<i>sulfadiazine oral tablet 500 mg</i>	Tier 1	
<i>tinidazole oral tablet 250 mg, 500 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIFUNGALS - DRUGS TO TREAT FUNGAL INFECTIONS		
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (<i>isavuconazonium sulfate</i>)	Tier 3	
<i>fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml</i>	Tier 1	
<i>fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Tier 1	
<i>griseofulvin microsize oral suspension 125 mg/5ml</i>	Tier 1	
<i>griseofulvin microsize oral tablet 500 mg</i>	Tier 1	
<i>griseofulvin ultramicrosize oral tablet 125 mg, 250 mg</i>	Tier 1	
<i>itraconazole oral capsule 100 mg</i>	Tier 1	PA
<i>itraconazole oral solution 10 mg/ml</i>	Tier 1	PA
<i>nystatin oral tablet 500000 unit</i>	Tier 1	
<i>posaconazole oral suspension 40 mg/ml</i>	Tier 1	PA
<i>posaconazole oral tablet delayed release 100 mg</i>	Tier 1	PA
<i>terbinafine hcl oral tablet 250 mg</i>	Tier 1	
<i>voriconazole oral suspension reconstituted 40 mg/ml</i>	Tier 1	PA
<i>voriconazole oral tablet 200 mg, 50 mg</i>	Tier 1	PA
ANTIMALARIALS - DRUGS TO TREAT MALARIA		
<i>atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg</i>	Tier 1	
<i>chloroquine phosphate oral tablet 250 mg, 500 mg</i>	Tier 1	
COARTEM ORAL TABLET 20-120 MG (<i>artemether-lumefantrine</i>)	Tier 3	
<i>mefloquine hcl oral tablet 250 mg</i>	Tier 1	
<i>primaquine phosphate oral tablet 26.3 (15 base) mg, 26.3 mg</i>	Tier 1	
<i>quinine sulfate oral capsule 324 mg</i>	Tier 1	
ANTIRETROVIRAL AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
<i>abacavir sulfate oral solution 20 mg/ml</i>	Tier 1	QL (900 ML per 30 DAYS)
<i>abacavir sulfate oral tablet 300 mg</i>	Tier 1	QL (60 TABLETS per 30 DAYS)
APTIVUS ORAL CAPSULE 250 MG (<i>tipranavir</i>)	Tier 2	QL (120 CAPSULES per 30 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>atazanavir sulfate oral capsule 150 mg, 300 mg</i>	Tier 1	QL (30 CAPSULES per 30 DAYS)
<i>atazanavir sulfate oral capsule 200 mg</i>	Tier 1	QL (60 CAPSULES per 30 DAYS)
<i>darunavir oral tablet 600 mg</i>	Tier 1	QL (60 TABLETS per 30 DAYS)
<i>darunavir oral tablet 800 mg</i>	Tier 1	QL (30 TABLETS per 30 DAYS)
EDURANT ORAL TABLET 25 MG (<i>rilpivirine hcl</i>)	Tier 2	QL (60 TABLETS per 30 DAYS)
<i>efavirenz oral capsule 200 mg, 50 mg</i>	Tier 1	QL (90 CAPSULES per 30 DAYS)
<i>efavirenz oral tablet 600 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
<i>emtricitabine oral capsule 200 mg</i>	Tier 1	QL (30 CAPSULES per 30 DAYS)
EMTRIVA ORAL SOLUTION 10 MG/ML (<i>emtricitabine</i>)	Tier 2	QL (680 ML per 28 days)
<i>etravirine oral tablet 100 mg</i>	Tier 1	QL (120 TABLETS per 30 DAYS)
<i>etravirine oral tablet 200 mg</i>	Tier 1	QL (60 TABLETS per 30 DAYS)
<i>fosamprenavir calcium oral tablet 700 mg</i>	Tier 1	QL (120 TABLETS per 30 DAYS)
INTELENCE ORAL TABLET 25 MG (<i>etravirine</i>)	Tier 2	QL (120 TABLETS per 30 DAYS)
ISENTRESS HD ORAL TABLET 600 MG (<i>raltegravir potassium</i>)	Tier 2	QL (60 TABLETS per 30 DAYS)
ISENTRESS ORAL PACKET 100 MG (<i>raltegravir potassium</i>)	Tier 2	QL (60 PACKETS per 30 DAYS)
ISENTRESS ORAL TABLET 400 MG (<i>raltegravir potassium</i>)	Tier 2	QL (120 TABLETS per 30 DAYS)
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (<i>raltegravir potassium</i>)	Tier 2	QL (180 TABLETS per 30 DAYS)
<i>lamivudine oral solution 10 mg/ml</i>	Tier 1	QL (960 ML per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lamivudine oral tablet 150 mg</i>	Tier 1	QL (60 TABLETS per 30 DAYS)
<i>lamivudine oral tablet 300 mg</i>	Tier 1	QL (30 TABLETS per 30 DAYS)
<i>maraviroc oral tablet 150 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>maraviroc oral tablet 300 mg</i>	Tier 1	QL (120 TABLETS per 30 days)
<i>nevirapine er oral tablet extended release 24 hour 400 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
<i>nevirapine oral suspension 50 mg/5ml</i>	Tier 1	QL (1200 ML per 30 days)
<i>nevirapine oral tablet 200 mg</i>	Tier 1	QL (60 TABLETS per 30 DAYS)
NORVIR ORAL PACKET 100 MG (<i>ritonavir</i>)	Tier 2	QL (360 PACKETS per 30 DAYS)
PIFELTRO ORAL TABLET 100 MG (<i>doravirine</i>)	Tier 3	QL (60 TABLETS per 30 DAYS)
PREZISTA ORAL SUSPENSION 100 MG/ML (<i>darunavir</i>)	Tier 2	QL (400 ML per 30 days)
PREZISTA ORAL TABLET 150 MG (<i>darunavir</i>)	Tier 2	QL (180 TABLETS per 30 days)
PREZISTA ORAL TABLET 75 MG (<i>darunavir</i>)	Tier 2	QL (300 TABLETS per 30 days)
REYATAZ ORAL PACKET 50 MG (<i>atazanavir sulfate</i>)	Tier 2	QL (180 PACKETS per 30 DAYS)
<i>ritonavir oral tablet 100 mg</i>	Tier 1	QL (360 TABLETS per 30 days)
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (<i>fostemsavir tromethamine</i>)	Tier 3	QL (60 TABLETS per 30 DAYS)
SELZENTRY ORAL SOLUTION 20 MG/ML (<i>maraviroc</i>)	Tier 2	QL (1840 ML per 30 days)
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG (<i>lenacapavir sodium</i>)	Tier 3	QL (4 TABLETS per 2 days)
SUNLENCA ORAL TABLET THERAPY PACK 5 X 300 MG (<i>lenacapavir sodium</i>)	Tier 3	QL (5 TABLETS per 8 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tenofovir disoproxil fumarate oral tablet 300 mg</i>	Tier 1	QL (30 TABLETS per 30 DAYS)
TIVICAY ORAL TABLET 50 MG (<i>dolutegravir sodium</i>)	Tier 2	QL (60 TABLETS per 30 DAYS)
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (<i>dolutegravir sodium</i>)	Tier 2	QL (360 TABLETS per 30 DAYS)
TYBOST ORAL TABLET 150 MG (<i>cobicistat</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
VIRACEPT ORAL TABLET 250 MG (<i>nelfinavir mesylate</i>)	Tier 2	QL (300 TABLETS per 30 DAYS)
VIRACEPT ORAL TABLET 625 MG (<i>nelfinavir mesylate</i>)	Tier 2	QL (120 TABLETS per 30 DAYS)
VIREAD ORAL POWDER 40 MG/GM (<i>tenofovir disoproxil fumarate</i>)	Tier 2	QL (240 G per 30 days)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG (<i>tenofovir disoproxil fumarate</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
<i>zidovudine oral capsule 100 mg</i>	Tier 1	QL (180 CAPSULES per 30 DAYS)
<i>zidovudine oral syrup 50 mg/5ml</i>	Tier 1	QL (1920 ML per 30 days)
<i>zidovudine oral tablet 300 mg</i>	Tier 1	QL (60 TABLETS per 30 DAYS)
ANTIRETROVIRAL COMBINATION AGENTS - DRUGS TO SUPPRESS HIV/AIDS INFECTION		
<i>abacavir sulfate-lamivudine oral tablet 600-300 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
BIKTARVY ORAL TABLET 30-120-15 MG (<i>bictegravir-emtricitab-tenofov</i>)	Tier 3	QL (30 TABLETS per 30 DAYS)
BIKTARVY ORAL TABLET 50-200-25 MG (<i>bictegravir-emtricitab-tenofov</i>)	Tier 3	QL (30 TABLETS per 30 days)
CIMDUO ORAL TABLET 300-300 MG (<i>lamivudine-tenofovir</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
COMPLERA ORAL TABLET 200-25-300 MG (<i>emtricitab-rilpivir-tenofovir</i>)	Tier 3	QL (30 TABLETS per 30 DAYS)
DELSTRIGO ORAL TABLET 100-300-300 MG (<i>doravirin-lamivudin-tenofov df</i>)	Tier 3	QL (30 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DESCOVY ORAL TABLET 120-15 MG (<i>emtricitabine-tenofovir af</i>)	Tier 2	QL (30 TABLETS per 30 days)
DESCOVY ORAL TABLET 200-25 MG (<i>emtricitabine-tenofovir af</i>)	Tier 2	DCN (Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis); QL (30 TABLETS per 30 days)
DOVATO ORAL TABLET 50-300 MG (<i>dolutegravir-lamivudine</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
<i>efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg</i>	Tier 1	QL (30 TABLETS per 30 Days)
<i>efavirenz-emtricitab-tenofovir oral tablet 600-200-300 mg</i>	Tier 1	QL (30 TABLETS per 30 DAYS)
<i>efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg</i>	Tier 1	QL (30 TABLETS per 30 DAYS)
<i>emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg</i>	Tier 1	QL (30 TABLETS per 30 DAYS)
<i>emtricitabine-tenofovir df oral tablet 200-300 mg</i>	Tier 1	DCN (\$0 copay for pre-exposure prophylaxis); PH; QL (30 TABLETS per 30 days)
EVOTAZ ORAL TABLET 300-150 MG (<i>atazanavir-cobicistat</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
GENVOYA ORAL TABLET 150-150-200-10 MG (<i>elviteg-cobic-emtricit-tenofaf</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
JULUCA ORAL TABLET 50-25 MG (<i>dolutegravir-rilpivirine</i>)	Tier 3	QL (30 TABLETS per 30 DAYS)
<i>lamivudine-zidovudine oral tablet 150-300 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>lopinavir-ritonavir oral solution 400-100 mg/5ml</i>	Tier 1	QL (480 ML per 30 days)
<i>lopinavir-ritonavir oral tablet 100-25 mg</i>	Tier 1	QL (300 TABLETS per 30 days)
<i>lopinavir-ritonavir oral tablet 200-50 mg</i>	Tier 1	QL (120 TABLETS per 30 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ODEFSEY ORAL TABLET 200-25-25 MG (<i>emtricitab-rilpivir-tenofovir af</i>)	Tier 3	QL (30 TABLETS per 30 DAYS)
PREZCOBIX ORAL TABLET 800-150 MG (<i>darunavir-cobicistat</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
STRIBILD ORAL TABLET 150-150-200-300 MG (<i>elviteg-cobic-emtricit-tenofovir</i>)	Tier 3	QL (30 TABLETS per 30 DAYS)
SYMTUZA ORAL TABLET 800-150-200-10 MG (<i>darun-cobic-emtricit-tenofovir</i>)	Tier 3	QL (30 TABLETS per 30 DAYS)
TRIUMEQ ORAL TABLET 600-50-300 MG (<i>abacavir-dolutegravir-lamivudine</i>)	Tier 2	QL (30 TABLETS per 30 DAYS)
<i>triumeq pd oral tablet soluble 60-5-30 mg</i>	Tier 2	QL (180 TABLETS per 30 days)
ANTITUBERCULAR AGENTS - DRUGS TO TREAT TUBERCULOSIS		
<i>cycloserine oral capsule 250 mg</i>	Tier 1	
<i>ethambutol hcl oral tablet 100 mg, 400 mg</i>	Tier 1	
<i>isoniazid oral syrup 50 mg/5ml</i>	Tier 1	
<i>isoniazid oral tablet 100 mg, 300 mg</i>	Tier 1	
PRIFTIN ORAL TABLET 150 MG (<i>rifapentine</i>)	Tier 2	
<i>pyrazinamide oral tablet 500 mg</i>	Tier 1	
<i>rifabutin oral capsule 150 mg</i>	Tier 1	
<i>rifampin oral capsule 150 mg, 300 mg</i>	Tier 1	
SIRTURO ORAL TABLET 100 MG, 20 MG (<i>bedaquiline fumarate</i>)	Tier 4	
TRECTOR ORAL TABLET 250 MG (<i>ethionamide</i>)	Tier 2	
ANTIVIRALS - DRUGS TO TREAT VIRAL INFECTIONS		
<i>acyclovir oral capsule 200 mg</i>	Tier 1	
<i>acyclovir oral suspension 200 mg/5ml</i>	Tier 1	
<i>acyclovir oral tablet 400 mg, 800 mg</i>	Tier 1	
<i>famciclovir oral tablet 125 mg, 250 mg, 500 mg</i>	Tier 1	
LAGEVRIO ORAL CAPSULE 200 MG (<i>molnupiravir</i>)	Tier 3	PH; QL (40 CAPSULES per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oseltamivir phosphate oral capsule 30 mg</i>	Tier 1	QL (40 CAPSULES per 90 days)
<i>oseltamivir phosphate oral capsule 45 mg, 75 mg</i>	Tier 1	QL (20 CAPSULES per 90 days)
<i>oseltamivir phosphate oral suspension reconstituted 6 mg/ml</i>	Tier 1	QL (360 ML per 90 days)
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	Tier 3	PH; QL (40 TABLETS per 30 days)
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (<i>nirmatrelvir-ritonavir</i>)	Tier 3	PH; QL (60 TABLETS per 30 days)
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (<i>zanamivir</i>)	Tier 2	QL (2 INHALERS per 90 days)
<i>ribavirin inhalation solution reconstituted 6 gm</i>	Tier 1	
<i>rimantadine hcl oral tablet 100 mg</i>	Tier 1	
<i>valacyclovir hcl oral tablet 1 gm, 500 mg</i>	Tier 1	
<i>valganciclovir hcl oral solution reconstituted 50 mg/ml</i>	Tier 4	PA; QL (1000 ML per 30 days)
<i>valganciclovir hcl oral tablet 450 mg</i>	Tier 4	PA; QL (120 TABLETS per 30 days)
CEPHALOSPORINS - DRUGS TO TREAT INFECTIONS		
<i>cefaclor oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>cefaclor oral suspension reconstituted 250 mg/5ml</i>	Tier 1	
<i>cefadroxil oral capsule 500 mg</i>	Tier 1	
<i>cefadroxil oral suspension reconstituted 250 mg/5ml, 500 mg/5ml</i>	Tier 1	
<i>cefadroxil oral tablet 1 gm</i>	Tier 1	
<i>cefdinir oral capsule 300 mg</i>	Tier 1	
<i>cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Tier 1	
<i>cefixime oral capsule 400 mg</i>	Tier 1	
<i>cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	Tier 1	
<i>cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml</i>	Tier 1	
<i>cefpodoxime proxetil oral tablet 100 mg, 200 mg</i>	Tier 1	
<i>cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cefprozil oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>cefuroxime axetil oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>cephalexin oral capsule 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Tier 1	
<i>cephalexin oral tablet 250 mg, 500 mg</i>	Tier 1	
ERYTHROMYCINS/MACROLIDES - DRUGS TO TREAT INFECTIONS		
<i>azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml</i>	Tier 1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	Tier 1	
<i>clarithromycin er oral tablet extended release 24 hour 500 mg</i>	Tier 1	
<i>clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml</i>	Tier 1	
<i>clarithromycin oral tablet 250 mg, 500 mg</i>	Tier 1	
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (<i>fidaxomicin</i>)	Tier 2	PA
DIFICID ORAL TABLET 200 MG (<i>fidaxomicin</i>)	Tier 2	PA
<i>erythromycin base</i> (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg)	Tier 1	
<i>erythromycin base oral capsule delayed release particles 250 mg</i>	Tier 1	
<i>erythromycin base oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml, 400 mg/5ml</i>	Tier 1	
<i>erythromycin ethylsuccinate oral tablet 400 mg</i>	Tier 1	
ZITHROMAX ORAL PACKET 1 GM (<i>azithromycin</i>)	Tier 2	
FLUOROQUINOLONES - DRUGS TO TREAT INFECTIONS		
BAXDELA ORAL TABLET 450 MG (<i>delafloxacin meglumine</i>)	Tier 3	
CIPRO ORAL SUSPENSION RECONSTITUTED 500 MG/5ML (10%) (<i>ciprofloxacin</i>)	Tier 3	
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>levofloxacin oral solution 25 mg/ml</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levofloxacin oral tablet 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>moxifloxacin hcl oral tablet 400 mg</i>	Tier 1	
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	Tier 1	
HEPATITIS B		
<i>adefovir dipivoxil oral tablet 10 mg</i>	Tier 4	
BARACLUDE ORAL SOLUTION 0.05 MG/ML (<i>entecavir</i>)	Tier 4	PA; QL (630 ML per 30 days)
<i>entecavir oral tablet 0.5 mg, 1 mg</i>	Tier 4	PA; QL (30 TABLETS per 30 days)
<i>lamivudine oral tablet 100 mg</i>	Tier 1	
VEMLIDY ORAL TABLET 25 MG (<i>tenofovir alafenamide fumarate</i>)	Tier 3	PA; QL (30 TABLETS per 30 days)
HEPATITIS C		
EPCLUSA ORAL PACKET 150-37.5 MG (<i>sofosbuvir-velpatasvir</i>)	Tier 4	PA; QL (28 PELLETS per 28 DAYS)
EPCLUSA ORAL PACKET 200-50 MG (<i>sofosbuvir-velpatasvir</i>)	Tier 4	PA; QL (56 PELLETS per 28 days)
EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG (<i>sofosbuvir-velpatasvir</i>)	Tier 2	PA; QL (28 TABLETS per 28 DAYS)
HARVONI ORAL PACKET 33.75-150 MG (<i>ledipasvir-sofosbuvir</i>)	Tier 2	PA; QL (28 PELLETS per 28 DAYS)
HARVONI ORAL PACKET 45-200 MG (<i>ledipasvir-sofosbuvir</i>)	Tier 2	PA; QL (56 PELLETS per 28 days)
HARVONI ORAL TABLET 45-200 MG, 90-400 MG (<i>ledipasvir-sofosbuvir</i>)	Tier 2	PA; QL (28 TABLETS per 28 DAYS)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (<i>peginterferon alfa-2a</i>)	Tier 4	PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (<i>peginterferon alfa-2a</i>)	Tier 4	PA
<i>ribavirin oral capsule 200 mg</i>	Tier 1	PA
<i>ribavirin oral tablet 200 mg</i>	Tier 1	PA
SOVALDI ORAL PACKET 150 MG (<i>sofosbuvir</i>)	Tier 4	PA; ST; QL (28 PELLETS per 28 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SOVALDI ORAL PACKET 200 MG (<i>sofosbuvir</i>)	Tier 4	PA; ST; QL (56 PELLETS per 28 days)
SOVALDI ORAL TABLET 200 MG, 400 MG (<i>sofosbuvir</i>)	Tier 4	PA; ST; QL (28 TABLETS per 28 DAYS)
VOSEVI ORAL TABLET 400-100-100 MG (<i>sofosbuv-velpatasv-voxilaprev</i>)	Tier 4	PA; QL (28 TABLETS per 28 DAYS)
MISCELLANEOUS		
ALINIA ORAL SUSPENSION RECONSTITUTED 100 MG/5ML (<i>nitazoxanide</i>)	Tier 3	QL (540 ML per 30 days)
<i>atovaquone oral suspension 750 mg/5ml</i>	Tier 1	
<i>clindamycin hcl oral capsule 150 mg, 300 mg, 75 mg</i>	Tier 1	
<i>clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml</i>	Tier 1	
<i>dapsone oral tablet 100 mg, 25 mg</i>	Tier 1	
<i>linezolid oral suspension reconstituted 100 mg/5ml</i>	Tier 1	
<i>linezolid oral tablet 600 mg</i>	Tier 1	
<i>methenamine hippurate oral tablet 1 gm</i>	Tier 1	
<i>metronidazole oral capsule 375 mg</i>	Tier 1	
<i>metronidazole oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>nitazoxanide oral tablet 500 mg</i>	Tier 1	QL (20 TABLETS per 30 days)
<i>nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>nitrofurantoin macrocrystal oral capsule 50 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>nitrofurantoin monohyd macro oral capsule 100 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>nitrofurantoin oral suspension 25 mg/5ml</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>pentamidine isethionate inhalation solution reconstituted 300 mg</i>	Tier 1	
<i>pyrimethamine oral tablet 25 mg</i>	Tier 1	PA

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml</i>	Tier 1	
<i>sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg</i>	Tier 1	
<i>trimethoprim oral tablet 100 mg</i>	Tier 1	
<i>vancomycin hcl oral capsule 125 mg, 250 mg</i>	Tier 1	QL (80 CAPSULES per 10 DAYS)
XIFAXAN ORAL TABLET 200 MG (<i>rifaximin</i>)	Tier 2	QL (9 TABLETS per 30 days)
XIFAXAN ORAL TABLET 550 MG (<i>rifaximin</i>)	Tier 2	PA
PENICILLINS - DRUGS TO TREAT INFECTIONS		
<i>amoxicillin oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml</i>	Tier 1	
<i>amoxicillin oral tablet 500 mg, 875 mg</i>	Tier 1	
<i>amoxicillin oral tablet chewable 125 mg, 250 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate er oral tablet extended release 12 hour 1000-62.5 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 250-62.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg</i>	Tier 1	
<i>amoxicillin-pot clavulanate oral tablet chewable 400-57 mg</i>	Tier 1	
<i>ampicillin oral capsule 500 mg</i>	Tier 1	
<i>dicloxacillin sodium oral capsule 250 mg, 500 mg</i>	Tier 1	
<i>penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml</i>	Tier 1	
<i>penicillin v potassium oral tablet 250 mg, 500 mg</i>	Tier 1	
TETRACYCLINES - DRUGS TO TREAT INFECTIONS		
<i>avidoxy oral tablet 100 mg</i>	Tier 1	
<i>demeclocycline hcl oral tablet 150 mg, 300 mg</i>	Tier 1	
<i>doxycycline hyclate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>doxycycline monohydrate oral suspension reconstituted 25 mg/5ml</i>	Tier 1	
<i>doxycycline monohydrate oral tablet 150 mg, 50 mg, 75 mg</i>	Tier 1	
<i>minocycline hcl oral capsule 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>minocycline hcl oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>tetracycline hcl oral capsule 250 mg, 500 mg</i>	Tier 1	QL (120 CAPSULES per 30 days)
ANTINEOPLASTIC AGENTS - DRUGS TO TREAT CANCER		
ALKYLATING AGENTS		
<i>cyclophosphamide oral capsule 25 mg, 50 mg</i>	Tier 1	OAC
EMCYT ORAL CAPSULE 140 MG (<i>estramustine phosphate sodium</i>)	Tier 4	OAC
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG (<i>lomustine</i>)	Tier 4	OAC
LEUKERAN ORAL TABLET 2 MG (<i>chlorambucil</i>)	Tier 2	OAC
MATULANE ORAL CAPSULE 50 MG (<i>procarbazine hcl</i>)	Tier 4	OAC
<i>temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg</i>	Tier 4	PA; OAC
ANTIMETABOLITES		
<i>capecitabine oral tablet 150 mg, 500 mg</i>	Tier 4	PA; OAC
<i>mercaptopurine oral tablet 50 mg</i>	Tier 1	OAC
<i>methotrexate sodium injection solution reconstituted 1 gm</i>	Tier 1	
TABLOID ORAL TABLET 40 MG (<i>thioguanine</i>)	Tier 2	OAC
ANTINEOPLASTIC, BCL-2 INHIBITORS		
VENCLEXTA ORAL TABLET 10 MG, 50 MG (<i>venetoclax</i>)	Tier 4	PA; OAC; QL (120 TABLETS per 30 DAYS)
VENCLEXTA ORAL TABLET 100 MG (<i>venetoclax</i>)	Tier 4	PA; OAC; QL (180 TABLETS per 30 DAYS)
VENCLEXTA STARTING PACK ORAL TABLET THERAPY PACK 10 & 50 & 100 MG (<i>venetoclax</i>)	Tier 4	PA; OAC; QL (1 PACK per 28 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
BIOLOGIC RESPONSE MODIFIERS		
POMALYST ORAL CAPSULE 1 MG, 2 MG, 3 MG, 4 MG (<i>pomalidomide</i>)	Tier 4	PA; OAC; QL (21 CAPSULES per 28 days)
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 5 MG (<i>lenalidomide</i>)	Tier 4	PA; OAC; QL (28 CAPSULES per 28 days)
REVLIMID ORAL CAPSULE 20 MG, 25 MG (<i>lenalidomide</i>)	Tier 4	PA; OAC; QL (21 CAPSULES per 28 days)
THALOMID ORAL CAPSULE 100 MG (<i>thalidomide</i>)	Tier 4	PA; QL (112 CAPSULES per 28 days)
THALOMID ORAL CAPSULE 50 MG (<i>thalidomide</i>)	Tier 4	PA; QL (28 CAPSULES per 28 days)
BIOSIMILARS		
RUXIENCE INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML (<i>rituximab-pvvr</i>)	Tier 3	PA
HORMONAL ANTINEOPLASTIC AGENTS		
<i>abiraterone acetate oral tablet 250 mg</i>	Tier 4	PA; OAC; QL (120 TABLETS per 30 DAYS)
<i>abiraterone acetate oral tablet 500 mg</i>	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)
<i>anastrozole oral tablet 1 mg</i>	Tier 1	DCN (\$0 copay for ages 35 and older for the primary prevention of breast cancer); OAC; AL (Min 35 Years)
<i>bicalutamide oral tablet 50 mg</i>	Tier 1	OAC
ELIGARD SUBCUTANEOUS KIT 22.5 MG (<i>leuprolide acetate (3 month)</i>)	Tier 4	PA
ELIGARD SUBCUTANEOUS KIT 30 MG (<i>leuprolide acetate (4 month)</i>)	Tier 4	PA
ELIGARD SUBCUTANEOUS KIT 45 MG (<i>leuprolide acetate (6 month)</i>)	Tier 4	PA
ELIGARD SUBCUTANEOUS KIT 7.5 MG (<i>leuprolide acetate</i>)	Tier 4	PA
<i>exemestane oral tablet 25 mg</i>	Tier 1	DCN (\$0 copay for ages 35 and older for the primary prevention of breast cancer); OAC; AL (Min 35 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>letrozole oral tablet 2.5 mg</i>	Tier 1	OAC
<i>leuprolide acetate injection kit 1 mg/0.2ml</i>	Tier 1	PA
LYSODREN ORAL TABLET 500 MG (<i>mitotane</i>)	Tier 2	OAC
<i>megestrol acetate oral tablet 20 mg, 40 mg</i>	Tier 1	OAC
NUBEQA ORAL TABLET 300 MG (<i>darolutamide</i>)	Tier 4	PA; OAC; QL (120 TABLETS per 30 DAYS)
<i>tamoxifen citrate oral tablet 10 mg, 20 mg</i>	Tier 1	DCN (\$0 copay for ages 35 and older for the primary prevention of breast cancer); OAC; AL (Min 35 Years)
<i>toremifene citrate oral tablet 60 mg</i>	Tier 1	OAC
XTANDI ORAL CAPSULE 40 MG (<i>enzalutamide</i>)	Tier 4	PA; OAC; QL (120 CAPSULES per 30 DAYS)
XTANDI ORAL TABLET 40 MG (<i>enzalutamide</i>)	Tier 4	PA; OAC; QL (120 tablets per 30 days)
XTANDI ORAL TABLET 80 MG (<i>enzalutamide</i>)	Tier 4	PA; OAC; QL (60 tablets per 30 days)
KINASE INHIBITORS		
ALECENSA ORAL CAPSULE 150 MG (<i>alectinib hcl</i>)	Tier 4	PA; OAC; QL (240 CAPSULES per 30 DAYS)
CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG (<i>cabozantinib s-malate</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYS)
CALQUENCE ORAL TABLET 100 MG (<i>acalabrutinib maleate</i>)	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)
CAPRELSA ORAL TABLET 100 MG (<i>vandetanib</i>)	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)
CAPRELSA ORAL TABLET 300 MG (<i>vandetanib</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYS)
<i>dasatinib oral tablet 100 mg, 140 mg, 50 mg, 70 mg, 80 mg</i>	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYS)
<i>dasatinib oral tablet 20 mg</i>	Tier 4	PA; OAC; QL (90 TABLETS per 30 DAYS)
<i>erlotinib hcl oral tablet 100 mg, 150 mg</i>	Tier 4	PA; OAC; QL (30 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>erlotinib hcl oral tablet 25 mg</i>	Tier 4	PA; OAC; QL (60 TABLETS per 30 days)
<i>everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg</i>	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYS)
<i>everolimus oral tablet soluble 2 mg, 5 mg</i>	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)
<i>everolimus oral tablet soluble 3 mg</i>	Tier 4	PA; OAC; QL (90 TABLETS per 30 DAYS)
IBRANCE ORAL CAPSULE 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	Tier 4	PA; OAC; QL (21 CAPSULES per 28 DAYS)
IBRANCE ORAL TABLET 100 MG, 125 MG, 75 MG (<i>palbociclib</i>)	Tier 4	PA; OAC; QL (21 TABLETS per 28 DAYS)
<i>imatinib mesylate oral tablet 100 mg</i>	Tier 4	PA; OAC; QL (120 TABLETS per 30 days)
<i>imatinib mesylate oral tablet 400 mg</i>	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)
IMBRUVICA ORAL CAPSULE 140 MG (<i>ibrutinib</i>)	Tier 4	PA; OAC; QL (90 CAPSULES per 30 DAYS)
IMBRUVICA ORAL CAPSULE 70 MG (<i>ibrutinib</i>)	Tier 4	PA; OAC; QL (30 CAPSULES per 30 DAYS)
IMBRUVICA ORAL SUSPENSION 70 MG/ML (<i>ibrutinib</i>)	Tier 4	PA; OAC; QL (216 ML per 36 DAYS)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG (<i>ibrutinib</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYS)
INLYTA ORAL TABLET 1 MG (<i>axitinib</i>)	Tier 4	PA; OAC; QL (240 TABLETS per 30 DAYS)
INLYTA ORAL TABLET 5 MG (<i>axitinib</i>)	Tier 4	PA; OAC; QL (120 TABLETS per 30 DAYS)
ITOVEBI ORAL TABLET 3 MG (<i>inavolisib</i>)	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)
ITOVEBI ORAL TABLET 9 MG (<i>inavolisib</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYS)
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 25 MG, 5 MG (<i>ruxolitinib phosphate</i>)	Tier 4	PA; OAC; QL (60 TABLETS per 30 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LENVIMA (10 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (30 CAPSULES per 30 DAYs)
LENVIMA (12 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 3 X 4 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (90 CAPSULES per 30 DAYs)
LENVIMA (14 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 & 4 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (60 CAPSULES per 30 DAYs)
LENVIMA (18 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 10 MG & 2 X 4 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (90 CAPSULES per 30 DAYs)
LENVIMA (20 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (60 CAPSULES per 30 DAYs)
LENVIMA (24 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 10 MG & 4 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (90 CAPSULES per 30 DAYs)
LENVIMA (4 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 4 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (30 CAPSULES per 30 DAYs)
LENVIMA (8 MG DAILY DOSE) ORAL CAPSULE THERAPY PACK 2 X 4 MG (<i>lenvatinib mesylate</i>)	Tier 4	PA; OAC; QL (60 CAPSULES per 30 DAYs)
LORBRENA ORAL TABLET 100 MG (<i>lorlatinib</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYs)
LORBRENA ORAL TABLET 25 MG (<i>lorlatinib</i>)	Tier 4	PA; OAC; QL (90 TABLETS per 30 DAYs)
MEKINIST ORAL SOLUTION RECONSTITUTED 0.05 MG/ML (<i>trametinib dimethyl sulfoxide</i>)	Tier 4	PA; OAC; QL (12 BOTTLES per 28 DAYs)
MEKINIST ORAL TABLET 0.5 MG (<i>trametinib dimethyl sulfoxide</i>)	Tier 4	PA; OAC; QL (90 TABLETS per 30 days)
MEKINIST ORAL TABLET 2 MG (<i>trametinib dimethyl sulfoxide</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 days)
RYDAPT ORAL CAPSULE 25 MG (<i>midostaurin</i>)	Tier 4	PA; OAC; QL (224 CAPSULES per 28 DAYs)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 70 MG, 80 MG (<i>dasatinib</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYs)
SPRYCEL ORAL TABLET 20 MG (<i>dasatinib</i>)	Tier 4	PA; OAC; QL (90 TABLETS per 30 DAYs)
STIVARGA ORAL TABLET 40 MG (<i>regorafenib</i>)	Tier 4	PA; OAC; QL (84 TABLETS per 28 DAYs)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sunitinib malate oral capsule 12.5 mg, 25 mg, 37.5 mg, 50 mg</i>	Tier 4	PA; OAC; QL (30 CAPSULES per 30 DAYs)
TAFINLAR ORAL CAPSULE 50 MG, 75 MG (<i>dabrafenib mesylate</i>)	Tier 4	PA; OAC; QL (120 CAPSULES per 30 DAYs)
TAFINLAR ORAL TABLET SOLUBLE 10 MG (<i>dabrafenib mesylate</i>)	Tier 4	PA; OAC; QL (4 BOTTLES per 28 DAYs)
TAGRISSE ORAL TABLET 40 MG, 80 MG (<i>osimertinib mesylate</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 days)
TUKYSA ORAL TABLET 150 MG, 50 MG (<i>tucatinib</i>)	Tier 4	PA; OAC; QL (120 TABLETS per 30 DAYs)
VERZENIO ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (<i>abemaciclib</i>)	Tier 4	PA; OAC; QL (56 TABLETS per 28 DAYs)
VITRAKVI ORAL CAPSULE 100 MG (<i>larotrectinib sulfate</i>)	Tier 4	PA; OAC; QL (60 CAPSULES per 30 DAYs)
VITRAKVI ORAL CAPSULE 25 MG (<i>larotrectinib sulfate</i>)	Tier 4	PA; OAC; QL (180 CAPSULES per 30 DAYs)
VITRAKVI ORAL SOLUTION 20 MG/ML (<i>larotrectinib sulfate</i>)	Tier 4	PA; OAC; QL (300 ML per 30 DAYs)
MISCELLANEOUS		
<i>bexarotene oral capsule 75 mg</i>	Tier 4	PA; OAC
<i>hydroxyurea oral capsule 500 mg</i>	Tier 1	OAC
LYNPARZA ORAL TABLET 100 MG, 150 MG (<i>olaparib</i>)	Tier 4	PA; OAC; QL (120 TABLETS per 30 DAYs)
ODOMZO ORAL CAPSULE 200 MG (<i>sonidegib phosphate</i>)	Tier 4	PA; OAC; QL (30 CAPSULES per 30 DAYs)
<i>tretinoin oral capsule 10 mg</i>	Tier 1	OAC
VISTOGARD ORAL PACKET 10 GM (<i>uridine triacetate</i>)	Tier 4	QL (20 PACKETS per 5 DAYs)
ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG (<i>niraparib tosylate</i>)	Tier 4	PA; OAC; QL (30 TABLETS per 30 DAYs)
PROTECTIVE AGENTS		
<i>leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg</i>	Tier 1	OAC
MESNEX ORAL TABLET 400 MG (<i>mesna</i>)	Tier 4	OAC

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
TOPOISOMERASE INHIBITORS		
<i>etoposide oral capsule 50 mg</i>	Tier 1	OAC
CARDIOVASCULAR - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS		
ACE INHIBITOR COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg</i>	Tier 1	
<i>benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg</i>	Tier 1	
<i>enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg</i>	Tier 1	
<i>fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg</i>	Tier 1	
<i>lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg</i>	Tier 1	
<i>quinapril-hydrochlorothiazide oral tablet 10-12.5 mg</i>	Tier 1	
<i>trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg</i>	Tier 1	
ACE INHIBITORS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	
<i>fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg</i>	Tier 1	
<i>moexipril hcl oral tablet 15 mg, 7.5 mg</i>	Tier 1	
<i>perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>trandolapril oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	
ALDOSTERONE RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>epplerenone oral tablet 25 mg, 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KERENDIA ORAL TABLET 10 MG, 20 MG (<i>finerenone</i>)	Tier 3	PA
<i>spironolactone oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
ALPHA BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>prazosin hcl oral capsule 1 mg, 2 mg, 5 mg</i>	Tier 1	
ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg</i>	Tier 1	
<i>amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg</i>	Tier 1	
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg</i>	Tier 1	
<i>irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg</i>	Tier 1	
<i>losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg</i>	Tier 1	
<i>olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg</i>	Tier 1	
<i>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</i>	Tier 1	
<i>telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg</i>	Tier 1	
<i>telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg</i>	Tier 1	
<i>valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg</i>	Tier 1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS - DRUGS TO TREAT HIGH BLOOD PRESSURE		
<i>candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Tier 1	
<i>irbesartan oral tablet 150 mg, 300 mg, 75 mg</i>	Tier 1	
<i>losartan potassium oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>telmisartan oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg</i>	Tier 1	
ANTIARRHYTHMICS - DRUGS TO CONTROL HEART RHYTHM		
<i>amiodarone hcl oral tablet 200 mg, 400 mg</i>	Tier 1	
<i>disopyramide phosphate oral capsule 100 mg, 150 mg</i>	Tier 1	
<i>dofetilide oral capsule 125 mcg, 250 mcg, 500 mcg</i>	Tier 1	PA
<i>flecainide acetate oral tablet 100 mg, 150 mg, 50 mg</i>	Tier 1	
MULTAQ ORAL TABLET 400 MG (<i>dronedarone hcl</i>)	Tier 3	PA
NORPACE CR ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 150 MG (<i>disopyramide phosphate</i>)	Tier 2	
<i>amiodarone hcl</i> (Pacerone Oral Tablet 100 Mg, 200 Mg)	Tier 1	
<i>propafenone hcl er oral capsule extended release 12 hour 225 mg, 325 mg, 425 mg</i>	Tier 1	
<i>propafenone hcl oral tablet 150 mg, 225 mg, 300 mg</i>	Tier 1	
<i>sotalol hcl (af) oral tablet 120 mg, 160 mg, 80 mg</i>	Tier 1	
<i>sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg</i>	Tier 1	
ANTILIPEMICS, ACL INHIBITORS/COMBINATIONS - DRUGS TO TREAT HIGH CHOLESTEROL		
NEXLETOL ORAL TABLET 180 MG (<i>bempedoic acid</i>)	Tier 2	
ANTILIPEMICS, BILE ACID RESINS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>cholestyramine light oral packet 4 gm</i>	Tier 1	
<i>cholestyramine light oral powder 4 gm/dose</i>	Tier 1	
<i>cholestyramine oral packet 4 gm</i>	Tier 1	
<i>cholestyramine oral powder 4 gm/dose</i>	Tier 1	
<i>colestipol hcl oral granules 5 gm</i>	Tier 1	
<i>colestipol hcl oral packet 5 gm</i>	Tier 1	
<i>colestipol hcl oral tablet 1 gm</i>	Tier 1	
<i>cholestyramine light</i> (Prevalite Oral Powder 4 Gm/Dose)	Tier 1	
ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>ezetimibe oral tablet 10 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILIPEMICS, FIBRATES - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>fenofibrate micronized oral capsule 200 mg, 43 mg, 67 mg</i>	Tier 1	
<i>fenofibrate oral capsule 134 mg, 150 mg</i>	Tier 1	
<i>fenofibrate oral tablet 145 mg, 160 mg, 48 mg, 54 mg</i>	Tier 1	
<i>fenofibric acid oral capsule delayed release 135 mg, 45 mg</i>	Tier 1	
<i>gemfibrozil oral tablet 600 mg</i>	Tier 1	
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>atorvastatin calcium oral tablet 10 mg, 20 mg</i>	Tier 1	PH; AL (Min 40 Years and Max 75 Years)
<i>atorvastatin calcium oral tablet 40 mg, 80 mg</i>	Tier 1	DCN (Exception process available for \$0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)
<i>fluvastatin sodium er oral tablet extended release 24 hour 80 mg</i>	Tier 1	
<i>fluvastatin sodium oral capsule 20 mg, 40 mg</i>	Tier 1	
<i>lovastatin oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	
<i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i>	Tier 1	PH; AL (Min 40 Years and Max 75 Years)
<i>simvastatin oral tablet 80 mg</i>	Tier 1	ST; DCN (Exception process available for \$0 copay for members age 40 through 75 when medically necessary for primary prevention of cardiovascular disease)
ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTILIPEMICS, MISCELLANEOUS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg</i>	Tier 1	
ANTILIPEMICS, OMEGA-3 FATTY ACIDS - DRUGS TO TREAT HIGH CHOLESTEROL		
<i>icosapent ethyl oral capsule 0.5 gm</i>	Tier 1	
<i>icosapent ethyl oral capsule 1 gm</i>	Tier 1	DCN (Only indicated as an adjunct to diet to reduce TG levels in adult patients with severe (greater than or equal to 500 mg/dL) hypertriglyceridemia)
<i>omega-3-acid ethyl esters oral capsule 1 gm</i>	Tier 1	
ANTILIPEMICS, PCSK9 INHIBITORS - DRUGS TO TREAT HIGH CHOLESTEROL		
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (<i>evolocumab</i>)	Tier 2	PA; QL (1 CARTRIDGE per 28 days)
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (<i>evolocumab</i>)	Tier 2	PA; QL (3 SYRINGES per 28 days)
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (<i>evolocumab</i>)	Tier 2	PA; QL (3 PENS per 28 days)
BETA-BLOCKER/DIURETIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
<i>atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg</i>	Tier 1	
<i>bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg</i>	Tier 1	
<i>metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg</i>	Tier 1	
BETA-BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
<i>acebutolol hcl oral capsule 200 mg, 400 mg</i>	Tier 1	
<i>atenolol oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>betaxolol hcl oral tablet 10 mg, 20 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bisoprolol fumarate oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg</i>	Tier 1	
<i>carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>labetalol hcl oral tablet 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>nadolol oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg</i>	Tier 1	
<i>pindolol oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg</i>	Tier 1	
<i>propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml</i>	Tier 1	
<i>propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
<i>timolol maleate oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
<i>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</i>	Tier 1	
CALCIUM CHANNEL BLOCKERS - DRUGS TO TREAT HIGH BLOOD PRESSURE AND HEART CONDITIONS		
<i>amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)</i>	Tier 1	
<i>diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i>	Tier 1	
<i>diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg</i>	Tier 1	
<i>diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>diltiazem hcl er oral tablet extended release 24 hour 120 mg</i>	Tier 1	
<i>diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg</i>	Tier 1	
<i>felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>isradipine oral capsule 2.5 mg, 5 mg</i>	Tier 1	
<i>diltiazem hcl</i> (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Tier 1	
<i>nicardipine hcl oral capsule 20 mg, 30 mg</i>	Tier 1	
<i>nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg</i>	Tier 1	
<i>nimodipine oral capsule 30 mg</i>	Tier 1	
<i>nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg</i>	Tier 1	
<i>verapamil hcl er oral capsule extended release 24 hour 100 mg, 120 mg, 180 mg, 200 mg, 240 mg, 300 mg, 360 mg</i>	Tier 1	
<i>verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg</i>	Tier 1	
<i>verapamil hcl oral tablet 120 mg, 40 mg, 80 mg</i>	Tier 1	
DIGITALIS GLYCOSIDES - DRUGS TO TREAT HEART CONDITIONS		
<i>digoxin oral solution 0.05 mg/ml</i>	Tier 1	
<i>digoxin oral tablet 125 mcg, 250 mcg, 62.5 mcg</i>	Tier 1	
DIRECT RENIN INHIBITORS/COMBINATIONS - DRUGS TO TREAT HEART CONDITIONS		
<i>aliskiren fumarate oral tablet 150 mg, 300 mg</i>	Tier 1	
DIURETICS - DRUGS TO TREAT HEART CONDITIONS		
<i>acetazolamide er oral capsule extended release 12 hour 500 mg</i>	Tier 1	
<i>acetazolamide oral tablet 125 mg, 250 mg</i>	Tier 1	
<i>amiloride hcl oral tablet 5 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amiloride-hydrochlorothiazide oral tablet 5-50 mg</i>	Tier 1	
<i>bumetanide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	Tier 1	
DIURIL ORAL SUSPENSION 250 MG/5ML (<i>chlorothiazide</i>)	Tier 3	
<i>ethacrynic acid oral tablet 25 mg</i>	Tier 1	
<i>furosemide oral solution 10 mg/ml, 8 mg/ml</i>	Tier 1	
<i>furosemide oral tablet 20 mg, 40 mg, 80 mg</i>	Tier 1	
<i>hydrochlorothiazide oral capsule 12.5 mg</i>	Tier 1	
<i>hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg</i>	Tier 1	
<i>indapamide oral tablet 1.25 mg, 2.5 mg</i>	Tier 1	
<i>methazolamide oral tablet 25 mg, 50 mg</i>	Tier 1	
<i>metolazone oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>spironolactone-hctz oral tablet 25-25 mg</i>	Tier 1	
<i>toremide oral tablet 10 mg, 100 mg, 20 mg, 5 mg</i>	Tier 1	
<i>triamterene oral capsule 100 mg, 50 mg</i>	Tier 1	
<i>triamterene-hctz oral capsule 37.5-25 mg</i>	Tier 1	
<i>triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg</i>	Tier 1	
HEART FAILURE		
CORLANOR ORAL SOLUTION 5 MG/5ML (<i>ivabradine hcl</i>)	Tier 2	
CORLANOR ORAL TABLET 5 MG, 7.5 MG (<i>ivabradine hcl</i>)	Tier 2	
ENTRESTO ORAL CAPSULE SPRINKLE 15-16 MG, 6-6 MG (<i>sacubitril-valsartan</i>)	Tier 2	
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (<i>sacubitril-valsartan</i>)	Tier 2	
<i>isosorb dinitrate-hydralazine oral tablet 20-37.5 mg</i>	Tier 1	
<i>ivabradine hcl oral tablet 5 mg, 7.5 mg</i>	Tier 1	
MISCELLANEOUS		
<i>clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg</i>	Tier 1	
<i>clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr</i>	Tier 1	
<i>guanfacine hcl oral tablet 1 mg, 2 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>methyldopa oral tablet 250 mg, 500 mg</i>	Tier 1	
<i>midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>minoxidil oral tablet 10 mg, 2.5 mg</i>	Tier 1	
<i>phenoxybenzamine hcl oral capsule 10 mg</i>	Tier 4	PA; QL (360 CAPSULES per 30 days)
<i>ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg</i>	Tier 1	ST
NITRATES - DRUGS TO TREAT HEART CONDITIONS		
<i>isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg</i>	Tier 1	
<i>isosorbide mononitrate oral tablet 10 mg, 20 mg</i>	Tier 1	
NITRO-BID TRANSDERMAL OINTMENT 2 % (<i>nitroglycerin</i>)	Tier 3	
NITRO-DUR TRANSDERMAL PATCH 24 HOUR 0.3 MG/HR, 0.8 MG/HR (<i>nitroglycerin</i>)	Tier 2	
<i>nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg, 0.6 mg</i>	Tier 1	
<i>nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr, 0.4 mg/hr, 0.6 mg/hr</i>	Tier 1	
<i>nitroglycerin translingual solution 0.4 mg/spray</i>	Tier 1	
PULMONARY ARTERIAL HYPERTENSION - DRUGS TO TREAT PULMONARY HYPERTENSION		
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (<i>riociguat</i>)	Tier 4	PA; QL (90 TABLETS per 30 DAYS)
<i>ambrisentan oral tablet 10 mg, 5 mg</i>	Tier 4	PA; QL (30 TABLETS per 30 DAYS)
<i>bosentan oral tablet 125 mg, 62.5 mg</i>	Tier 4	PA; QL (60 TABLETS per 30 DAYS)
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	Tier 4	PA

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (<i>treprostinil diolamine</i>)	Tier 4	PA
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 & 1 MG (<i>treprostinil diolamine</i>)	Tier 4	PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (<i>treprostinil diolamine</i>)	Tier 4	PA
REMODULIN INJECTION SOLUTION 100 MG/20ML, 20 MG/20ML, 200 MG/20ML, 50 MG/20ML (<i>treprostinil</i>)	Tier 4	PA
<i>sildenafil citrate oral tablet 20 mg</i>	Tier 4	PA; QL (360 TABLETS per 30 days)
<i>tadalafil (pah) oral tablet 20 mg</i>	Tier 4	PA; QL (60 TABLETS per 30 DAYS)
<i>treprostinil injection solution 100 mg/20ml, 20 mg/20ml, 200 mg/20ml, 50 mg/20ml</i>	Tier 4	PA
TYVASO INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	Tier 4	PA; QL (28 AMPULES per 28 DAYS)
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	Tier 4	PA; QL (28 AMPULES per 28 DAYS)
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (<i>treprostinil</i>)	Tier 4	PA; QL (28 AMPULES per 28 DAYS)
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (<i>iloprost</i>)	Tier 4	PA; QL (270 AMPULES per 30 DAYS)
CENTRAL NERVOUS SYSTEM - DRUGS TO TREAT NERVOUS SYSTEM DISORDERS		
ALCOHOL DETERRENTS		
<i>acamprosate calcium oral tablet delayed release 333 mg</i>	Tier 1	
<i>disulfiram oral tablet 250 mg, 500 mg</i>	Tier 1	
AMYOTROPHIC LATERAL SCLEROSIS (ALS) - DRUGS TO TREAT ALS		
<i>riluzole oral tablet 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTI-ANXIETY - DRUGS TO TREAT ANXIETY		
ALPRAZOLAM INTENSOL ORAL CONCENTRATE 1 MG/ML (<i>alprazolam</i>)	Tier 2	QL (300 ML per 30 days)
<i>alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	QL (150 TABLETS per 30 days)
<i>alprazolam oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg</i>	Tier 1	QL (150 TABLETS per 30 days)
<i>buspirone hcl oral tablet 10 mg, 15 mg, 30 mg, 5 mg, 7.5 mg</i>	Tier 1	
<i>chlordiazepoxide hcl oral capsule 10 mg, 25 mg, 5 mg</i>	Tier 1	QL (360 CAPSULES per 30 days)
<i>clomipramine hcl oral capsule 25 mg, 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (150 CAPSULES per 30 days); AL (Max 65 Years)
<i>clomipramine hcl oral capsule 75 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (90 CAPSULES per 30 days); AL (Max 65 Years)
<i>fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg</i>	Tier 1	
<i>fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>lorazepam oral concentrate 2 mg/ml</i>	Tier 1	QL (150 ML per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	QL (150 TABLETS per 30 days)
<i>meprobamate oral tablet 200 mg, 400 mg</i>	Tier 1	
<i>oxazepam oral capsule 10 mg, 15 mg, 30 mg</i>	Tier 1	QL (120 CAPSULES per 30 days)
ANTIDEMENTIA - DRUGS TO TREAT DEMENTIA AND MEMORY LOSS		
<i>donepezil hcl oral tablet 10 mg, 23 mg, 5 mg</i>	Tier 1	
<i>donepezil hcl oral tablet dispersible 10 mg, 5 mg</i>	Tier 1	
<i>galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg</i>	Tier 1	
<i>galantamine hydrobromide oral solution 4 mg/ml</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg</i>	Tier 1	
<i>memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg</i>	Tier 1	
<i>memantine hcl oral solution 2 mg/ml</i>	Tier 1	
<i>memantine hcl oral tablet 10 mg, 28 x 5 mg & 21 x 10 mg, 5 mg</i>	Tier 1	
<i>rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg</i>	Tier 1	
<i>rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr</i>	Tier 1	
ANTIDEPRESSANTS - DRUGS TO TREAT DEPRESSION		
<i>amitriptyline hcl oral tablet 10 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (150 TABLETS per 30 days); AL (Max 65 Years)
<i>amitriptyline hcl oral tablet 100 mg, 150 mg, 75 mg</i>	Tier 1	AL (Max 65 Years)
<i>amitriptyline hcl oral tablet 25 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>amitriptyline hcl oral tablet 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>amoxapine oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (90 TABLETS per 30 days); AL (Max 65 Years)
<i>amoxapine oral tablet 150 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (<i>dextromethorphan-bupropion</i>)	Tier 3	
<i>bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg</i>	Tier 1	
<i>bupropion hcl oral tablet 100 mg, 75 mg</i>	Tier 1	
<i>citalopram hydrobromide oral solution 10 mg/5ml</i>	Tier 1	
<i>citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>desipramine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (90 TABLETS per 30 days); AL (Max 65 Years)
<i>desipramine hcl oral tablet 100 mg, 150 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>desipramine hcl oral tablet 75 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>doxepin hcl oral capsule 10 mg, 25 mg, 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (90 CAPSULES per 30 days); AL (Max 65 Years)
<i>doxepin hcl oral capsule 100 mg, 150 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>doxepin hcl oral capsule 75 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 CAPSULES per 30 days); AL (Max 65 Years)
<i>doxepin hcl oral concentrate 10 mg/ml</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (450 ML per 30 days); AL (Max 65 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg</i>	Tier 1	
<i>escitalopram oxalate oral solution 5 mg/5ml</i>	Tier 1	
<i>escitalopram oxalate oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (<i>levomilnacipran hcl</i>)	Tier 3	
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (<i>levomilnacipran hcl</i>)	Tier 3	
<i>fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg</i>	Tier 1	
<i>fluoxetine hcl oral capsule delayed release 90 mg</i>	Tier 1	
<i>fluoxetine hcl oral solution 20 mg/5ml</i>	Tier 1	
<i>fluoxetine hcl oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>imipramine hcl oral tablet 10 mg, 25 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (120 TABLETS per 30 days); AL (Max 65 Years)
<i>imipramine hcl oral tablet 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>imipramine pamoate oral capsule 100 mg, 75 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>imipramine pamoate oral capsule 125 mg, 150 mg</i>	Tier 1	AL (Max 65 Years)
MARPLAN ORAL TABLET 10 MG (<i>isocarboxazid</i>)	Tier 3	
<i>mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg</i>	Tier 1	
<i>mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg</i>	Tier 1	
<i>nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg</i>	Tier 1	
<i>nortriptyline hcl oral capsule 10 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (150 CAPSULES per 30 days); AL (Max 65 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nortriptyline hcl oral capsule 25 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 CAPSULES per 30 days); AL (Max 65 Years)
<i>nortriptyline hcl oral capsule 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>nortriptyline hcl oral capsule 75 mg</i>	Tier 1	AL (Max 65 Years)
<i>nortriptyline hcl oral solution 10 mg/5ml</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (750 ML per 30 days); AL (Max 65 Years)
<i>paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg</i>	Tier 1	
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	
<i>phenelzine sulfate oral tablet 15 mg</i>	Tier 1	
<i>protriptyline hcl oral tablet 10 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>protriptyline hcl oral tablet 5 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (90 TABLETS per 30 days); AL (Max 65 Years)
<i>sertraline hcl oral concentrate 20 mg/ml</i>	Tier 1	
<i>sertraline hcl oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
SPRAVATO (56 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	Tier 3	PA
SPRAVATO (84 MG DOSE) NASAL SOLUTION THERAPY PACK 28 MG/DEVICE (<i>esketamine hcl</i>)	Tier 3	PA
<i>tranylcypromine sulfate oral tablet 10 mg</i>	Tier 1	
<i>trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>trimipramine maleate oral capsule 100 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 CAPSULES per 30 days); AL (Max 65 Years)
<i>trimipramine maleate oral capsule 25 mg, 50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 CAPSULES per 30 days); AL (Max 65 Years)
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (<i>vortioxetine hbr</i>)	Tier 3	ST
<i>venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	Tier 1	
<i>venlafaxine hcl er oral tablet extended release 24 hour 150 mg, 37.5 mg, 75 mg</i>	Tier 1	
<i>venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg</i>	Tier 1	
<i>vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg</i>	Tier 1	
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (<i>zuranolone</i>)	Tier 4	PA; QL (28 CAPSULES per 14 days)
ZURZUVAE ORAL CAPSULE 30 MG (<i>zuranolone</i>)	Tier 4	PA; QL (14 CAPSULES per 14 days)
ANTIPARKINSONIAN AGENTS - DRUGS TO TREAT PARKINSONS DISEASE		
<i>amantadine hcl oral capsule 100 mg</i>	Tier 1	
<i>amantadine hcl oral solution 50 mg/5ml</i>	Tier 1	
<i>amantadine hcl oral tablet 100 mg</i>	Tier 1	
APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE 30 MG/3ML (<i>apomorphine hcl</i>)	Tier 4	PA; QL (20 CARTRIDGES per 30 days)
<i>benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>bromocriptine mesylate oral capsule 5 mg</i>	Tier 1	
<i>bromocriptine mesylate oral tablet 2.5 mg</i>	Tier 1	
<i>carbidopa oral tablet 25 mg</i>	Tier 1	
<i>carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg</i>	Tier 1	
<i>carbidopa-levodopa oral tablet dispersible 10-100 mg, 25-100 mg, 25-250 mg</i>	Tier 1	
<i>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</i>	Tier 1	
<i>entacapone oral tablet 200 mg</i>	Tier 1	
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (<i>rotigotine</i>)	Tier 2	
<i>pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg</i>	Tier 1	
<i>pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg</i>	Tier 1	
<i>rasagiline mesylate oral tablet 0.5 mg, 1 mg</i>	Tier 1	
<i>ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg</i>	Tier 1	
<i>selegiline hcl oral capsule 5 mg</i>	Tier 1	
<i>selegiline hcl oral tablet 5 mg</i>	Tier 1	
<i>trihexyphenidyl hcl oral solution 0.4 mg/ml</i>	Tier 1	
<i>trihexyphenidyl hcl oral tablet 2 mg, 5 mg</i>	Tier 1	
ANTIPSYCHOTICS - DRUGS TO TREAT PSYCHOSES		
<i>aripiprazole oral solution 1 mg/ml</i>	Tier 1	
<i>aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg</i>	Tier 1	
<i>aripiprazole oral tablet dispersible 10 mg, 15 mg</i>	Tier 1	
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (<i>aripiprazole lauroxil</i>)	Tier 3	
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML (<i>aripiprazole lauroxil</i>)	Tier 3	
<i>asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (<i>lumateperone tosylate</i>)	Tier 3	
<i>chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	Tier 1	
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (<i>iloperidone</i>)	Tier 3	
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG (<i>iloperidone</i>)	Tier 3	
<i>fluphenazine hcl oral concentrate 5 mg/ml</i>	Tier 1	
<i>fluphenazine hcl oral elixir 2.5 mg/5ml</i>	Tier 1	
<i>fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>haloperidol lactate oral concentrate 2 mg/ml</i>	Tier 1	
<i>haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg</i>	Tier 1	
<i>loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg</i>	Tier 1	
<i>lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (<i>olanzapine-samidorphan</i>)	Tier 3	
<i>olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg</i>	Tier 1	
<i>olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg</i>	Tier 1	
<i>paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg</i>	Tier 1	
<i>perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	
<i>quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg</i>	Tier 1	
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (<i>brexpiprazole</i>)	Tier 3	
<i>risperidone oral solution 1 mg/ml</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
<i>risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR (<i>asenapine</i>)	Tier 3	
<i>thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
<i>trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (<i>cariprazine hcl</i>)	Tier 3	
<i>ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
ANTISEIZURE AGENTS - DRUGS TO TREAT SEIZURES		
<i>carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>carbamazepine er oral tablet extended release 12 hour 100 mg, 200 mg, 400 mg</i>	Tier 1	
<i>carbamazepine oral suspension 100 mg/5ml</i>	Tier 1	
<i>carbamazepine oral tablet 200 mg</i>	Tier 1	
<i>carbamazepine oral tablet chewable 100 mg, 200 mg</i>	Tier 1	
<i>clobazam oral suspension 2.5 mg/ml</i>	Tier 1	
<i>clobazam oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>clonazepam oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
<i>clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg</i>	Tier 1	QL (180 TABLETS per 30 days)
<i>diazepam</i> (Diazepam Intensol Oral Concentrate 5 Mg/Ml)	Tier 1	QL (240 ML per 30 days)
<i>diazepam oral solution 5 mg/5ml</i>	Tier 1	QL (1200 ML per 30 days)
<i>diazepam oral tablet 10 mg, 2 mg, 5 mg</i>	Tier 1	QL (120 TABLETS per 30 days)
<i>diazepam rectal gel 10 mg, 2.5 mg, 20 mg</i>	Tier 1	
DILANTIN ORAL CAPSULE 30 MG (<i>phenytoin sodium extended</i>)	Tier 3	
<i>divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>divalproex sodium oral capsule delayed release sprinkle 125 mg</i>	Tier 1	
<i>divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg</i>	Tier 1	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (<i>cannabidiol</i>)	Tier 4	PA; QL (800 ML per 30 days)
<i>carbamazepine</i> (Epilex Oral Tablet 200 Mg)	Tier 1	
<i>ethosuximide oral capsule 250 mg</i>	Tier 1	
<i>ethosuximide oral solution 250 mg/5ml</i>	Tier 1	
<i>felbamate oral suspension 600 mg/5ml</i>	Tier 1	
<i>felbamate oral tablet 400 mg, 600 mg</i>	Tier 1	
<i>gabapentin oral capsule 100 mg, 300 mg, 400 mg</i>	Tier 1	QL (6 CAPSULES per 1 day)
<i>gabapentin oral solution 250 mg/5ml</i>	Tier 1	QL (72 ML per 1 day)
<i>gabapentin oral tablet 600 mg</i>	Tier 1	QL (6 TABLETS per 1 day)
<i>gabapentin oral tablet 800 mg</i>	Tier 1	QL (4 TABLETS per 1 day)
<i>lacosamide oral solution 10 mg/ml</i>	Tier 1	
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg</i>	Tier 1	
<i>lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg</i>	Tier 1	
<i>lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg</i>	Tier 1	
<i>lamotrigine oral tablet chewable 25 mg, 5 mg</i>	Tier 1	
<i>lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>lamotrigine starter kit-blue oral kit 35 x 25 mg</i>	Tier 1	
<i>lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg</i>	Tier 1	
<i>lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg</i>	Tier 1	
<i>levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg</i>	Tier 1	
<i>levetiracetam oral solution 100 mg/ml</i>	Tier 1	
<i>levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg</i>	Tier 1	
<i>methsuximide oral capsule 300 mg</i>	Tier 1	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (<i>midazolam (anticonvulsant)</i>)	Tier 3	PA; QL (10 SOLUTION per 30 days)
<i>oxcarbazepine oral suspension 300 mg/5ml</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg</i>	Tier 1	
<i>phenobarbital oral elixir 20 mg/5ml</i>	Tier 1	
<i>phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg</i>	Tier 1	
<i>phenytoin oral suspension 125 mg/5ml</i>	Tier 1	
<i>phenytoin oral tablet chewable 50 mg</i>	Tier 1	
<i>phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg</i>	Tier 1	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg</i>	Tier 1	ST
<i>pregabalin oral solution 20 mg/ml</i>	Tier 1	ST
<i>primidone oral tablet 250 mg, 50 mg</i>	Tier 1	
<i>rufinamide oral suspension 40 mg/ml</i>	Tier 1	
<i>rufinamide oral tablet 200 mg, 400 mg</i>	Tier 1	
<i>tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg</i>	Tier 1	
<i>topiramate oral capsule sprinkle 15 mg, 25 mg</i>	Tier 1	
<i>topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	Tier 1	
<i>valproic acid oral capsule 250 mg</i>	Tier 1	
<i>valproic acid oral solution 250 mg/5ml</i>	Tier 1	
<i>vigabatrin oral packet 500 mg</i>	Tier 4	PA; QL (180 PACKETS per 30 days)
<i>vigabatrin oral tablet 500 mg</i>	Tier 4	PA; QL (180 TABLETS per 30 days)
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG (<i>cenobamate</i>)	Tier 2	
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (<i>cenobamate</i>)	Tier 2	
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (<i>cenobamate</i>)	Tier 2	
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X 200 MG, 14 X 50 MG & 14 X 100 MG (<i>cenobamate</i>)	Tier 2	
<i>zonisamide oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ATTENTION DEFICIT HYPERACTIVITY DISORDER - DRUGS TO TREAT ADHD		
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 10 mg, 5 mg</i>	Tier 1	QL (90 CAPSULES per 30 days)
<i>amphetamine-dextroamphetamine oral capsule extended release 24 hour 15 mg, 20 mg, 25 mg, 30 mg</i>	Tier 1	QL (30 CAPSULES per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 5 mg, 7.5 mg</i>	Tier 1	QL (90 TABLETS per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 15 mg, 20 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>amphetamine-dextroamphetamine oral tablet 30 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
<i>atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg</i>	Tier 1	
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 5 mg</i>	Tier 1	QL (60 CAPSULES per 30 days)
<i>dexmethylphenidate hcl er oral capsule extended release 24 hour 25 mg, 30 mg, 35 mg, 40 mg</i>	Tier 1	QL (30 CAPSULES per 30 days)
<i>dexmethylphenidate hcl oral tablet 10 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>dexmethylphenidate hcl oral tablet 2.5 mg, 5 mg</i>	Tier 1	QL (120 TABLETS per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 5 mg</i>	Tier 1	QL (120 CAPSULES per 30 days)
<i>dextroamphetamine sulfate er oral capsule extended release 24 hour 15 mg</i>	Tier 1	QL (60 CAPSULES per 30 days)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	Tier 1	QL (1200 ML per 30 days)
<i>dextroamphetamine sulfate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (120 TABLETS per 30 days)
<i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>dextroamphetamine sulfate oral tablet 30 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
<i>guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg</i>	Tier 1	QL (60 CAPSULES per 30 days)
<i>lisdexamfetamine dimesylate oral capsule 40 mg, 50 mg, 60 mg, 70 mg</i>	Tier 1	QL (30 CAPSULES per 30 days)
<i>lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>lisdexamfetamine dimesylate oral tablet chewable 40 mg, 50 mg, 60 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
<i>methamphetamine hcl oral tablet 5 mg</i>	Tier 1	QL (150 TABLETS per 30 days)
<i>methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg</i>	Tier 1	QL (60 CAPSULES per 30 days)
<i>methylphenidate hcl er (cd) oral capsule extended release 40 mg, 50 mg, 60 mg</i>	Tier 1	QL (30 CAPSULES per 30 days)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 30 mg</i>	Tier 1	QL (60 CAPSULES per 30 days)
<i>methylphenidate hcl er (la) oral capsule extended release 24 hour 40 mg, 60 mg</i>	Tier 1	QL (30 CAPSULES per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 36 mg</i>	Tier 1	QL (60 TABLETS per 30 days)
<i>methylphenidate hcl er (osm) oral tablet extended release 54 mg</i>	Tier 1	QL (30 TABLETS per 30 days)
<i>methylphenidate hcl er oral tablet extended release 10 mg, 20 mg</i>	Tier 1	QL (90 TABLETS per 30 days)
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	Tier 1	QL (900 ML per 30 days)
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	Tier 1	QL (1800 ML per 30 days)
<i>methylphenidate hcl oral tablet 10 mg, 5 mg</i>	Tier 1	QL (180 TABLETS per 30 days)
<i>methylphenidate hcl oral tablet 20 mg</i>	Tier 1	QL (90 TABLETS per 30 days)
<i>methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (180 TABLETS per 30 days)
<i>dextroamphetamine sulfate</i> (Zenzedi Oral Tablet 2.5 Mg, 7.5 Mg)	Tier 1	QL (120 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FIBROMYALGIA		
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (<i>milnacipran hcl</i>)	Tier 3	ST
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (<i>milnacipran hcl</i>)	Tier 3	ST
HYPNOTICS - DRUGS TO TREAT INSOMNIA		
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (<i>suvorexant</i>)	Tier 3	PA; QL (30 TABLETS per 30 days)
DAYVIGO ORAL TABLET 10 MG, 5 MG (<i>lemborexant</i>)	Tier 3	PA; QL (30 TABLETS per 30 days)
<i>doxepin hcl oral tablet 3 mg, 6 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>estazolam oral tablet 1 mg, 2 mg</i>	Tier 1	QL (15 TABLETS per 30 days)
<i>eszopiclone oral tablet 1 mg, 2 mg, 3 mg</i>	Tier 1	QL (15 TABLETS per 30 days)
<i>ramelteon oral tablet 8 mg</i>	Tier 1	QL (15 TABLETS per 30 days)
<i>sleep-aid oral tablet 25 mg</i>	Tier 1	
<i>tasimelteon oral capsule 20 mg</i>	Tier 4	PA; QL (30 CAPSULES per 30 days)
<i>temazepam oral capsule 15 mg, 22.5 mg, 30 mg, 7.5 mg</i>	Tier 1	QL (15 CAPSULES per 30 days)
<i>triazolam oral tablet 0.125 mg, 0.25 mg</i>	Tier 1	QL (10 TABLETS per 30 days)
<i>zaleplon oral capsule 10 mg, 5 mg</i>	Tier 1	QL (15 CAPSULES per 30 days)
<i>zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg</i>	Tier 1	QL (15 TABLETS per 30 days)
<i>zolpidem tartrate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (15 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MIGRAINE - ERGOTAMINE DERIVATIVES - DRUGS TO TREAT SEVERE HEADACHES		
<i>dihydroergotamine mesylate injection solution 1 mg/ml</i>	Tier 1	
<i>ergotamine-caffeine oral tablet 1-100 mg</i>	Tier 1	
MIGRAINE - MISCELLANEOUS - DRUGS TO TREAT SEVERE HEADACHES		
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (<i>atogepant</i>)	Tier 2	
UBRELVY ORAL TABLET 100 MG, 50 MG (<i>ubrogepant</i>)	Tier 3	
MIGRAINE - MONOCLONAL ANTIBODIES - DRUGS TO TREAT SEVERE HEADACHES		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (<i>erenumab-aooe</i>)	Tier 2	
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	Tier 2	
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (<i>fremanezumab-vfrm</i>)	Tier 2	
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>galcanezumab-gnlm</i>)	Tier 2	
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (<i>galcanezumab-gnlm</i>)	Tier 2	
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (<i>galcanezumab-gnlm</i>)	Tier 2	
MIGRAINE - TRIPTANS AND COMBINATIONS - DRUGS TO TREAT SEVERE HEADACHES		
<i>almotriptan malate oral tablet 12.5 mg, 6.25 mg</i>	Tier 1	QL (12 TABLETS per 30 days)
<i>eletriptan hydrobromide oral tablet 20 mg, 40 mg</i>	Tier 1	QL (12 TABLETS per 30 days)
<i>frovatriptan succinate oral tablet 2.5 mg</i>	Tier 1	QL (18 TABLETS per 30 days)
<i>naratriptan hcl oral tablet 1 mg, 2.5 mg</i>	Tier 1	QL (12 TABLETS per 30 days)
<i>rizatriptan benzoate oral tablet 10 mg, 5 mg</i>	Tier 1	QL (18 TABLETS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg</i>	Tier 1	QL (18 TABLETS per 30 days)
<i>sumatriptan nasal solution 20 mg/act</i>	Tier 1	QL (12 SPRAYS per 30 days)
<i>sumatriptan nasal solution 5 mg/act</i>	Tier 1	QL (24 SPRAYS per 30 days)
<i>sumatriptan succinate oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	QL (12 TABLETS per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml</i>	Tier 1	QL (18 SYRINGES per 30 days)
<i>sumatriptan succinate refill subcutaneous solution cartridge 6 mg/0.5ml</i>	Tier 1	QL (12 SOLUTION CARTRIDGE per 30 days)
<i>sumatriptan succinate subcutaneous solution 6 mg/0.5ml</i>	Tier 1	QL (12 VIALS per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml</i>	Tier 1	QL (18 SYRINGES per 30 days)
<i>sumatriptan succinate subcutaneous solution auto-injector 6 mg/0.5ml</i>	Tier 1	QL (12 SOLUTION AUTO-INJECTOR per 30 days)
<i>sumatriptan-naproxen sodium oral tablet 85-500 mg</i>	Tier 1	ST; QL (9 TABLETS per 30 days)
<i>zolmitriptan nasal solution 2.5 mg, 5 mg</i>	Tier 1	QL (12 SPRAYS per 30 days)
<i>zolmitriptan oral tablet 2.5 mg, 5 mg</i>	Tier 1	QL (12 TABLETS per 30 days)
<i>zolmitriptan oral tablet dispersible 2.5 mg, 5 mg</i>	Tier 1	QL (12 TABLETS per 30 days)
MISCELLANEOUS		
EVRYSDI ORAL SOLUTION RECONSTITUTED 0.75 MG/ML (<i>risdiplam</i>)	Tier 4	PA; QL (2 BOTTLES per 24 days)
MOOD STABILIZERS - DRUGS TO TREAT MOOD DISORDERS		
<i>lithium carbonate er oral tablet extended release 300 mg, 450 mg</i>	Tier 1	
<i>lithium carbonate oral capsule 150 mg, 300 mg, 600 mg</i>	Tier 1	
<i>lithium carbonate oral tablet 300 mg</i>	Tier 1	
<i>lithium oral solution 8 meq/5ml</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MOVEMENT DISORDERS		
<i>tetrabenazine oral tablet 12.5 mg</i>	Tier 4	PA; QL (120 TABLETS per 30 DAYs)
<i>tetrabenazine oral tablet 25 mg</i>	Tier 4	PA; QL (60 TABLETS per 30 DAYs)
MULTIPLE SCLEROSIS AGENTS - DRUGS TO TREAT MULTIPLE SCLEROSIS		
BETASERON SUBCUTANEOUS KIT 0.3 MG (<i>interferon beta-1b</i>)	Tier 2	PA; QL (14 INJECTIONS per 28 DAYs)
<i>dalfampridine er oral tablet extended release 12 hour 10 mg</i>	Tier 4	PA; QL (60 TABLETS per 30 days)
<i>dimethyl fumarate oral capsule delayed release 120 mg</i>	Tier 1	PA; QL (14 CAPSULES per 28 DAYs)
<i>dimethyl fumarate oral capsule delayed release 240 mg</i>	Tier 1	PA; QL (60 CAPSULES per 30 DAYs)
<i>dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg</i>	Tier 1	PA; QL (1 KIT per 30 days)
<i>fingolimod hcl oral capsule 0.5 mg</i>	Tier 1	PA; QL (30 CAPSULES per 30 DAYs)
<i>glatiramer acetate subcutaneous solution prefilled syringe 40 mg/ml</i>	Tier 1	PA; QL (12 SYRINGES per 28 DAYs)
<i>glatiramer acetate</i> (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/Ml)	Tier 1	PA; QL (30 INJECTIONS per 30 DAYs)
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (<i>cladribine</i>)	Tier 4	PA; QL (20 TABLETS per 270 days)
MAYZENT ORAL TABLET 0.25 MG (<i>siponimod fumarate</i>)	Tier 4	PA; QL (12 TABLETS per 5 days)
MAYZENT ORAL TABLET 1 MG, 2 MG (<i>siponimod fumarate</i>)	Tier 4	PA; QL (30 TABLETS per 30 days)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (<i>siponimod fumarate</i>)	Tier 4	PA; QL (12 TABLETS per 5 days)
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (<i>siponimod fumarate</i>)	Tier 4	PA; QL (7 TABLETS per 4 days)
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Tier 4	PA; QL (2 SYRINGES per 28 DAYS)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Tier 4	PA; QL (2 PENS per 28 days)
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Tier 4	PA; QL (2 SYRINGES per 28 DAYS)
PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Tier 4	PA; QL (2 PENS per 28 days)
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (<i>peginterferon beta-1a</i>)	Tier 4	PA; QL (2 SYRINGES per 28 DAYS)
PONVORY ORAL TABLET 20 MG (<i>ponesimod</i>)	Tier 4	PA; QL (30 TABLETS per 30 days)
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG (<i>ponesimod</i>)	Tier 4	PA; QL (14 TABLETS per 14 days)
<i>teriflunomide oral tablet 14 mg, 7 mg</i>	Tier 1	PA; QL (30 TABLETS per 30 days)
MUSCULOSKELETAL THERAPY AGENTS		
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
<i>carisoprodol oral tablet 350 mg</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>chlorzoxazone oral tablet 500 mg</i>	Tier 1	PA; AL (Max 70 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>cyclobenzaprine hcl oral tablet 10 mg, 5 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>metaxalone oral tablet 800 mg</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>methocarbamol oral tablet 500 mg, 750 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>orphenadrine citrate er oral tablet extended release 12 hour 100 mg</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>tizanidine hcl oral tablet 2 mg, 4 mg</i>	Tier 1	
MYASTHENIA GRAVIS - DRUGS TO TREAT MYASTHENIA GRAVIS		
<i>pyridostigmine bromide er oral tablet extended release 180 mg</i>	Tier 1	
<i>pyridostigmine bromide oral solution 60 mg/5ml</i>	Tier 1	
<i>pyridostigmine bromide oral tablet 60 mg</i>	Tier 1	
NARCOLEPSY/CATAPLEXY - DRUGS FOR SLEEP DISORDERS		
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg</i>	Tier 1	PA; QL (30 TABLETS per 30 days)
<i>armodafinil oral tablet 50 mg</i>	Tier 1	PA; QL (60 TABLETS per 30 days)
<i>modafinil oral tablet 100 mg, 200 mg</i>	Tier 1	PA; QL (60 TABLETS per 30 days)
SUNOSI ORAL TABLET 150 MG, 75 MG (<i>solriamfetol hcl</i>)	Tier 3	PA; QL (30 TABLETS per 30 days)
OPIOID AGONIST/ANTAGONIST		
<i>buprenorphine hcl-naloxone hcl sublingual film 12-3 mg</i>	Tier 1	QL (2 FILM per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 4-1 mg, 8-2 mg</i>	Tier 1	QL (3 FILM per 1 day)
<i>buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg</i>	Tier 1	PH; QL (3 TABLETS per 1 day)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
OPIOID ANTAGONIST		
KLOXXADO NASAL LIQUID 8 MG/0.1ML (<i>naloxone hcl</i>)	Tier 3	QL (4 SPRAYS per 25 DAYS)
<i>naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml</i>	Tier 1	
<i>naloxone hcl injection solution cartridge 0.4 mg/ml</i>	Tier 1	
<i>naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml</i>	Tier 1	
<i>naloxone hcl nasal liquid 4 mg/0.1ml</i>	Tier 1	QL (4 SPRAYS per 25 days)
<i>naltrexone hcl oral tablet 50 mg</i>	Tier 1	PH
NARCAN NASAL LIQUID 4 MG/0.1ML (<i>naloxone hcl</i>)	Tier 1	QL (4 SPRAYS per 25 DAYS)
RIVIVE NASAL LIQUID 3 MG/0.1ML (<i>naloxone hcl</i>)	Tier 1	QL (4 SPRAYS per 25 days)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (<i>naltrexone</i>)	Tier 4	
OPIOID PARTIAL AGONISTS		
<i>buprenorphine hcl sublingual tablet sublingual 2 mg, 8 mg</i>	Tier 1	DCN (\$0 copay); PH
PSYCHOTHERAPEUTIC-MISC		
<i>chlordiazepoxide-amitriptyline oral tablet 10-25 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>chlordiazepoxide-amitriptyline oral tablet 5-12.5 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (120 TABLETS per 30 days); AL (Max 65 Years)
<i>lofexidine hcl oral tablet 0.18 mg</i>	Tier 1	
LUCEMYRA ORAL TABLET 0.18 MG (<i>lofexidine hcl</i>)	Tier 3	
<i>perphenazine-amitriptyline oral tablet 2-10 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (150 TABLETS per 30 days); AL (Max 65 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>perphenazine-amitriptyline oral tablet 2-25 mg, 4-25 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (60 TABLETS per 30 days); AL (Max 65 Years)
<i>perphenazine-amitriptyline oral tablet 4-10 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (120 TABLETS per 30 days); AL (Max 65 Years)
<i>perphenazine-amitriptyline oral tablet 4-50 mg</i>	Tier 1	QLR (QL applies to members age 65 and older); QL (30 TABLETS per 30 days); AL (Max 65 Years)
<i>pimozide oral tablet 1 mg, 2 mg</i>	Tier 1	
SMOKING DETERRENENTS		
<i>bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>goodsense nicotine mouth/throat gum 4 mg</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>goodsense nicotine mouth/throat lozenge 4 mg</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>nicotine polacrilex mouth/throat gum 2 mg, 4 mg</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>nicotine polacrilex mouth/throat lozenge 2 mg</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>nicotine step 3 transdermal patch 24 hour 7 mg/24hr</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>nicotine transdermal kit 21-14-7 mg/24hr</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
NICOTROL INHALATION INHALER 10 MG (<i>nicotine</i>)	Tier 3	DCN (\$0 copay limited to 2 treatment cycles/year); PH; QL (168 DAYS OF TREATMENT per 365 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NICOTROL NS NASAL SOLUTION 10 MG/ML (<i>nicotine</i>)	Tier 3	DCN (\$0 copay limited to 2 treatment cycles/year); PH; QL (168 DAYS OF TREATMENT per 365 DAYS)
<i>sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
<i>varenicline tartrate oral tablet 0.5 mg, 1 mg</i>	Tier 1	DCN (\$0 copay limited to 2 treatment cycles/year); PH
ENDOCRINE AND METABOLIC - DRUGS TO TREAT DIABETES AND REGULATE HORMONES		
ACROMEGALY - DRUGS TO TREAT CONDITIONS THAT CAUSE EXCESSIVE GROWTH		
<i>octreotide acetate injection solution 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	Tier 4	PA; QL (90 ML per 30 days)
<i>octreotide acetate injection solution 1000 mcg/ml</i>	Tier 4	PA; QL (45 ML per 30 days)
<i>octreotide acetate injection solution 200 mcg/ml</i>	Tier 4	PA; QL (225 ML per 30 days)
<i>octreotide acetate subcutaneous solution prefilled syringe 100 mcg/ml, 50 mcg/ml, 500 mcg/ml</i>	Tier 4	PA; QL (90 ML per 30 days)
SOMATULINE DEPOT SUBCUTANEOUS SOLUTION 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML (<i>lanreotide acetate</i>)	Tier 4	PA; QL (1 INJECTION per 28 days)
SOMAVERT SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 15 MG, 20 MG, 25 MG, 30 MG (<i>pegvisomant</i>)	Tier 4	PA; QL (30 VIALS per 30 DAYS)
ANDROGENS - DRUGS TO REGULATE MALE HORMONES		
<i>testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml</i>	Tier 1	PA
<i>testosterone enanthate intramuscular solution 200 mg/ml</i>	Tier 1	PA
<i>testosterone transdermal gel 10 mg/act (2%), 25 mg/2.5gm (1%)</i>	Tier 1	PA
ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>miglitol oral tablet 100 mg, 25 mg, 50 mg</i>	Tier 1	
ANTIDIABETICS, AMYLIN ANALOGS		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML (<i>pramlintide acetate</i>)	Tier 3	ST
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML (<i>pramlintide acetate</i>)	Tier 3	ST
ANTIDIABETICS, BIGUANIDE		
<i>metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg</i>	Tier 1	
<i>metformin hcl oral tablet 1000 mg, 500 mg</i>	Tier 1	
<i>metformin hcl oral tablet 850 mg</i>	Tier 1	PH; AL (Min 35 Years and Max 70 Years)
ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS		
<i>glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg</i>	Tier 1	
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITOR COMBINATIONS		
<i>alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg</i>	Tier 1	ST
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (<i>sitagliptin-metformin hcl</i>)	Tier 2	ST
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (<i>sitagliptin-metformin hcl</i>)	Tier 2	ST
ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
<i>alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg</i>	Tier 1	ST
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (<i>sitagliptin phosphate</i>)	Tier 2	ST
ANTIDIABETICS, INCRETIN MIMETIC AGENTS		
<i>liraglutide subcutaneous solution pen-injector 18 mg/3ml</i>	Tier 1	ST; QL (3 PENS per 30 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (<i>tirzepatide</i>)	Tier 3	ST; QL (4 PENS per 28 days)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (<i>semaglutide</i>)	Tier 2	ST; QL (30 TABLETS per 30 DAYS)
TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML (<i>dulaglutide</i>)	Tier 2	ST; QL (4 PENS per 28 days)
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide</i>)	Tier 2	ST; QL (3 PENS per 30 days)
ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS		
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML (<i>insulin degludec-liraglutide</i>)	Tier 3	ST
ANTIDIABETICS, INSULIN		
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	Tier 2	
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin glargine</i>)	Tier 2	
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Tier 2	
FIASP INJECTION SOLUTION 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Tier 2	
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Tier 2	
FIASP PUMPCART SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Tier 2	
FIASP SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin aspart (w/niacinamide)</i>)	Tier 2	
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML (<i>insulin regular human</i>)	Tier 2	
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (<i>insulin regular human</i>)	Tier 2	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin detemir</i>)	Tier 2	
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin detemir</i>)	Tier 2	
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Tier 2	DCN (RELION not covered)
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin nph isophane & regular</i>)	Tier 2	DCN (RELION not covered)
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Tier 2	DCN (RELION not covered)
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (<i>insulin nph human (isophane)</i>)	Tier 2	DCN (RELION not covered)
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin regular human</i>)	Tier 2	DCN (RELION not covered)
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (<i>insulin regular human</i>)	Tier 2	DCN (RELION not covered)
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (<i>insulin aspart</i>)	Tier 2	
NOVOLOG INJECTION SOLUTION 100 UNIT/ML (<i>insulin aspart</i>)	Tier 2	
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (<i>insulin aspart prot & aspart</i>)	Tier 2	
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (<i>insulin aspart prot & aspart</i>)	Tier 2	
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (<i>insulin aspart</i>)	Tier 2	
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (<i>insulin degludec</i>)	Tier 2	
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML (<i>insulin degludec</i>)	Tier 2	
ANTIDIABETICS, INSULIN SENSITIZER		
<i>pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION		
<i>pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg</i>	Tier 1	
ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION		
<i>pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg</i>	Tier 1	
ANTIDIABETICS, MEGLITINIDE		
<i>nateglinide oral tablet 120 mg, 60 mg</i>	Tier 1	
<i>repaglinide oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR COMBINATIONS		
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (<i>empagliflozin-metformin hcl</i>)	Tier 2	ST
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (<i>empagliflozin-metformin hcl</i>)	Tier 2	ST
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITOR/DPP-4 INHIBITOR COMBINATIONS		
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (<i>empagliflozin-linagliptin</i>)	Tier 2	ST
ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS		
JARDIANCE ORAL TABLET 10 MG, 25 MG (<i>empagliflozin</i>)	Tier 2	ST
ANTIDIABETICS, SULFONYLUREA		
<i>glimepiride oral tablet 1 mg, 2 mg, 4 mg</i>	Tier 1	
<i>glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>glipizide oral tablet 10 mg, 5 mg</i>	Tier 1	
ANTI-OBESITY		
<i>benzphetamine hcl oral tablet 50 mg</i>	Tier 1	PA; QL (90 TABLETS per 25 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CONTRAVE ORAL TABLET EXTENDED RELEASE 12 HOUR 8-90 MG (<i>naltrexone-bupropion hcl</i>)	Tier 3	PA; QL (120 TABLETS per 25 days)
<i>diethylpropion hcl er oral tablet extended release 24 hour 75 mg</i>	Tier 1	PA; QL (30 TABLETS per 25 DAYS)
<i>diethylpropion hcl oral tablet 25 mg</i>	Tier 1	PA; QL (90 TABLETS per 25 DAYS)
<i>phendimetrazine tartrate oral tablet 35 mg</i>	Tier 1	PA; QL (180 TABLETS per 25 days)
<i>phentermine hcl oral capsule 15 mg</i>	Tier 1	PA; QL (60 CAPSULES per 25 DAYS)
<i>phentermine hcl oral capsule 30 mg</i>	Tier 1	PA; QL (30 CAPSULES per 25 days)
<i>phentermine hcl oral capsule 37.5 mg</i>	Tier 1	PA; QL (30 CAPSULES per 25 DAYS)
<i>phentermine hcl oral tablet 37.5 mg</i>	Tier 1	PA; QL (30 TABLETS per 25 days)
QSYMIA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 11.25-69 MG, 15-92 MG, 3.75-23 MG, 7.5-46 MG (<i>phentermine-topiramate</i>)	Tier 2	PA; QL (30 CAPSULES per 25 DAYS)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (<i>liraglutide -weight management</i>)	Tier 2	PA; QL (1 PACKAGE per 25 DAYS)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML (<i>semaglutide-weight management</i>)	Tier 2	PA; QL (1 PACKAGE per 21 DAYS)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 1.7 MG/0.75ML, 2.4 MG/0.75ML (<i>semaglutide-weight management</i>)	Tier 2	PA; QL (1 PACKAGE per 25 DAYS)
ZEPBOUND SUBCUTANEOUS SOLUTION 2.5 MG/0.5ML, 5 MG/0.5ML (<i>tirzepatide-weight management</i>)	Tier 2	PA; QL (4 VIALS per 28 days)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (<i>tirzepatide-weight management</i>)	Tier 2	PA; QL (4 PENS per 28 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
CALCIUM RECEPTOR AGONISTS		
<i>cinacalcet hcl oral tablet 30 mg, 60 mg</i>	Tier 4	PA; QL (60 TABLETS per 30 days)
<i>cinacalcet hcl oral tablet 90 mg</i>	Tier 4	PA; QL (120 TABLETS per 30 days)
CALCIUM REGULATORS, BISPHOSPHONATES - DRUGS TO TREAT BONE LOSS		
<i>alendronate sodium oral solution 70 mg/75ml</i>	Tier 1	
<i>alendronate sodium oral tablet 10 mg, 35 mg, 5 mg, 70 mg</i>	Tier 1	
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (<i>alendronate-cholecalciferol</i>)	Tier 3	ST
<i>ibandronate sodium oral tablet 150 mg</i>	Tier 1	
<i>risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg</i>	Tier 1	
<i>risedronate sodium oral tablet delayed release 35 mg</i>	Tier 1	
CALCIUM REGULATORS, MISCELLANEOUS		
<i>calcitonin (salmon) nasal solution 200 unit/act</i>	Tier 1	
CALCIUM REGULATORS, PARATHYROID HORMONES		
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (<i>abaloparatide</i>)	Tier 4	PA; QL (1 PEN per 30 days)
CHELATING AGENTS		
CHEMET ORAL CAPSULE 100 MG (<i>succimer</i>)	Tier 3	
<i>deferiprone oral tablet 1000 mg, 500 mg</i>	Tier 4	PA
FERRIPROX ORAL SOLUTION 100 MG/ML (<i>deferiprone</i>)	Tier 4	PA
FERRIPROX TWICE-A-DAY ORAL TABLET 1000 MG (<i>deferiprone</i>)	Tier 4	PA
<i>penicillamine oral tablet 250 mg</i>	Tier 4	
CONTRACEPTIVES - PRODUCTS FOR BIRTH CONTROL		
<i>levonorgestrel-ethinyl estrad</i> (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
AFTERA ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
AFTERPILL ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i> (Altavera Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>alyacen 1/35 oral tablet 1-35 mg-mcg</i>	Tier 1	PH
<i>alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg</i>	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Amethyst Oral Tablet 90-20 Mcg)	Tier 1	PH
ANNOVERA VAGINAL RING 0.013-0.15 MG/24HR (<i>segesterone-ethinyl estradiol</i>)	Tier 1	PH; QL (1 RING per 300 DAYS)
<i>desogestrel-ethinyl estradiol</i> (Apri Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>norethin-eth estrad triphasic</i> (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Ashlyna Oral Tablet 0.15-0.03 &0.01 Mg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Aurovela 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Aviane Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Balziva Oral Tablet 0.4-35 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Blisovi 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>briellyn oral tablet 0.4-35 mg-mcg</i>	Tier 1	PH
<i>norethindrone</i> (Camila Oral Tablet 0.35 Mg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Camrese Oral Tablet 0.15-0.03 & 0.01 Mg)	Tier 1	PH
CAYA VAGINAL DIAPHRAGM (<i>diaphragm arc-spring</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
<i>norethin ace-eth estrad-fe</i> (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>condoms</i>	Tier 1	PH; QL (12 CONDOMS per 25 days)
<i>norgestrel-ethinyl estradiol</i> (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	Tier 1	PH
CURAE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Cyclafem 1/35 Oral Tablet 1-35 Mg-Mcg)	Tier 1	PH
<i>norethin-eth estrad triphasic</i> (Cyclafem 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	Tier 1	PH
<i>norethin-eth estrad triphasic</i> (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Daysee Oral Tablet 0.15-0.03 & 0.01 Mg)	Tier 1	PH
<i>norethindrone</i> (Deblitane Oral Tablet 0.35 Mg)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgestrel-ethinyl estrad</i> (Delyla Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (<i>medroxyprogesterone acetate</i>)	Tier 1	PH; QL (4 INJECTIONS per 300 DAYs)
<i>desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)</i>	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Dolishale Oral Tablet 90-20 Mcg)	Tier 1	PH
<i>drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg</i>	Tier 1	PH
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg</i>	Tier 1	PH
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
<i>norgestrel-ethinyl estradiol</i> (Elinest Oral Tablet 0.3-30 Mg-Mcg)	Tier 1	PH
ELLA ORAL TABLET 30 MG (<i>ulipristal acetate</i>)	Tier 1	PH
<i>etonogestrel-ethinyl estradiol</i> (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	Tier 1	PH; QL (13 RING per 300 days)
<i>norethindrone</i> (Emzahh Oral Tablet 0.35 Mg)	Tier 1	PH
<i>etonogestrel-ethinyl estradiol</i> (Enilloring Vaginal Ring 0.12-0.015 Mg/24Hr)	Tier 1	PH; QL (13 RING per 300 DAYs)
<i>levonorg-eth estrad triphasic</i> (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone</i> (Errin Oral Tablet 0.35 Mg)	Tier 1	PH
<i>norgestimate-eth estradiol</i> (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	Tier 1	PH
<i>ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg</i>	Tier 1	PH
<i>etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr</i>	Tier 1	PH; QL (13 RING per 300 DAYs)
<i>levonorgestrel-ethinyl estrad</i> (Falmina Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
FC2 FEMALE CONDOM (<i>condoms - female</i>)	Tier 1	PH; QL (12 CONDOMS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
FEMCAP VAGINAL DEVICE 22 MM, 26 MM, 30 MM (<i>cervical caps</i>)	Tier 1	PH; QL (1 DEVICE per 300 DAYS)
FEMLYV ORAL TABLET DISPERSIBLE 1-0.02 MG (<i>norethindrone acet-ethinyl est</i>)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Gemmy Oral Capsule 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Hailey 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>etonogestrel-ethinyl estradiol</i> (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	Tier 1	PH; QL (13 RING per 300 days)
<i>norethindrone</i> (Heather Oral Tablet 0.35 Mg)	Tier 1	PH
HER STYLE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Iclevia Oral Tablet 0.15-0.03 Mg)	Tier 1	PH
<i>norethindrone</i> (Incassia Oral Tablet 0.35 Mg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Introvale Oral Tablet 0.15-0.03 Mg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Jaimiess Oral Tablet 0.15-0.03 & 0.01 Mg)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Jasmiel Oral Tablet 3-0.02 Mg)	Tier 1	PH
<i>norethindrone</i> (Jencycla Oral Tablet 0.35 Mg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Jolessa Oral Tablet 0.15-0.03 Mg)	Tier 1	PH
<i>levonorgest-eth estrad-fe bisg</i> (Joyeaux Oral Tablet 0.1-20 Mg-Mcg(21))	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>desogestrel-ethinyl estradiol</i> (Juleber Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Junel Fe 24 Oral Tablet 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin-eth estradiol-fe</i> (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Tier 1	PH
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	Tier 1	PH
<i>ethynodiol diac-eth estradiol</i> (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (<i>levonorgestrel</i>)	Tier 1	PH; QL (1 INTRAUTERINE DEVICE per 300 DAYS)
<i>norethindrone acet-ethinyl est</i> (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Larin 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin ace-eth estrad-fe</i> (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin-eth estradiol-fe</i> (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Tier 1	PH
<i>norethin-eth estrad triphasic</i> (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Lessina Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
<i>levonorg-eth estrad triphasic</i> (Levonest Oral Tablet 50-30/75-40/125-30 Mcg)	Tier 1	PH
<i>levonorgest-eth est & eth est oral tablet 42-21-21-7 days</i>	Tier 1	PH
<i>levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 & 0.01 mg, 0.15-0.03 mg</i>	Tier 1	PH
<i>levonorgest-eth estradiol-iron oral tablet 0.1-20 mg-mcg(21)</i>	Tier 1	PH
<i>levonorgestrel oral tablet 1.5 mg</i>	Tier 1	PH
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg, 90-20 mcg</i>	Tier 1	PH
<i>levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg</i>	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (<i>levonorgestrel</i>)	Tier 1	PH; QL (1 INTRAUTERINE DEVICE per 300 Days)
LO LOESTRIN FE ORAL TABLET 1 MG-10 MCG / 10 MCG (<i>norethin-eth estrad-fe biphas</i>)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Loestrin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estrad 91-day</i> (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Loryna Oral Tablet 3-0.02 Mg)	Tier 1	PH
<i>norgestrel-ethinyl estradiol</i> (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Lutera Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
<i>norethindrone</i> (Lyleq Oral Tablet 0.35 Mg)	Tier 1	PH
<i>norethindrone</i> (Lyza Oral Tablet 0.35 Mg)	Tier 1	PH
<i>marlissa oral tablet 0.15-30 mg-mcg</i>	Tier 1	PH
<i>medroxyprogesterone acetate intramuscular suspension 150 mg/ml</i>	Tier 1	PH; QL (4 INJECTIONS per 300 days)
<i>medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml</i>	Tier 1	PH; QL (4 INJECTIONS per 300 DAYs)
<i>norethin ace-eth estrad-fe</i> (Merzee Oral Capsule 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethindrone acet-ethinyl est</i> (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norgestimate-eth estradiol</i> (Mili Oral Tablet 0.25-35 Mg-Mcg)	Tier 1	PH
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (<i>levonorgestrel</i>)	Tier 1	PH; QL (1 INTRAUTERINE DEVICE per 300 Days)
<i>norgestimate-eth estradiol</i> (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	Tier 1	PH
MY CHOICE ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
MY WAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (<i>estradiol valerate-dienogest</i>)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Tier 1	PH
NEW DAY ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (<i>etonogestrel</i>)	Tier 1	PH; QL (1 IMPLANT per 300 days)
NEXTSTELLIS ORAL TABLET 3-14.2 MG (<i>drospirenone-estetrol</i>)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Nikki Oral Tablet 3-0.02 Mg)	Tier 1	PH
<i>norethindrone</i> (Nora-Be Oral Tablet 0.35 Mg)	Tier 1	PH
<i>norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr</i>	Tier 1	PH
<i>norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)</i>	Tier 1	PH
<i>norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Tier 1	PH
<i>norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)</i>	Tier 1	PH
<i>norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i>	Tier 1	PH
<i>norethindrone oral tablet 0.35 mg</i>	Tier 1	PH
<i>norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg</i>	Tier 1	PH
<i>norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg</i>	Tier 1	PH
<i>norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg</i>	Tier 1	PH
<i>norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg</i>	Tier 1	PH
<i>norethindrone</i> (Norlyroc Oral Tablet 0.35 Mg)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norethin-eth estrad triphasic</i> (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	Tier 1	PH
<i>norethin-eth estrad triphasic</i> (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Ocella Oral Tablet 3-0.03 Mg)	Tier 1	PH
OMNIFLEX DIAPHRAGM VAGINAL DIAPHRAGM (<i>diaphragms</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
OPCICON ONE-STEP ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
OPILL ORAL TABLET 0.075 MG (<i>norgestrel</i>)	Tier 1	PH
OPTION 2 ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Orsythia Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (<i>copper</i>)	Tier 1	PH; QL (1 INTRAUTERINE DEVICE per 300 days)
<i>norethindrone-eth estradiol</i> (Philith Oral Tablet 0.4-35 Mg-Mcg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>norgestimate-eth estradiol</i> (Previfem Oral Tablet 0.25-35 Mg-Mcg)	Tier 1	PH
REACT ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Rivelsa Oral Tablet 42-21-21-7 Days)	Tier 1	PH
<i>levonorgest-eth estrad 91-day</i> (Setlakin Oral Tablet 0.15-0.03 Mg)	Tier 1	PH
<i>norethindrone</i> (Sharobel Oral Tablet 0.35 Mg)	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>levonorgest-eth estrad 91-day</i> (Simpesse Oral Tablet 0.15-0.03 & 0.01 Mg)	Tier 1	PH
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (<i>levonorgestrel</i>)	Tier 1	PH; QL (1 INTRAUTERINE DEVICE per 300 DAYs)
SLYND ORAL TABLET 4 MG (<i>drospirenone</i>)	Tier 1	PH
<i>norgestimate-eth estradiol</i> (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Syeda Oral Tablet 3-0.03 Mg)	Tier 1	PH
TAKE ACTION ORAL TABLET 1.5 MG (<i>levonorgestrel</i>)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Tarina 24 Fe Oral Tablet 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	Tier 1	PH
<i>norethin ace-eth estrad-fe</i> (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	Tier 1	PH
<i>norethindron-ethinyl estrad-fe</i> (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Tier 1	PH
<i>norethindron-ethinyl estrad-fe</i> (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 1	PH

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>norgestim-eth estrad triphasic</i> (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Tier 1	PH
<i>levonorg-eth estrad triphasic</i> (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Tier 1	PH
<i>norgestim-eth estrad triphasic</i> (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Tier 1	PH
<i>norgestrel-ethinyl estradiol</i> (Turqoz Oral Tablet 0.3-30 Mg-Mcg)	Tier 1	PH
TWIRLA TRANSDERMAL PATCH WEEKLY 120-30 MCG/24HR (<i>levonorgestrel-eth estradiol</i>)	Tier 1	PH
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (<i>levonorgestrel-ethinyl estrad</i>)	Tier 1	PH
<i>drospiren-eth estrad-levomefol</i> (Tydemy Oral Tablet 3-0.03-0.451 Mg)	Tier 1	PH
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (<i>desogestrel-ethinyl estradiol</i>)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Vestura Oral Tablet 3-0.02 Mg)	Tier 1	PH
<i>levonorgestrel-ethinyl estrad</i> (Vienna Oral Tablet 0.1-20 Mg-Mcg)	Tier 1	PH
<i>viorele oral tablet 0.15-0.02/0.01 mg (21/5)</i>	Tier 1	PH
<i>desogestrel-ethinyl estradiol</i> (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	Tier 1	PH
<i>norgestimate-eth estradiol</i> (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	Tier 1	PH
<i>norethindrone-eth estradiol</i> (Wera Oral Tablet 0.5-35 Mg-Mcg)	Tier 1	PH
WIDE-SEAL DIAPHRAGM 60 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
WIDE-SEAL DIAPHRAGM 65 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
WIDE-SEAL DIAPHRAGM 70 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
WIDE-SEAL DIAPHRAGM 75 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
WIDE-SEAL DIAPHRAGM 80 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
WIDE-SEAL DIAPHRAGM 85 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
WIDE-SEAL DIAPHRAGM 90 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
WIDE-SEAL DIAPHRAGM 95 VAGINAL DIAPHRAGM 2 % (<i>diaphragm wide seal</i>)	Tier 1	PH; QL (1 DIAPHRAGM per 300 DAYs)
<i>norethin-eth estradiol-fe</i> (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	Tier 1	PH
<i>norelgestromin-eth estradiol</i> (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	Tier 1	PH
<i>norelgestromin-eth estradiol</i> (Zafemy Transdermal Patch Weekly 150-35 Mcg/24Hr)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Zarah Oral Tablet 3-0.03 Mg)	Tier 1	PH
<i>ethynodiol diac-eth estradiol</i> (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Tier 1	PH
<i>drospirenone-ethinyl estradiol</i> (Zumandimine Oral Tablet 3-0.03 Mg)	Tier 1	PH
DIABETIC SUPPLIES		
ACCU-CHEK AVIVA PLUS IN VITRO STRIP (<i>glucose blood</i>)	Tier 2	QL (150 TEST STRIPS per 30 days)
ACCU-CHEK GUIDE TEST IN VITRO STRIP (<i>glucose blood</i>)	Tier 2	QL (150 TEST STRIPS per 30 DAYs)
ACCU-CHEK SMARTVIEW CONTROL IN VITRO LIQUID (<i>blood glucose calibration</i>)	Tier 2	
ACCU-CHEK SMARTVIEW IN VITRO STRIP (<i>glucose blood</i>)	Tier 2	QL (150 TEST STRIPS per 30 days)
ACCU-CHEK SOFTCLIX LANCETS (<i>lancets</i>)	Tier 2	
<i>alcohol prep pad</i>	Tier 2	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
AUTOLET PLATFORMS (<i>lancets misc.</i>)	Tier 2	
BD VEO INSULIN SYRINGE U/F 31G X 15/64" 1 ML (<i>insulin syringe-needle u-100</i>)	Tier 2	
CHEMSTRIP 9 IN VITRO STRIP (<i>multiple urine tests</i>)	Tier 2	
DEXCOM G6 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	Tier 2	
DEXCOM G6 SENSOR (<i>continuous glucose sensor</i>)	Tier 2	QL (3 SENSORS per 25 DAYS)
DEXCOM G6 TRANSMITTER (<i>continuous glucose transmitter</i>)	Tier 2	
DEXCOM G7 RECEIVER DEVICE (<i>continuous glucose receiver</i>)	Tier 2	
DEXCOM G7 SENSOR (<i>continuous glucose sensor</i>)	Tier 2	QL (3 SENSORS per 25 DAYS)
DIASTIX IN VITRO STRIP (<i>glucose urine test-glucose ox</i>)	Tier 2	
KETOSTIX IN VITRO STRIP (<i>acetone (urine) test</i>)	Tier 2	
<i>lancets</i>	Tier 2	
<i>lancing device</i>	Tier 2	
NOVOFINE PEN NEEDLE 32G X 6 MM (<i>insulin pen needle</i>)	Tier 2	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD 5 DEXG7G6 PODS GEN 5 (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD 5 G7 INTRO (GEN 5) KIT (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD 5 G7 PODS (GEN 5) (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD CLASSIC PODS (GEN 3) (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD DASH INTRO (GEN 4) KIT (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD DASH PDM (GEN 4) KIT (<i>insulin disposable pump</i>)	Tier 2	
OMNIPOD DASH PODS (GEN 4) (<i>insulin disposable pump</i>)	Tier 2	
PRECISION XTRA KETONE IN VITRO STRIP (<i>ketone blood test</i>)	Tier 2	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
V-GO 20 KIT 20 UNIT/24HR (<i>insulin disposable pump</i>)	Tier 2	
V-GO 30 KIT 30 UNIT/24HR (<i>insulin disposable pump</i>)	Tier 2	
V-GO 40 KIT 40 UNIT/24HR (<i>insulin disposable pump</i>)	Tier 2	
ENDOMETRIOSIS		
<i>danazol oral capsule 100 mg, 200 mg, 50 mg</i>	Tier 1	
ORLISSA ORAL TABLET 150 MG, 200 MG (<i>elagolix sodium</i>)	Tier 2	
SYNAREL NASAL SOLUTION 2 MG/ML (<i>nafarelin acetate</i>)	Tier 4	PA
FERTILITY REGULATORS		
<i>chorionic gonadotropin intramuscular solution reconstituted 10000 unit</i>	Tier 4	PA
GLUCOCORTICOIDS - DRUGS TO TREAT INFLAMMATORY RESPONSE		
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML (<i>dexamethasone</i>)	Tier 2	
<i>dexamethasone oral elixir 0.5 mg/5ml</i>	Tier 1	
<i>dexamethasone oral solution 0.5 mg/5ml</i>	Tier 1	
<i>dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg</i>	Tier 1	
<i>fludrocortisone acetate oral tablet 0.1 mg</i>	Tier 1	
<i>hydrocortisone oral tablet 10 mg, 20 mg, 5 mg</i>	Tier 1	
MEDROL ORAL TABLET 2 MG (<i>methylprednisolone</i>)	Tier 2	
<i>methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg</i>	Tier 1	
<i>methylprednisolone oral tablet therapy pack 4 mg</i>	Tier 1	
<i>prednisolone oral solution 15 mg/5ml</i>	Tier 1	
<i>prednisolone sodium phosphate oral solution 15 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml</i>	Tier 1	
<i>prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg</i>	Tier 1	
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML (<i>prednisone</i>)	Tier 2	
<i>prednisone oral solution 5 mg/5ml</i>	Tier 1	
<i>prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)</i>	Tier 1	
GLUCOSE ELEVATING AGENTS - DRUGS TO TREAT LOW BLOOD SUGAR		
<i>glucagon emergency injection kit 1 mg</i>	Tier 1	
HEREDITARY TYROSINEMIA TYPE 1 AGENTS - DRUGS FOR REPLACEMENT, MODIFICATION, TREATMENT		
<i>nitisinone oral capsule 10 mg, 2 mg, 20 mg, 5 mg</i>	Tier 4	PA
ORFADIN ORAL SUSPENSION 4 MG/ML (<i>nitisinone</i>)	Tier 4	PA
HUMAN GROWTH HORMONES - DRUGS TO REGULATE PITUITARY HORMONES		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (<i>somatropin</i>)	Tier 4	PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (<i>somatropin</i>)	Tier 4	PA
NORDIPEN 5 INJECTION DEVICE (<i>injection device</i>)	Tier 2	
NORDIPEN DELIVERY SYSTEM (<i>injection device</i>)	Tier 2	
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML (<i>somatropin</i>)	Tier 4	PA
LYSOSOMAL STORAGE DISORDERS - GAUCHER DISEASE - DRUGS TO TREAT GAUCHER DISEASE		
CERDELGA ORAL CAPSULE 84 MG (<i>eliglustat tartrate</i>)	Tier 4	PA; QL (56 CAPSULES per 28 days)
MENOPAUSAL SYMPTOM AGENTS - DRUGS TO TREAT MENOPAUSE		
BIJUVA ORAL CAPSULE 0.5-100 MG, 1-100 MG (<i>estradiol-progesterone</i>)	Tier 3	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
CLIMARA PRO TRANSDERMAL PATCH WEEKLY 0.045-0.015 MG/DAY (<i>estradiol-levonorgestrel</i>)	Tier 2	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DEPO-ESTRADIOL INTRAMUSCULAR OIL 5 MG/ML (<i>estradiol cypionate</i>)	Tier 3	
DUAVEE ORAL TABLET 0.45-20 MG (<i>conj estrogens-bazedoxifene</i>)	Tier 2	
ELESTRIN TRANSDERMAL GEL 0.52 MG/0.87 GM (0.06%) (<i>estradiol</i>)	Tier 3	PA; AL (Max 70 Years)
<i>estradiol oral tablet 0.5 mg, 2 mg</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>estradiol oral tablet 1 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>estradiol transdermal gel 0.25 mg/0.25gm, 1.25 mg/1.25gm</i>	Tier 1	PA; AL (Max 70 Years)
<i>estradiol transdermal gel 0.5 mg/0.5gm, 0.75 mg/0.75gm, 0.75 mg/1.25 gm (0.06%), 1 mg/gm</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>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</i>	Tier 1	PA; AL (Max 70 Years)
<i>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</i>	Tier 1	PA; AL (Max 70 Years)
<i>estradiol vaginal cream 0.1 mg/gm</i>	Tier 1	
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	Tier 1	
<i>estradiol-norethindrone acet oral tablet 0.5-0.1 mg, 1-0.5 mg</i>	Tier 1	
EVAMIST TRANSDERMAL SOLUTION 1.53 MG/SPRAY (<i>estradiol</i>)	Tier 3	PA; AL (Max 70 Years)
<i>norethindrone-eth estradiol</i> (Fyavolv Oral Tablet 0.5-2.5 Mg-Mcg)	Tier 1	
<i>norethindrone-eth estradiol</i> (Jinteli Oral Tablet 1-5 Mg-Mcg)	Tier 1	
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG, 2.5 MG (<i>esterified estrogens</i>)	Tier 3	PA; AL (Max 70 Years)
<i>estradiol-norethindrone acet</i> (Mimvey Oral Tablet 1-0.5 Mg)	Tier 1	
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
PREMARIN ORAL TABLET 0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG (<i>estrogens conjugated</i>)	Tier 3	PA; AL (Max 70 Years)
PREMARIN VAGINAL CREAM 0.625 MG/GM (<i>estrogens, conjugated</i>)	Tier 3	
<i>estradiol</i> (Yuvafem Vaginal Tablet 10 Mcg)	Tier 1	
MISCELLANEOUS		
<i>betaine oral powder</i>	Tier 4	PA
<i>cabergoline oral tablet 0.5 mg</i>	Tier 1	
CYSTAGON ORAL CAPSULE 150 MG, 50 MG (<i>cysteamine bitartrate</i>)	Tier 4	PA
INTRAROSA VAGINAL INSERT 6.5 MG (<i>prasterone</i>)	Tier 3	
MIFEPREX ORAL TABLET 200 MG (<i>mifepristone</i>)	Tier 3	
<i>mifepristone oral tablet 200 mg</i>	Tier 1	DCN (Available at \$0 copay)
MYALEPT SUBCUTANEOUS SOLUTION RECONSTITUTED 11.3 MG (<i>metreleptin</i>)	Tier 4	PA; QL (30 VIALS per 30 days)
OSPHENA ORAL TABLET 60 MG (<i>ospemifene</i>)	Tier 3	PA
<i>raloxifene hcl oral tablet 60 mg</i>	Tier 1	DCN (\$0 copay for ages 35 and older for the primary prevention of breast cancer); PH; AL (Min 35 Years)
<i>sapropterin dihydrochloride oral packet 100 mg, 500 mg</i>	Tier 4	PA
<i>sapropterin dihydrochloride oral tablet 100 mg</i>	Tier 4	PA
SIGNIFOR SUBCUTANEOUS SOLUTION 0.3 MG/ML, 0.6 MG/ML, 0.9 MG/ML (<i>pasireotide diaspertate</i>)	Tier 4	PA; QL (60 AMPULES per 30 DAYs)
<i>tolvaptan oral tablet 15 mg, 30 mg</i>	Tier 4	PA
PHOSPHATE BINDER AGENTS - DRUGS TO REGULATE CALCIUM AND PHOSPHORUS LEVELS		
<i>calcium acetate (phos binder) oral capsule 667 mg</i>	Tier 1	
<i>calcium acetate oral tablet 667 mg</i>	Tier 1	
FOSRENOL ORAL PACKET 1000 MG, 750 MG (<i>lanthanum carbonate</i>)	Tier 3	
<i>sevelamer carbonate oral packet 0.8 gm, 2.4 gm</i>	Tier 1	
<i>sevelamer carbonate oral tablet 800 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VELPHORO ORAL TABLET CHEWABLE 500 MG (<i>sucroferric oxyhydroxide</i>)	Tier 3	
POTASSIUM-REMOVING AGENTS - DRUGS TO REGULATE POTASSIUM		
<i>sodium polystyrene sulfonate</i> (Sps (Sodium Polystyrene Sulf) Combination Suspension 15 Gm/60MI)	Tier 1	
POTASSIUM-REMOVING AGENTS - DRUGS TO REGULATE POTASSIUM LEVELS		
<i>sodium polystyrene sulfonate</i> (Kionex Combination Suspension 15 Gm/60MI)	Tier 1	
SPS (SODIUM POLYSTYRENE SULF) RECTAL SUSPENSION 30 GM/120ML (<i>sodium polystyrene sulfonate</i>)	Tier 1	
PROGESTINS - DRUGS TO REGULATE PROGESTIN		
CRINONE VAGINAL GEL 4 %, 8 % (<i>progesterone</i>)	Tier 2	
<i>medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg</i>	Tier 1	
<i>megestrol acetate oral suspension 40 mg/ml, 625 mg/5ml</i>	Tier 1	OAC
<i>norethindrone acetate oral tablet 5 mg</i>	Tier 1	
<i>progesterone oral capsule 100 mg, 200 mg</i>	Tier 1	
THYROID AGENTS - DRUGS TO REGULATE THYROID LEVELS		
<i>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</i>	Tier 1	
<i>levothyroxine sodium</i> (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)	Tier 1	
<i>liothyronine sodium oral tablet 25 mcg, 5 mcg, 50 mcg</i>	Tier 1	
<i>methimazole oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>propylthiouracil oral tablet 50 mg</i>	Tier 1	
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 (<i>levothyroxine sodium</i>)	Tier 2	
<i>levothyroxine sodium</i> (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
UREA CYCLE DISORDER - DRUGS TO TREAT UREA CYCLE DISORDER		
<i>carglumic acid oral tablet soluble 200 mg</i>	Tier 4	PA
<i>sodium phenylbutyrate oral powder 3 gm/tsp</i>	Tier 4	PA; QL (798 G per 30 days)
<i>sodium phenylbutyrate oral tablet 500 mg</i>	Tier 4	PA; QL (1200 TABLETS per 30 days)
VASOPRESSINS - DRUGS TO REGULATE PITUITARY HORMONES		
<i>desmopressin ace spray refrig nasal solution 0.01 %</i>	Tier 1	
<i>desmopressin acetate oral tablet 0.1 mg, 0.2 mg</i>	Tier 1	
<i>desmopressin acetate spray nasal solution 0.01 %</i>	Tier 1	
VITAMIN D ANALOGS		
<i>calcitriol oral capsule 0.25 mcg, 0.5 mcg</i>	Tier 1	
<i>calcitriol oral solution 1 mcg/ml</i>	Tier 1	
<i>doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg</i>	Tier 1	
<i>paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg</i>	Tier 1	
GASTROINTESTINAL - DRUGS TO TREAT STOMACH AND INTESTINAL DISORDERS		
ANTICHOLINERGICS		
<i>dicyclomine hcl oral capsule 10 mg</i>	Tier 1	
<i>dicyclomine hcl oral solution 10 mg/5ml</i>	Tier 1	
<i>dicyclomine hcl oral tablet 20 mg</i>	Tier 1	
<i>glycopyrrolate oral solution 1 mg/5ml</i>	Tier 1	
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>methscopolamine bromide oral tablet 2.5 mg, 5 mg</i>	Tier 1	PA; AL (Max 70 Years)
ANTIDIARRHEALS		
<i>diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml</i>	Tier 1	
<i>diphenoxylate-atropine oral tablet 2.5-0.025 mg</i>	Tier 1	
<i>loperamide hcl oral capsule 2 mg</i>	Tier 1	
MOTOFEN ORAL TABLET 1-0.025 MG (<i>difenoxin-atropine</i>)	Tier 3	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ANTIEMETICS - DRUGS FOR NAUSEA AND VOMITING		
AKYNZEO ORAL CAPSULE 300-0.5 MG (<i>netupitant-palonosetron</i>)	Tier 3	QL (2 CAPSULES per 28 days)
<i>aprepitant oral capsule 125 mg</i>	Tier 1	QL (2 CAPSULES per 28 days)
<i>aprepitant oral capsule 40 mg</i>	Tier 1	QL (3 CAPSULES per 180 days)
<i>aprepitant oral capsule 80 & 125 mg</i>	Tier 1	QL (2 PACKS per 28 days)
<i>aprepitant oral capsule 80 mg</i>	Tier 1	QL (4 CAPSULES per 28 days)
<i>prochlorperazine</i> (Compro Rectal Suppository 25 Mg)	Tier 1	
<i>doxylamine-pyridoxine oral tablet delayed release 10-10 mg</i>	Tier 1	
<i>dronabinol oral capsule 10 mg, 2.5 mg, 5 mg</i>	Tier 1	QL (60 CAPSULES per 30 days)
<i>granisetron hcl oral tablet 1 mg</i>	Tier 1	QL (12 TABLETS per 28 days)
<i>meclizine hcl oral tablet 12.5 mg, 25 mg</i>	Tier 1	
<i>metoclopramide hcl oral solution 10 mg/10ml</i>	Tier 1	
<i>metoclopramide hcl oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>metoclopramide hcl oral tablet dispersible 5 mg</i>	Tier 1	
<i>ondansetron hcl oral solution 4 mg/5ml</i>	Tier 1	QL (200 ML per 28 days)
<i>ondansetron hcl oral tablet 24 mg</i>	Tier 1	QL (2 TABLETS per 28 days)
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	Tier 1	QL (18 TABLETS per 28 days)
<i>ondansetron oral tablet dispersible 4 mg, 8 mg</i>	Tier 1	QL (18 TABLETS per 28 days)
<i>prochlorperazine maleate oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>prochlorperazine rectal suppository 25 mg</i>	Tier 1	
<i>promethazine hcl oral solution 6.25 mg/5ml</i>	Tier 1	PA; AL (Max 70 Years)
<i>promethazine hcl oral tablet 12.5 mg, 50 mg</i>	Tier 1	PA; AL (Max 70 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>promethazine hcl oral tablet 25 mg</i>	Tier 1	PA; DCN (High Risk Medications require PA for members age 70 and older); AL (Max 70 Years)
<i>promethazine hcl rectal suppository 12.5 mg, 25 mg</i>	Tier 1	
<i>promethazine hcl</i> (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	Tier 1	
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (<i>promethazine hcl</i>)	Tier 1	
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR (<i>granisetron</i>)	Tier 2	QL (2 PATCHES per 28 days)
<i>scopolamine transdermal patch 72 hour 1 mg/3days</i>	Tier 1	
<i>trimethobenzamide hcl oral capsule 300 mg</i>	Tier 1	
VARUBI (180 MG DOSE) ORAL TABLET THERAPY PACK 2 X 90 MG (<i>rolapitant hcl</i>)	Tier 2	
H2-RECEPTOR ANTAGONISTS - DRUGS FOR ULCERS AND STOMACH ACID		
<i>cimetidine hcl oral solution 300 mg/5ml</i>	Tier 1	
<i>cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg</i>	Tier 1	
<i>famotidine oral suspension reconstituted 40 mg/5ml</i>	Tier 1	
<i>famotidine oral tablet 20 mg, 40 mg</i>	Tier 1	
<i>nizatidine oral capsule 150 mg, 300 mg</i>	Tier 1	
INFLAMMATORY BOWEL DISEASE - BOWEL, INTESTINE, AND STOMACH CONDITION DRUGS		
<i>balsalazide disodium oral capsule 750 mg</i>	Tier 1	
<i>budesonide er oral tablet extended release 24 hour 9 mg</i>	Tier 1	
<i>budesonide oral capsule delayed release particles 3 mg</i>	Tier 1	
DIPENTUM ORAL CAPSULE 250 MG (<i>olsalazine sodium</i>)	Tier 3	
<i>hydrocortisone rectal enema 100 mg/60ml</i>	Tier 1	
<i>mesalamine er oral capsule extended release 24 hour 0.375 gm</i>	Tier 1	
<i>mesalamine oral capsule delayed release 400 mg</i>	Tier 1	
<i>mesalamine oral tablet delayed release 1.2 gm, 800 mg</i>	Tier 1	
<i>mesalamine rectal enema 4 gm</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>mesalamine rectal suppository 1000 mg</i>	Tier 1	
<i>mesalamine-cleanser rectal kit 4 gm</i>	Tier 1	
<i>sulfasalazine oral tablet 500 mg</i>	Tier 1	
<i>sulfasalazine oral tablet delayed release 500 mg</i>	Tier 1	
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION		
LINZESS ORAL CAPSULE 145 MCG, 290 MCG, 72 MCG (<i>linaclotide</i>)	Tier 2	PA
<i>lubiprostone oral capsule 24 mcg, 8 mcg</i>	Tier 1	PA
IRRITABLE BOWEL SYNDROME WITH DIARRHEA		
<i>alose tron hcl oral tablet 0.5 mg, 1 mg</i>	Tier 1	PA
LAXATIVES - DRUGS FOR CONSTIPATION		
CLENPIQ ORAL SOLUTION 10-3.5-12 MG-GM -GM/175ML (<i>sod picosulfate-mag ox-cit acid</i>)	Tier 2	DCN (\$0 copay for members age 45 through 75, Preferred Brand tier for all others); PH; AL (Min 45 Years and Max 75 Years)
<i>enulose oral solution 10 gm/15ml</i>	Tier 1	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (<i>peg 3350-kcl-nabcb-nacl-nasulf</i>)	Tier 1	
<i>peg 3350-kcl-nabcb-nacl-nasulf</i> (Gavilyte-G Oral Solution Reconstituted 236 Gm)	Tier 1	
<i>generlac oral solution 10 gm/15ml</i>	Tier 1	
<i>lactulose oral solution 10 gm/15ml</i>	Tier 1	
<i>na sulfate-k sulfate-mg sulf oral solution 17.5-3.13-1.6 gm/177ml</i>	Tier 1	DCN (\$0 copay for members age 45 through 75, otherwise preferred generic); PH; AL (Min 45 Years and Max 75 Years)
<i>peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm</i>	Tier 1	
<i>peg-3350/electrolytes oral solution reconstituted 236 gm</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm</i>	Tier 1	DCN (\$0 copay for members age 45 through 75, otherwise not covered); PH; AL (Min 45 Years and Max 75 Years)
PEG-PREP ORAL KIT 5-210 MG-GM (<i>bisacodyl-peg-kcl-nabicar-nacl</i>)	Tier 3	DCN (\$0 copay for members age 45 through 75, otherwise not covered); PH; AL (Min 45 Years and Max 75 Years)
PLENVU ORAL SOLUTION RECONSTITUTED 140 GM (<i>peg-kcl-nacl-nasulf-na asc-c</i>)	Tier 3	DCN (\$0 copay for members age 45 through 75, otherwise not covered); PH; AL (Min 45 Years and Max 75 Years)
<i>polyethylene glycol 3350 oral powder 17 gm/scoop</i>	Tier 1	
SUFLAVE ORAL SOLUTION RECONSTITUTED 178.7 GM (<i>peg 3350-kcl-nacl-nasulf-mgsul</i>)	Tier 3	DCN (\$0 copay for members age 45 through 75, otherwise not covered); PH; AL (Min 45 Years and Max 75 Years)
SUTAB ORAL TABLET 1479-225-188 MG (<i>sodium sulfate-mag sulfate-kcl</i>)	Tier 3	DCN (\$0 copay for members age 45 through 75, otherwise not covered); PH; AL (Min 45 Years and Max 75 Years)
MISCELLANEOUS		
<i>cromolyn sodium oral concentrate 100 mg/5ml</i>	Tier 1	
<i>misoprostol oral tablet 100 mcg, 200 mcg</i>	Tier 1	DCN (Available at \$0 copay)
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (<i>naloxegol oxalate</i>)	Tier 2	
SUCRAID ORAL SOLUTION 8500 UNIT/ML (<i>sacrosidase</i>)	Tier 3	PA; QL (354 ML per 30 days)
<i>sucralfate oral tablet 1 gm</i>	Tier 1	
<i>ursodiol oral capsule 300 mg</i>	Tier 1	
<i>ursodiol oral tablet 250 mg, 500 mg</i>	Tier 1	
PANCREATIC ENZYMES		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Tier 2	PA

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Tier 2	PA
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT, 60000-189600 UNIT (<i>pancrelipase (lip-prot-amyl)</i>)	Tier 2	PA
PROTON PUMP INHIBITORS - DRUGS FOR ULCERS AND STOMACH ACID		
<i>esomeprazole magnesium oral capsule delayed release 20 mg, 40 mg</i>	Tier 1	QL (90 CAPSULES per 365 days)
<i>esomeprazole magnesium oral packet 10 mg</i>	Tier 1	QL (90 PACKETS per 365 days); AL (Max 1 Years)
<i>lansoprazole oral capsule delayed release 15 mg, 30 mg</i>	Tier 1	QL (90 CAPSULES per 365 days)
NEXIUM ORAL PACKET 2.5 MG, 5 MG (<i>esomeprazole magnesium</i>)	Tier 3	QL (90 PACKETS per 365 days); AL (Max 1 Years)
<i>omeprazole oral capsule delayed release 10 mg, 20 mg, 40 mg</i>	Tier 1	QL (90 CAPSULES per 365 days)
<i>omeprazole-sodium bicarbonate oral packet 20-1680 mg, 40-1680 mg</i>	Tier 1	QL (90 PACKETS per 365 days)
<i>pantoprazole sodium oral tablet delayed release 20 mg, 40 mg</i>	Tier 1	QL (90 TABLETS per 365 days)
<i>rabeprazole sodium oral tablet delayed release 20 mg</i>	Tier 1	QL (90 TABLETS per 365 days)
RECTAL, CORTICOSTEROIDS		
<i>hydrocortisone (perianal) external cream 1 %, 2.5 %</i>	Tier 1	
<i>hydrocortisone (Proctozone-Hc External Cream 2.5 %)</i>	Tier 1	
ULCER THERAPY COMBINATIONS		
<i>amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
GENITOURINARY - DRUGS TO TREAT GENITAL AND URINARY TRACT CONDITIONS		
BENIGN PROSTATIC HYPERPLASIA - DRUGS TO TREAT ENLARGED PROSTATE		
<i>alfuzosin hcl er oral tablet extended release 24 hour 10 mg</i>	Tier 1	
CARDURA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (<i>doxazosin mesylate</i>)	Tier 3	ST
<i>doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg</i>	Tier 1	
<i>dutasteride oral capsule 0.5 mg</i>	Tier 1	
<i>dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg</i>	Tier 1	
<i>finasteride oral tablet 5 mg</i>	Tier 1	
<i>silodosin oral capsule 4 mg, 8 mg</i>	Tier 1	
<i>tamsulosin hcl oral capsule 0.4 mg</i>	Tier 1	
<i>terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg</i>	Tier 1	
CONTRACEPTIVES - PRODUCTS FOR BIRTH CONTROL		
ENCARE VAGINAL SUPPOSITORY 100 MG (<i>nonoxynol-9</i>)	Tier 1	PH
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (<i>nonoxynol-9</i>)	Tier 1	PH
PHEXXI VAGINAL GEL 1.8-1-0.4 % (<i>lactic ac-citric ac-pot bitart</i>)	Tier 1	PH
SHUR-SEAL CONTRACEPTIVE VAGINAL GEL 2 % (<i>nonoxynol-9</i>)	Tier 1	PH
TODAY SPONGE VAGINAL 1000 MG (<i>nonoxynol-9</i>)	Tier 1	PH
VCF VAGINAL CONTRACEPTIVE VAGINAL FILM 28 % (<i>nonoxynol-9</i>)	Tier 1	PH
VCF VAGINAL CONTRACEPTIVE VAGINAL GEL 4 % (<i>nonoxynol-9</i>)	Tier 1	PH
ERECTILE DYSFUNCTION		
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	Tier 1	PA; QL (30 TABLETS per 30 days)
MISCELLANEOUS		
<i>bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ELMIRON ORAL CAPSULE 100 MG (<i>pentosan polysulfate sodium</i>)	Tier 3	
<i>potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)</i>	Tier 1	
<i>urinary pain relief oral tablet 95 mg</i>	Tier 1	
URINARY ANTISPASMODICS - DRUGS TO TREAT URINARY INCONTINENCE		
<i>darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg</i>	Tier 1	
<i>fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg</i>	Tier 1	
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML (<i>mirabegron</i>)	Tier 2	
<i>oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg</i>	Tier 1	
<i>oxybutynin chloride oral solution 5 mg/5ml</i>	Tier 1	
<i>oxybutynin chloride oral tablet 5 mg</i>	Tier 1	
<i>solifenacin succinate oral tablet 10 mg, 5 mg</i>	Tier 1	
<i>tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg</i>	Tier 1	
<i>tolterodine tartrate oral tablet 1 mg, 2 mg</i>	Tier 1	
<i>tropium chloride er oral capsule extended release 24 hour 60 mg</i>	Tier 1	
<i>tropium chloride oral tablet 20 mg</i>	Tier 1	
VAGINAL ANTI-INFECTIVES - DRUGS TO TREAT VAGINAL INFECTIONS		
CLEOCIN VAGINAL SUPPOSITORY 100 MG (<i>clindamycin phosphate</i>)	Tier 2	
<i>clindamycin phosphate vaginal cream 2 %</i>	Tier 1	
GYNAZOLE-1 VAGINAL CREAM 2 % (<i>butoconazole nitrate (1 dose)</i>)	Tier 3	
<i>metronidazole vaginal gel 0.75 %</i>	Tier 1	
<i>miconazole 3 vaginal suppository 200 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>terconazole vaginal cream 0.4 %, 0.8 %</i>	Tier 1	
<i>terconazole vaginal suppository 80 mg</i>	Tier 1	
HEMATOLOGIC - DRUGS TO TREAT BLOOD DISORDERS		
ANTICOAGULANTS - BLOOD THINNERS		
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (<i>apixaban</i>)	Tier 2	
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (<i>apixaban</i>)	Tier 2	
<i>enoxaparin sodium injection solution 300 mg/3ml</i>	Tier 1	
<i>enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml</i>	Tier 1	
<i>fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml</i>	Tier 1	
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (<i>dalteparin sodium</i>)	Tier 3	
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (<i>dalteparin sodium</i>)	Tier 3	
<i>heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml</i>	Tier 1	
<i>heparin sodium (porcine) pf injection solution 1000 unit/ml, 5000 unit/0.5ml</i>	Tier 1	
<i>warfarin sodium</i> (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	Tier 1	
<i>warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg</i>	Tier 1	
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (<i>rivaroxaban</i>)	Tier 2	
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG (<i>rivaroxaban</i>)	Tier 2	
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (<i>rivaroxaban</i>)	Tier 2	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEMATOPOIETIC GROWTH FACTORS		
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (<i>darbepoetin alfa</i>)	Tier 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 (<i>darbepoetin alfa</i>)	Tier 4	PA
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-pbbk</i>)	Tier 4	PA; QL (2 INJECTIONS per 28 DAYs)
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 120 MCG/0.3ML, 150 MCG/0.3ML, 200 MCG/0.3ML, 30 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML (<i>methoxy peg-epoetin beta</i>)	Tier 4	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (<i>filgrastim-aafi</i>)	Tier 4	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (<i>filgrastim-aafi</i>)	Tier 4	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (<i>pegfilgrastim-apgf</i>)	Tier 4	PA; QL (2 INJECTIONS per 28 DAYs)
RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (<i>epoetin alfa-epbx</i>)	Tier 4	PA
MISCELLANEOUS		
<i>anagrelide hcl oral capsule 0.5 mg, 1 mg</i>	Tier 1	
<i>cilostazol oral tablet 100 mg, 50 mg</i>	Tier 1	
<i>pentoxifylline er oral tablet extended release 400 mg</i>	Tier 1	
<i>tranexamic acid oral tablet 650 mg</i>	Tier 1	
PLATELET AGGREGATION INHIBITORS - BLOOD THINNERS		
<i>aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg</i>	Tier 1	
<i>clopidogrel bisulfate oral tablet 300 mg, 75 mg</i>	Tier 1	
<i>dipyridamole oral tablet 25 mg, 50 mg, 75 mg</i>	Tier 1	PA; AL (Max 70 Years)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>prasugrel hcl oral tablet 10 mg, 5 mg</i>	Tier 1	
YOSPRALA ORAL TABLET DELAYED RELEASE 325-40 MG, 81-40 MG (<i>aspirin-omeprazole</i>)	Tier 3	
ZONTIVITY ORAL TABLET 2.08 MG (<i>vorapaxar sulfate</i>)	Tier 3	
SICKLE CELL DISEASE		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (<i>hydroxyurea</i>)	Tier 2	
THROMBOCYTOPENIA AGENTS - DRUGS TO TREAT PLATELET DISORDERS		
DOPTELET TABLET 20 MG ORAL (<i>avatrombopag maleate</i>)	Tier 4	PA; QL (1 CARTON per 5 DAYS)
DOPTELET TABLET 20 MG ORAL (<i>avatrombopag maleate</i>)	Tier 4	PA; QL (60 TABLETS per 30 DAYS)
IMMUNOLOGIC AGENTS - DRUGS TO TREAT DISORDERS OF THE IMMUNE SYSTEM		
AUTOIMMUNE AGENTS (SELF-ADMINISTERED)		
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (<i>tocilizumab</i>)	Tier 2	PA; QL (4 INJECTIONS per 28 DAYS)
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (<i>tocilizumab</i>)	Tier 2	PA; QL (4 SYRINGES per 28 days)
<i>adalimumab-adaz subcutaneous solution auto-injector 40 mg/0.4ml</i>	Tier 2	PA; QL (4 PENS per 28 DAYS)
<i>adalimumab-adaz subcutaneous solution prefilled syringe 40 mg/0.4ml</i>	Tier 2	PA; QL (4 SYRINGES per 28 DAYS)
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>secukinumab</i>)	Tier 2	PA; QL (300 MG per 28 days)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	Tier 2	PA; QL (300 MG per 28 days)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>secukinumab</i>)	Tier 2	PA; QL (1 PEN per 28 days)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML (<i>secukinumab</i>)	Tier 2	PA; QL (1 SYRINGE per 28 days)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>secukinumab</i>)	Tier 2	PA; QL (1 PEN per 28 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (<i>etanercept</i>)	Tier 2	PA; QL (4 CARTRIDGES per 28 days)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (<i>etanercept</i>)	Tier 2	PA; QL (8 VIALS per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (<i>etanercept</i>)	Tier 2	PA; QL (8 SYRINGES per 28 days)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (<i>etanercept</i>)	Tier 2	PA; QL (4 SYRINGES per 28 days)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (<i>etanercept</i>)	Tier 2	PA; QL (4 SYRINGES per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-adaz</i>)	Tier 2	PA; QL (4 PENS per 28 DAYS)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>adalimumab-adaz</i>)	Tier 2	PA; QL (2 PENS per 28 days)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML (<i>adalimumab-adaz</i>)	Tier 2	PA; QL (2 SYRINGES per 28 DAYS)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML (<i>adalimumab-adaz</i>)	Tier 2	PA; QL (4 SYRINGES per 28 DAYS)
HYRIMOZ-CROHNS/UC STARTER SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (<i>adalimumab-adaz</i>)	Tier 2	PA; DCN (Starter pack - initial dose only); QL (1 KIT per 28 days)
HYRIMOZ-PED<40KG CROHN STARTER SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab-adaz</i>)	Tier 2	PA; DCN (Starter pack - initial dose only); QL (1 KIT per 28 DAYS)
HYRIMOZ-PED>=40KG CROHN START SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML (<i>adalimumab-adaz</i>)	Tier 2	PA; DCN (Starter pack - initial dose only); QL (1 KIT per 28 DAYS)
HYRIMOZ-PLAQUE PSORIASIS START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML (<i>adalimumab-adaz</i>)	Tier 2	PA; DCN (Starter pack - initial dose only); QL (1 KIT per 28 DAYS)
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (<i>baricitinib</i>)	Tier 4	PA; QL (30 TABLETS per 30 DAYS)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (<i>abatacept</i>)	Tier 4	PA; QL (4 PENS per 28 DAYS)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML (<i>abatacept</i>)	Tier 4	PA; QL (4 SYRINGES per 28 DAYS)
OTEZLA ORAL TABLET 20 MG (<i>apremilast</i>)	Tier 2	PA; QL (60 TABLETS per 30 DAYS)
OTEZLA ORAL TABLET 30 MG (<i>apremilast</i>)	Tier 2	PA; QL (60 TABLETS per 30 days)
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (<i>apremilast</i>)	Tier 2	PA; QL (55 TABLETS per 28 days)
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (<i>apremilast</i>)	Tier 2	PA; QL (55 TABLETS per 28 DAYS)
RINVOQ LQ ORAL SOLUTION 1 MG/ML (<i>upadacitinib</i>)	Tier 2	PA; QL (360 ML per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (<i>upadacitinib</i>)	Tier 2	PA; QL (30 TABLETS per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 45 MG (<i>upadacitinib</i>)	Tier 2	PA; DCN (Use only for induction); QL (1 FILL per 1 INDUCTION PERIOD)
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>risankizumab-rzaa</i>)	Tier 2	PA; QL (1 SYRINGE per 84 days)
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML (<i>risankizumab-rzaa</i>)	Tier 2	PA; QL (1 CARTRIDGE per 56 days)
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>risankizumab-rzaa</i>)	Tier 2	PA; QL (1 SYRINGE per 84 days)
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (<i>ustekinumab</i>)	Tier 2	PA; QL (1 VIAL per 84 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML (<i>ustekinumab</i>)	Tier 2	PA; QL (1 SYRINGE per 84 days)
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML (<i>ustekinumab</i>)	Tier 2	PA; QL (1 SYRINGE per 56 days)
DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) - DRUGS TO TREAT RHEUMATOID ARTHRITIS		
<i>hydroxychloroquine sulfate oral tablet 200 mg</i>	Tier 1	
<i>leflunomide oral tablet 10 mg, 20 mg</i>	Tier 1	
<i>methotrexate sodium oral tablet 2.5 mg</i>	Tier 1	OAC

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
HEREDITARY ANGIOEDEMA		
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (<i>c1 esterase inhibitor (human)</i>)	Tier 4	PA; QL (20 VIALS per 30 days)
<i>icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml</i>	Tier 4	PA; QL (45 SYRINGES per 90 days)
IMMUNOGLOBULIN		
HYQVIA SUBCUTANEOUS KIT 10 GM/100ML, 2.5 GM/25ML, 20 GM/200ML, 30 GM/300ML, 5 GM/50ML (<i>immune globulin-hyaluronidase</i>)	Tier 4	PA
IMMUNOMODULATORS		
ACTIMMUNE SUBCUTANEOUS SOLUTION 100 MCG/0.5ML (<i>interferon gamma-1b</i>)	Tier 4	PA
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (<i>rilonacept</i>)	Tier 4	PA; QL (8 VIALS per 28 days)
IMMUNOSUPPRESSANTS		
ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG (<i>tacrolimus</i>)	Tier 3	
<i>azathioprine oral tablet 100 mg, 50 mg, 75 mg</i>	Tier 1	
<i>cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	
<i>cyclosporine modified oral solution 100 mg/ml</i>	Tier 1	
<i>cyclosporine oral capsule 100 mg, 25 mg</i>	Tier 1	
<i>everolimus oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg</i>	Tier 1	
<i>cyclosporine modified</i> (Gengraf Oral Capsule 100 Mg, 25 Mg)	Tier 1	
<i>cyclosporine modified</i> (Gengraf Oral Solution 100 Mg/Ml)	Tier 1	
<i>mycophenolate mofetil oral capsule 250 mg</i>	Tier 1	
<i>mycophenolate mofetil oral suspension reconstituted 200 mg/ml</i>	Tier 1	
<i>mycophenolate mofetil oral tablet 500 mg</i>	Tier 1	
<i>mycophenolate sodium oral tablet delayed release 180 mg, 360 mg</i>	Tier 1	
SANDIMMUNE ORAL SOLUTION 100 MG/ML (<i>cyclosporine</i>)	Tier 3	
<i>sirolimus oral solution 1 mg/ml</i>	Tier 1	
<i>sirolimus oral tablet 0.5 mg, 1 mg, 2 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg</i>	Tier 1	
NUTRITIONAL/SUPPLEMENTS - VITAMINS AND SUPPLEMENTS		
ELECTROLYTES		
<i>potassium bicarbonate</i> (Effer-K Oral Tablet Effervescent 25 Meq)	Tier 1	
<i>potassium chloride</i> (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	Tier 1	
<i>potassium chloride crys er</i> (Klor-Con M15 Oral Tablet Extended Release 15 Meq)	Tier 1	
<i>potassium chloride</i> (Klor-Con Oral Tablet Extended Release 8 Meq)	Tier 1	
<i>potassium chloride crys er oral tablet extended release 10 meq, 20 meq</i>	Tier 1	
<i>potassium chloride er oral capsule extended release 10 meq, 8 meq</i>	Tier 1	
<i>potassium chloride er oral tablet extended release 10 meq, 15 meq, 20 meq, 8 meq</i>	Tier 1	
<i>potassium chloride oral solution 10 %, 20 meq/15ml (10%), 40 meq/15ml (20%)</i>	Tier 1	
<i>sodium fluoride oral solution 1.1 (0.5 f) mg/ml</i>	Tier 1	PH; AL (Max 5 Years)
<i>sodium fluoride oral tablet 1.1 (0.5 f) mg</i>	Tier 1	PH; AL (Max 5 Years)
<i>sodium fluoride oral tablet 2.2 (1 f) mg</i>	Tier 1	
<i>sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg</i>	Tier 1	PH; AL (Max 5 Years)
<i>sodium fluoride oral tablet chewable 2.2 (1 f) mg</i>	Tier 1	
SOLUVITA ORAL SOLUTION 0.5 MG/ML (<i>sodium fluoride</i>)	Tier 3	DCN (\$0 applies for ages 5 and under, otherwise not covered); PH; AL (Max 5 Years)
PRENATAL VITAMINS		
ELITE-OB ORAL TABLET 50-1.25 MG (<i>prenatal vit-iron carbonyl-fa</i>)	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
VITAMINS - VITAMINS AND SUPPLEMENTS		
<i>cyanocobalamin injection solution 1000 mcg/ml</i>	Tier 1	
<i>folic acid oral capsule 0.8 mg</i>	Tier 1	PH; QL (100 CAPSULES per 30 DAYS); AL (Max 55 Years)
<i>folic acid oral tablet 1 mg</i>	Tier 1	
<i>folic acid oral tablet 400 mcg, 800 mcg</i>	Tier 1	PH; QL (100 TABLETS per 30 DAYS); AL (Max 55 Years)
<i>vitamin d (ergocalciferol) oral capsule 50000 unit</i>	Tier 1	
OPHTHALMIC - DRUGS TO TREAT EYE CONDITIONS		
ANTIALLERGICS - DRUGS TO TREAT ALLERGIES		
ALOCRILOPHTHALMIC SOLUTION 2 % (<i>nedocromil sodium</i>)	Tier 3	
ALOMIDE OPHTHALMIC SOLUTION 0.1 % (<i>lodoxamide tromethamine</i>)	Tier 3	
<i>azelastine hcl ophthalmic solution 0.05 %</i>	Tier 1	
<i>bepotastine besilate ophthalmic solution 1.5 %</i>	Tier 1	
<i>cromolyn sodium ophthalmic solution 4 %</i>	Tier 1	
<i>epinastine hcl ophthalmic solution 0.05 %</i>	Tier 1	
<i>olopatadine hcl ophthalmic solution 0.2 %</i>	Tier 1	
ZERVIALE OPHTHALMIC SOLUTION 0.24 % (<i>cetirizine hcl</i>)	Tier 3	
ANTIGLAUCOMA BETA-BLOCKERS - DRUGS TO TREAT GLAUCOMA		
<i>betaxolol hcl ophthalmic solution 0.5 %</i>	Tier 1	
BETIMOLOPHTHALMIC SOLUTION 0.25 %, 0.5 % (<i>timolol hemihydrate</i>)	Tier 3	
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (<i>betaxolol hcl</i>)	Tier 2	
<i>carteolol hcl ophthalmic solution 1 %</i>	Tier 1	
<i>levobunolol hcl ophthalmic solution 0.5 %</i>	Tier 1	
<i>timolol maleate (once-daily) ophthalmic solution 0.5 %</i>	Tier 1	
<i>timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>timolol maleate ophthalmic solution 0.25 %, 0.5 %</i>	Tier 1	
ANTIGLAUCOMA COMBINATION AGENTS - DRUGS TO TREAT GLAUCOMA		
<i>brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %</i>	Tier 1	
<i>dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %</i>	Tier 1	
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (<i>brinzolamide-brimonidine</i>)	Tier 2	
ANTI-INFECTIVE/ANTI-INFLAMMATORY - DRUGS TO TREAT INFECTIONS AND INFLAMMATION		
<i>bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %</i>	Tier 1	
<i>neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1</i>	Tier 1	
<i>neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1</i>	Tier 1	
<i>neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1</i>	Tier 1	
<i>sulfacetamide-prednisolone ophthalmic solution 10-0.23 %</i>	Tier 1	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (<i>tobramycin-dexamethasone</i>)	Tier 2	
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (<i>tobramycin-dexamethasone</i>)	Tier 2	
<i>tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %</i>	Tier 1	
ANTI-INFECTIVES - DRUGS TO TREAT INFECTIONS		
AZASITE OPHTHALMIC SOLUTION 1 % (<i>azithromycin</i>)	Tier 2	
<i>bacitracin ophthalmic ointment 500 unit/gm</i>	Tier 1	
<i>bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm</i>	Tier 1	
<i>ciprofloxacin hcl ophthalmic solution 0.3 %</i>	Tier 1	
<i>erythromycin ophthalmic ointment 5 mg/gm</i>	Tier 1	
<i>gatifloxacin ophthalmic solution 0.5 %</i>	Tier 1	
<i>gentamicin sulfate ophthalmic solution 0.3 %</i>	Tier 1	
<i>moxifloxacin hcl (2x day) ophthalmic solution 0.5 %</i>	Tier 1	
<i>moxifloxacin hcl ophthalmic solution 0.5 %</i>	Tier 1	
NATACYN OPHTHALMIC SUSPENSION 5 % (<i>natamycin</i>)	Tier 2	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000</i>	Tier 1	
<i>neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025</i>	Tier 1	
<i>ofloxacin ophthalmic solution 0.3 %</i>	Tier 1	
<i>bacitracin-polymyxin b</i> (Polycin Ophthalmic Ointment 500-10000 Unit/Gm)	Tier 1	
<i>polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%</i>	Tier 1	
<i>sulfacetamide sodium ophthalmic ointment 10 %</i>	Tier 1	
<i>sulfacetamide sodium ophthalmic solution 10 %</i>	Tier 1	
<i>tobramycin ophthalmic solution 0.3 %</i>	Tier 1	
<i>trifluridine ophthalmic solution 1 %</i>	Tier 1	
ANTI-INFLAMMATORIES - DRUGS TO TREAT INFLAMMATION		
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (<i>ketorolac tromethamine</i>)	Tier 2	
<i>bromfenac sodium (once-daily) ophthalmic solution 0.09 %</i>	Tier 1	
<i>dexamethasone sodium phosphate ophthalmic solution 0.1 %</i>	Tier 1	
<i>diclofenac sodium ophthalmic solution 0.1 %</i>	Tier 1	
<i>difluprednate ophthalmic emulsion 0.05 %</i>	Tier 1	
<i>flurbiprofen sodium ophthalmic solution 0.03 %</i>	Tier 1	
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (<i>nepafenac</i>)	Tier 2	
<i>ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %</i>	Tier 1	
<i>loteprednol etabonate ophthalmic suspension 0.5 %</i>	Tier 1	
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (<i>nepafenac</i>)	Tier 2	
<i>prednisolone acetate ophthalmic suspension 1 %</i>	Tier 1	
<i>prednisolone sodium phosphate ophthalmic solution 1 %</i>	Tier 2	
CARBONIC ANHYDRASE INHIBITORS - DRUGS TO TREAT GLAUCOMA		
<i>brinzolamide ophthalmic suspension 1 %</i>	Tier 1	
<i>dorzolamide hcl ophthalmic solution 2 %</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
DRY EYE DISEASE		
<i>cyclosporine emulsion 0.05 % ophthalmic</i>	Tier 1	PA; QL (1 MULTI-USE VIAL per 28 Days)
<i>cyclosporine emulsion 0.05 % ophthalmic</i>	Tier 1	PA; QL (60 SINGLE USE VIALS per 30 Days)
MISCELLANEOUS		
<i>atropine sulfate ophthalmic solution 1 %</i>	Tier 1	
CYSTARAN OPHTHALMIC SOLUTION 0.44 % (<i>cysteamine hcl</i>)	Tier 4	PA; QL (4 BOTTLES per 28 days)
LACRISERT OPHTHALMIC INSERT 5 MG (<i>artificial tear insert</i>)	Tier 3	
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (<i>echothiophate iodide</i>)	Tier 3	
<i>pilocarpine hcl ophthalmic solution 1 %</i>	Tier 1	
<i>proparacaine hcl ophthalmic solution 0.5 %</i>	Tier 1	
<i>tropicamide ophthalmic solution 0.5 %, 1 %</i>	Tier 1	
PROSTAGLANDINS - DRUGS TO TREAT GLAUCOMA		
<i>latanoprost ophthalmic solution 0.005 %</i>	Tier 1	
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (<i>bimatoprost</i>)	Tier 2	ST
<i>tafluprost (pf) ophthalmic solution 0.0015 %</i>	Tier 1	
<i>travoprost (bak free) ophthalmic solution 0.004 %</i>	Tier 1	
SYMPATHOMIMETICS - DRUGS TO TREAT GLAUCOMA		
<i>apraclonidine hcl ophthalmic solution 0.5 %</i>	Tier 1	
<i>brimonidine tartrate ophthalmic solution 0.1 %, 0.15 %, 0.2 %</i>	Tier 1	
IOPIDINE OPHTHALMIC SOLUTION 1 % (<i>apraclonidine hcl</i>)	Tier 3	
OTHER		
IRRIGATION SOLUTIONS		
<i>irrigation solns physiological</i> (Physiolyte Irrigation Solution)	Tier 1	
<i>irrigation solns physiological</i> (Physiosol Irrigation Irrigation Solution)	Tier 1	
<i>ringers irrigation</i> (Tis-U-Sol Irrigation Solution)	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
RESPIRATORY - DRUGS TO TREAT BREATHING DISORDERS		
ANAPHYLAXIS TREATMENT AGENTS		
<i>epinephrine injection solution auto-injector 0.15 mg/0.15ml, 0.15 mg/0.3ml, 0.3 mg/0.3ml</i>	Tier 1	QL (4 AUTO-INJECTORS per 30 days)
ANTICHOLINERGIC/BETA AGONIST COMBINATIONS - DRUGS TO TREAT COPD		
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (<i>umeclidinium-vilanterol</i>)	Tier 3	QL (1 PACKAGE per 30 days)
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (<i>glycopyrrolate-formoterol</i>)	Tier 3	QL (1 PACKAGE per 30 days)
<i>ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml</i>	Tier 1	QL (6 BOXES per 30 days)
ANTICHOLINERGIC/BETA AGONIST/STEROID COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT, 200-62.5-25 MCG/ACT (<i>fluticasone-umeclidin-vilant</i>)	Tier 2	QL (1 PACKAGE per 30 days)
ANTICHOLINERGICS		
<i>ipratropium bromide inhalation solution 0.02 %</i>	Tier 1	QL (5 BOXES per 30 days)
<i>ipratropium bromide nasal solution 0.03 %, 0.06 %</i>	Tier 1	
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (<i>tiotropium bromide monohydrate</i>)	Tier 2	QL (1 PACKAGE per 30 days)
<i>tiotropium bromide monohydrate inhalation capsule 18 mcg</i>	Tier 1	QL (1 PACKAGE per 30 days)
ANTI-HISTAMINE COMBINATIONS		
<i>azelastine-fluticasone nasal suspension 137-50 mcg/act</i>	Tier 1	QL (1 PACKAGE per 30 days)
ANTI-HISTAMINES - DRUGS TO TREAT ALLERGIES		
<i>azelastine hcl nasal solution 0.1 %, 0.15 %</i>	Tier 1	QL (2 BOTTLES per 30 days)
<i>carbinoxamine maleate oral solution 4 mg/5ml</i>	Tier 1	
<i>carbinoxamine maleate oral tablet 4 mg</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>clemastine fumarate oral tablet 2.68 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>cyproheptadine hcl oral syrup 2 mg/5ml</i>	Tier 1	
<i>cyproheptadine hcl oral tablet 4 mg</i>	Tier 1	
<i>desloratadine oral tablet 5 mg</i>	Tier 1	
<i>desloratadine oral tablet dispersible 2.5 mg, 5 mg</i>	Tier 1	
<i>diphenhydramine hcl oral elixir 12.5 mg/5ml</i>	Tier 1	PA; AL (Max 70 Years)
<i>hydroxyzine hcl oral syrup 10 mg/5ml</i>	Tier 1	PA; AL (Max 70 Years)
<i>hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>hydroxyzine pamoate oral capsule 100 mg, 25 mg, 50 mg</i>	Tier 1	PA; AL (Max 70 Years)
<i>levocetirizine dihydrochloride oral solution 2.5 mg/5ml</i>	Tier 1	
<i>levocetirizine dihydrochloride oral tablet 5 mg</i>	Tier 1	
<i>olopatadine hcl nasal solution 0.6 %</i>	Tier 1	QL (1 CONTAINER per 30 days)
RYCLORA ORAL SOLUTION 2 MG/5ML (<i>dexchlorpheniramine maleate</i>)	Tier 1	PA; AL (Max 70 Years)
BETA AGONISTS - DRUGS TO TREAT ASTHMA AND COPD		
<i>albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act</i>	Tier 1	QL (2 INHALERS per 30 days)
<i>albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml</i>	Tier 1	QL (5 BOXES per 30 days)
<i>albuterol sulfate inhalation nebulization solution 2.5 mg/0.5ml</i>	Tier 1	QL (60 ML per 30 days)
<i>albuterol sulfate oral syrup 2 mg/5ml</i>	Tier 1	
<i>albuterol sulfate oral tablet 2 mg, 4 mg</i>	Tier 1	
<i>arformoterol tartrate inhalation nebulization solution 15 mcg/2ml</i>	Tier 1	QL (60 VIALS per 30 days)
<i>formoterol fumarate inhalation nebulization solution 20 mcg/2ml</i>	Tier 1	QL (60 VIALS per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/3ml</i>	Tier 1	QL (300 ML per 30 days)
<i>levalbuterol hcl inhalation nebulization solution 1.25 mg/0.5ml</i>	Tier 1	QL (45 ML per 30 days)
<i>levalbuterol tartrate inhalation aerosol 45 mcg/act</i>	Tier 1	QL (2 INHALERS per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (<i>salmeterol xinafoate</i>)	Tier 3	QL (1 PACKAGE per 30 days)
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (<i>olodaterol hcl</i>)	Tier 2	QL (1 PACKAGE per 30 days)
<i>terbutaline sulfate oral tablet 2.5 mg, 5 mg</i>	Tier 1	
COLD/COUGH		
<i>benzonatate oral capsule 100 mg, 200 mg</i>	Tier 1	
<i>guaifenesin-codeine oral solution 100-10 mg/5ml</i>	Tier 1	DCN (Limited to 7 day supply per month); QL (60 ML per 1 month)
<i>hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml</i>	Tier 1	DCN (Limited to 7 day supply per month); QL (10 ML per 1 Day)
<i>hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml</i>	Tier 1	DCN (Limited to 7 day supply per month); QL (30 ML per 1 day)
<i>hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg</i>	Tier 1	DCN (Limited to 7 day supply per month); QL (6 TABLETS per 1 day)
<i>hydromet oral solution 5-1.5 mg/5ml</i>	Tier 1	DCN (Limited to 7 day supply per month); QL (30 ML per 1 day)
<i>promethazine vc oral syrup 6.25-5 mg/5ml</i>	Tier 1	
<i>promethazine-codeine oral solution 6.25-10 mg/5ml</i>	Tier 1	DCN (Limited to 7 day supply per month); QL (30 ML per 1 day)
<i>promethazine-dm oral syrup 6.25-15 mg/5ml</i>	Tier 1	
<i>pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml</i>	Tier 1	
CYSTIC FIBROSIS		
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (<i>aztreonam lysine</i>)	Tier 4	PA; QL (84 VIALS per 28 DAYs)
KALYDECO ORAL PACKET 13.4 MG, 5.8 MG (<i>ivacaftor</i>)	Tier 4	PA; QL (56 PACKETS per 28 DAYs)
KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG (<i>ivacaftor</i>)	Tier 4	PA; QL (56 PACKETS per 28 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
KALYDECO ORAL TABLET 150 MG (<i>ivacaftor</i>)	Tier 4	PA; QL (56 TABLETS per 28 days)
ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG (<i>lumacaftor-ivacaftor</i>)	Tier 4	PA; QL (56 PACKETS per 28 days)
ORKAMBI ORAL TABLET 100-125 MG, 200-125 MG (<i>lumacaftor-ivacaftor</i>)	Tier 4	PA; QL (112 TABLETS per 28 days)
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (<i>dornase alfa</i>)	Tier 4	PA; QL (60 AMPULES per 30 DAYS)
SYMDEKO ORAL TABLET THERAPY PACK 100-150 & 150 MG, 50-75 & 75 MG (<i>tezacaftor-ivacaftor</i>)	Tier 4	PA; QL (56 TABLETS per 28 days)
<i>tobramycin inhalation nebulization solution 300 mg/4ml</i>	Tier 4	PA; QL (224 ML per 28 DAYS)
<i>tobramycin inhalation nebulization solution 300 mg/5ml</i>	Tier 1	PA; QL (280 ML per 28 DAYS)
TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	Tier 4	PA; QL (84 TABLETS per 28 DAYS)
TRIKAFTA ORAL THERAPY PACK 100-50-75 & 75 MG, 80-40-60 & 59.5 MG (<i>elexacaftor-tezacaftor-ivacaft</i>)	Tier 4	PA; QL (56 PACKETS per 28 DAYS)
LEUKOTRIENE MODIFIERS		
<i>zileuton er oral tablet extended release 12 hour 600 mg</i>	Tier 1	
LEUKOTRIENE RECEPTOR ANTAGONISTS - DRUGS TO TREAT ASTHMA AND ALLERGIES		
<i>montelukast sodium oral packet 4 mg</i>	Tier 1	
<i>montelukast sodium oral tablet 10 mg</i>	Tier 1	
<i>montelukast sodium oral tablet chewable 4 mg, 5 mg</i>	Tier 1	
<i>zafirlukast oral tablet 10 mg, 20 mg</i>	Tier 1	
MAST CELL STABILIZERS - DRUGS TO TREAT ALLERGIES		
<i>cromolyn sodium inhalation nebulization solution 20 mg/2ml</i>	Tier 1	QL (2 BOXES per 30 days)
MISCELLANEOUS		
<i>acetylcysteine inhalation solution 10 %, 20 %</i>	Tier 1	
<i>roflumilast oral tablet 250 mcg, 500 mcg</i>	Tier 1	PA

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>sodium chloride inhalation nebulization solution 0.9 %, 10 %, 3 %, 7 %</i>	Tier 1	
NASAL STEROIDS - DRUGS TO TREAT ALLERGIES		
<i>flunisolide nasal solution 25 mcg/act (0.025%)</i>	Tier 1	QL (3 CONTAINERS per 30 days)
<i>fluticasone propionate nasal suspension 50 mcg/act</i>	Tier 1	QL (1 CONTAINER per 30 days)
<i>mometasone furoate nasal suspension 50 mcg/act</i>	Tier 1	QL (2 PACKAGES per 30 days)
OMNARIS NASAL SUSPENSION 50 MCG/ACT (<i>ciclesonide</i>)	Tier 3	ST; QL (1 PACKAGE per 30 days)
<i>triamcinolone acetonide nasal aerosol 55 mcg/act</i>	Tier 1	QL (1 PACKAGE per 30 days)
PULMONARY FIBROSIS AGENTS		
OFEV ORAL CAPSULE 100 MG, 150 MG (<i>nintedanib esylate</i>)	Tier 4	PA; QL (60 CAPSULES per 30 days)
<i>pirfenidone oral capsule 267 mg</i>	Tier 4	PA; QL (270 CAPSULES per 30 DAYs)
<i>pirfenidone oral tablet 267 mg</i>	Tier 4	PA; QL (270 TABLETS per 30 days)
<i>pirfenidone oral tablet 801 mg</i>	Tier 4	PA; QL (90 TABLETS per 30 days)
RESPIRATORY THERAPY SUPPLIES		
AEROCHAMBER PLUS FLOW VU (<i>spacer/aero-holding chambers</i>)	Tier 2	
CLEVER CHOICE HOLDING CHAMBER DEVICE (<i>spacer/aero-holding chambers</i>)	Tier 2	
FLEXICHAMBER CHILD MASK/SMALL (<i>spacer/aero-hold chamber mask</i>)	Tier 2	
PEDIATRIC PANDA MASK (<i>spacer/aero-hold chamber mask</i>)	Tier 2	
SEVERE ASTHMA AGENTS		
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (<i>mepolizumab</i>)	Tier 4	PA; QL (3 INJECTIONS per 28 DAYs)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (<i>mepolizumab</i>)	Tier 4	PA; QL (3 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (<i>omalizumab</i>)	Tier 4	PA; QL (8 PENS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (<i>omalizumab</i>)	Tier 4	PA; QL (4 PENS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 75 MG/0.5ML (<i>omalizumab</i>)	Tier 4	PA; QL (2 PENS per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (<i>omalizumab</i>)	Tier 4	PA; QL (8 SYRINGES per 28 DAYS)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MG/2ML (<i>omalizumab</i>)	Tier 4	PA; QL (4 SYRINGES per 28 days)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML (<i>omalizumab</i>)	Tier 4	PA; QL (2 SYRINGES per 28 DAYS)
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (<i>omalizumab</i>)	Tier 4	PA; QL (8 VIALS per 28 DAYS)
STEROID INHALANTS - DRUGS TO TREAT ASTHMA		
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT, 50 MCG/ACT (<i>fluticasone furoate</i>)	Tier 3	QL (1 PACKAGE per 30 days)
<i>budesonide inhalation suspension 0.25 mg/2ml</i>	Tier 1	QL (3 BOXES per 30 days)
<i>budesonide inhalation suspension 0.5 mg/2ml</i>	Tier 1	QL (2 BOXES per 30 days)
<i>budesonide inhalation suspension 1 mg/2ml</i>	Tier 1	QL (1 BOX per 30 days)
QVAR REDHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (<i>beclomethasone diprop hfa</i>)	Tier 2	QL (2 PACKAGES per 30 days)
STEROID/BETA-AGONIST COMBINATIONS - DRUGS TO TREAT ASTHMA AND COPD		
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (<i>fluticasone furoate-vilanterol</i>)	Tier 2	QL (1 PACKAGE per 30 days)
<i>budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act</i>	Tier 1	DCN (Listing does not include certain NDCs); QL (3 PACKAGES per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act</i>	Tier 1	QL (1 PACKAGE per 30 days)
<i>fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 250-50 mcg/act, 500-50 mcg/act</i>	Tier 1	QL (1 PACKAGE per 30 days)
XANTHINES - DRUGS TO TREAT COPD		
<i>theophylline er oral tablet extended release 12 hour 100 mg, 200 mg, 300 mg, 450 mg</i>	Tier 1	
<i>theophylline er oral tablet extended release 24 hour 400 mg, 600 mg</i>	Tier 1	
<i>theophylline oral elixir 80 mg/15ml</i>	Tier 1	
<i>theophylline oral solution 80 mg/15ml</i>	Tier 1	
TOPICAL - DRUGS TO TREAT EAR AND SKIN CONDITIONS		
DERMATOLOGY, ACNE		
<i>adapalene external cream 0.1 %</i>	Tier 1	PA; QL (45 G per 28 days); AL (Max 35 Years)
<i>adapalene external gel 0.1 %, 0.3 %</i>	Tier 1	PA; QL (45 G per 28 days); AL (Max 35 Years)
<i>adapalene-benzoyl peroxide external gel 0.1-2.5 %, 0.3-2.5 %</i>	Tier 1	
<i>benzoyl peroxide-erythromycin external gel 5-3 %</i>	Tier 1	QL (47 G per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1.2-5 %</i>	Tier 1	QL (45 G per 30 days)
<i>clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %</i>	Tier 1	QL (50 G per 30 days)
<i>clindamycin phosphate external foam 1 %</i>	Tier 1	
<i>clindamycin phosphate external gel 1 %</i>	Tier 1	QL (75 G per 30 days)
<i>clindamycin phosphate external lotion 1 %</i>	Tier 1	QL (60 ML per 30 days)
<i>clindamycin phosphate external solution 1 %</i>	Tier 1	QL (60 ML per 30 days)
<i>clindamycin phosphate external swab 1 %</i>	Tier 1	
<i>ery external pad 2 %</i>	Tier 1	
<i>erythromycin external gel 2 %</i>	Tier 1	QL (60 G per 30 days)
<i>erythromycin external solution 2 %</i>	Tier 1	QL (60 ML per 30 days)
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	Tier 1	PA
<i>sulfacetamide sodium (acne) external lotion 10 %</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>tretinoin external cream 0.025 %, 0.05 %, 0.1 %</i>	Tier 1	PA; AL (Max 35 Years)
<i>tretinoin external gel 0.01 %, 0.025 %, 0.05 %</i>	Tier 1	PA; AL (Max 35 Years)
<i>tretinoin microsphere external gel 0.1 %</i>	Tier 1	PA; AL (Max 35 Years)
<i>tretinoin microsphere pump external gel 0.04 %</i>	Tier 1	PA; AL (Max 35 Years)
DERMATOLOGY, ACTINIC KERATOSIS		
<i>fluorouracil external cream 5 %</i>	Tier 1	
<i>fluorouracil external solution 2 %, 5 %</i>	Tier 1	
<i>imiquimod external cream 5 %</i>	Tier 1	
DERMATOLOGY, ANTIBIOTICS		
<i>gentamicin sulfate external cream 0.1 %</i>	Tier 1	
<i>gentamicin sulfate external ointment 0.1 %</i>	Tier 1	
<i>mupirocin external ointment 2 %</i>	Tier 1	QL (30 G per 30 days)
<i>silver sulfadiazine external cream 1 %</i>	Tier 1	
<i>silver sulfadiazine (Ssd External Cream 1 %)</i>	Tier 1	
SULFAMYLYON EXTERNAL CREAM 85 MG/GM (<i>mafenide acetate</i>)	Tier 3	
DERMATOLOGY, ANTIFUNGALS		
<i>ciclopirox external gel 0.77 %</i>	Tier 1	QL (120 G per 30 days)
<i>ciclopirox external shampoo 1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>ciclopirox olamine external cream 0.77 %</i>	Tier 1	QL (120 G per 30 days)
<i>ciclopirox olamine external suspension 0.77 %</i>	Tier 1	QL (120 ML per 30 days)
<i>clotrimazole external cream 1 %</i>	Tier 1	QL (120 G per 30 days)
<i>clotrimazole external solution 1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>clotrimazole-betamethasone external cream 1-0.05 %</i>	Tier 1	QL (60 G per 30 days)
<i>clotrimazole-betamethasone external lotion 1-0.05 %</i>	Tier 1	QL (60 ML per 30 days)
<i>econazole nitrate external cream 1 %</i>	Tier 1	QL (60 G per 30 days)
<i>keetoconazole external cream 2 %</i>	Tier 1	QL (120 G per 30 days)
<i>luliconazole external cream 1 %</i>	Tier 1	QL (60 G per 30 days)
<i>naftifine hcl external cream 1 %, 2 %</i>	Tier 1	QL (60 G per 30 days)
<i>nystatin (Nyamyc External Powder 100000 Unit/Gm)</i>	Tier 1	QL (120 G per 30 days)
<i>nystatin external cream 100000 unit/gm</i>	Tier 1	QL (120 G per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>nystatin external ointment 100000 unit/gm</i>	Tier 1	QL (120 G per 30 days)
<i>nystatin external powder 100000 unit/gm</i>	Tier 1	QL (120 G per 30 days)
<i>nystatin-triamcinolone external cream 100000-0.1 unit/gm-%</i>	Tier 1	QL (60 G per 30 days)
<i>nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%</i>	Tier 1	QL (60 G per 30 days)
<i>nystatin</i> (Nystop External Powder 100000 Unit/Gm)	Tier 1	QL (120 G per 30 days)
<i>oxiconazole nitrate external cream 1 %</i>	Tier 1	QL (60 G per 30 days)
<i>sulconazole nitrate external cream 1 %</i>	Tier 1	QL (60 G per 30 days)
<i>sulconazole nitrate external solution 1 %</i>	Tier 1	QL (60 ML per 30 days)
DERMATOLOGY, ANTIPRURITIC		
<i>doxepin hcl external cream 5 %</i>	Tier 1	ST; QL (45 G per 30 days)
DERMATOLOGY, ANTIPSORIATICS		
<i>acitretin oral capsule 10 mg, 17.5 mg, 25 mg</i>	Tier 1	
<i>calcipotriene external solution 0.005 %</i>	Tier 1	ST; QL (60 ML per 30 days)
<i>calcipotriene-betameth diprop external ointment 0.005-0.064 %</i>	Tier 1	ST; QL (60 G per 30 days)
<i>calcitriol external ointment 3 mcg/gm</i>	Tier 1	ST; QL (100 G per 30 days)
<i>methoxsalen rapid oral capsule 10 mg</i>	Tier 1	
<i>tazarotene external cream 0.05 %, 0.1 %</i>	Tier 1	PA
<i>tazarotene external gel 0.05 %, 0.1 %</i>	Tier 1	PA
TAZORAC EXTERNAL CREAM 0.05 % (<i>tazarotene</i>)	Tier 2	PA
VTAMA EXTERNAL CREAM 1 % (<i>tapinarof</i>)	Tier 3	
DERMATOLOGY, ANTISEBORRHEICS		
<i>ketoconazole external shampoo 2 %</i>	Tier 1	QL (120 ML per 30 days)
<i>selenium sulfide external lotion 2.5 %</i>	Tier 1	
DERMATOLOGY, ATOPIC DERMATITIS		
EUCRISA EXTERNAL OINTMENT 2 % (<i>crisaborole</i>)	Tier 3	ST; QL (60 G per 30 days)
<i>tacrolimus external ointment 0.03 %, 0.1 %</i>	Tier 1	
DERMATOLOGY, CORTICOSTEROIDS		
<i>ala-cort external cream 1 %</i>	Tier 1	QL (120 G per 30 days)
<i>alclometasone dipropionate external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>alclometasone dipropionate external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>amcinonide external lotion 0.1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>amcinonide external ointment 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone dipropionate aug external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone dipropionate aug external gel 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone dipropionate aug external lotion 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>betamethasone dipropionate aug external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone dipropionate external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone dipropionate external lotion 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>betamethasone valerate external cream 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone valerate external foam 0.12 %</i>	Tier 1	QL (120 G per 30 days)
<i>betamethasone valerate external lotion 0.1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>betamethasone valerate external ointment 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>clobetasol propionate e external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>clobetasol propionate external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>clobetasol propionate external foam 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>clobetasol propionate external gel 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>clobetasol propionate external liquid 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>clobetasol propionate external lotion 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>clobetasol propionate external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>clobetasol propionate external shampoo 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>clobetasol propionate external solution 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>clocortolone pivalate external cream 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>desonide external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>desonide external lotion 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>desonide external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>desoximetasone external cream 0.05 %, 0.25 %</i>	Tier 1	QL (120 G per 30 days)
<i>desoximetasone external gel 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>desoximetasone external ointment 0.25 %</i>	Tier 1	QL (120 G per 30 days)
<i>diflorasone diacetate external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>diflorasone diacetate external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>fluocinolone acetonide body external oil 0.01 %</i>	Tier 1	QL (120 ML per 30 days)
<i>fluocinolone acetonide external cream 0.01 %, 0.025 %</i>	Tier 1	QL (120 G per 30 days)
<i>fluocinolone acetonide external ointment 0.025 %</i>	Tier 1	QL (120 G per 30 days)
<i>fluocinolone acetonide external solution 0.01 %</i>	Tier 1	QL (120 ML per 30 days)
<i>fluocinolone acetonide scalp external oil 0.01 %</i>	Tier 1	QL (120 ML per 30 days)
<i>fluocinonide external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>fluocinonide external gel 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>fluocinonide external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>fluocinonide external solution 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>fluticasone propionate external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>fluticasone propionate external lotion 0.05 %</i>	Tier 1	QL (120 ML per 30 days)
<i>fluticasone propionate external ointment 0.005 %</i>	Tier 1	QL (120 G per 30 days)
<i>halobetasol propionate external cream 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>halobetasol propionate external ointment 0.05 %</i>	Tier 1	QL (120 G per 30 days)
<i>hydrocortisone butyrate external cream 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>hydrocortisone butyrate external ointment 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>hydrocortisone butyrate external solution 0.1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>hydrocortisone external cream 1 %, 2.5 %</i>	Tier 1	QL (120 G per 30 days)
<i>hydrocortisone external lotion 2.5 %</i>	Tier 1	QL (120 ML per 30 days)
<i>hydrocortisone external ointment 2.5 %</i>	Tier 1	QL (120 G per 30 days)
<i>hydrocortisone valerate external cream 0.2 %</i>	Tier 1	QL (120 G per 30 days)
<i>hydrocortisone valerate external ointment 0.2 %</i>	Tier 1	QL (120 G per 30 days)
<i>mometasone furoate external cream 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>mometasone furoate external ointment 0.1 %</i>	Tier 1	QL (120 G per 30 days)
<i>mometasone furoate external solution 0.1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %</i>	Tier 1	QL (120 G per 30 days)
<i>triamcinolone acetonide external lotion 0.025 %, 0.1 %</i>	Tier 1	QL (120 ML per 30 days)
<i>triamcinolone acetonide external ointment 0.025 %, 0.1 %, 0.5 %</i>	Tier 1	QL (120 G per 30 days)
DERMATOLOGY, LOCAL ANESTHETICS		
<i>lidocaine external ointment 5 %</i>	Tier 1	QL (50 G per 30 days)

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>lidocaine external patch 5 %</i>	Tier 1	PA; QL (90 PATCHES per 30 days)
<i>lidocaine hcl external solution 4 %</i>	Tier 1	QL (50 ML per 30 days)
<i>lidocaine hcl urethral/mucosal external prefilled syringe 2 %</i>	Tier 1	QL (60 ML per 30 days)
<i>lidocaine-prilocaine external cream 2.5-2.5 %</i>	Tier 1	QL (30 G per 30 days)
DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE		
<i>acyclovir external cream 5 %</i>	Tier 1	
<i>ammonium lactate external cream 12 %</i>	Tier 1	
<i>ammonium lactate external lotion 12 %</i>	Tier 1	
<i>bexarotene external gel 1 %</i>	Tier 4	PA
<i>diclofenac sodium external gel 1 %</i>	Tier 1	QL (300 G per 30 days)
<i>nitroglycerin rectal ointment 0.4 %</i>	Tier 1	
<i>penciclovir external cream 1 %</i>	Tier 1	
<i>podofilox external gel 0.5 %</i>	Tier 1	
<i>podofilox external solution 0.5 %</i>	Tier 1	
VOLTAREN ARTHRITIS PAIN EXTERNAL GEL 1 % (<i>diclofenac sodium</i>)	Tier 1	QL (300 G per 30 days)
DERMATOLOGY, ROSACEA		
<i>azelaic acid external gel 15 %</i>	Tier 1	
<i>brimonidine tartrate external gel 0.33 %</i>	Tier 1	PA
FINACEA EXTERNAL FOAM 15 % (<i>azelaic acid</i>)	Tier 2	
<i>metronidazole external cream 0.75 %</i>	Tier 1	QL (60 G per 30 days)
<i>metronidazole external gel 0.75 %, 1 %</i>	Tier 1	QL (60 G per 30 days)
<i>metronidazole external lotion 0.75 %</i>	Tier 1	QL (60 ML per 30 days)
DERMATOLOGY, SCABICIDES AND PEDICULICIDES		
CROTAN EXTERNAL LOTION 10 % (<i>crotamiton</i>)	Tier 1	
<i>cvs ivermectin lice treatment external lotion 0.5 %</i>	Tier 1	
<i>cvs lice treatment external liquid 1 %</i>	Tier 1	
<i>lice treatment external liquid 1 %</i>	Tier 1	
<i>malathion external lotion 0.5 %</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>permethrin external cream 5 %</i>	Tier 1	
<i>sb lice treatment external liquid 1 %</i>	Tier 1	
SKLICE EXTERNAL LOTION 0.5 % (<i>ivermectin</i>)	Tier 2	
<i>sm lice treatment external liquid 1 %</i>	Tier 1	
<i>spinosad external suspension 0.9 %</i>	Tier 1	
DERMATOLOGY, WOUND CARE AGENTS		
REGRANEX EXTERNAL GEL 0.01 % (<i>becaplermin</i>)	Tier 3	PA; QL (30 G per 30 days)
<i>sodium chloride irrigation solution 0.9 %</i>	Tier 1	
MOUTH/THROAT/DENTAL AGENTS		
<i>cevimeline hcl oral capsule 30 mg</i>	Tier 1	
<i>chlorhexidine gluconate mouth/throat solution 0.12 %</i>	Tier 1	
<i>clotrimazole mouth/throat troche 10 mg</i>	Tier 1	QL (90 LOZENGES per 30 days)
<i>lidocaine hcl mouth/throat solution 4 %</i>	Tier 1	
<i>lidocaine viscous hcl mouth/throat solution 2 %</i>	Tier 1	
<i>nystatin mouth/throat suspension 100000 unit/ml</i>	Tier 1	
<i>triamcinolone acetonide</i> (Oralene Mouth/Throat Paste 0.1 %)	Tier 1	
ORAVIG BUCCAL TABLET 50 MG (<i>miconazole</i>)	Tier 3	QL (14 TABLETS per 30 days)
<i>chlorhexidine gluconate</i> (Periogard Mouth/Throat Solution 0.12 %)	Tier 1	
<i>pilocarpine hcl oral tablet 5 mg, 7.5 mg</i>	Tier 1	
<i>triamcinolone acetonide mouth/throat paste 0.1 %</i>	Tier 1	
OTIC - DRUGS TO TREAT CONDITIONS OF THE EAR		
<i>acetic acid otic solution 2 %</i>	Tier 1	
<i>ciprofloxacin hcl otic solution 0.2 %</i>	Tier 1	
<i>ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %</i>	Tier 1	
<i>ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %</i>	Tier 1	
CORTISPORIN-TC OTIC SUSPENSION 3.3-3-10-0.5 MG/ML (<i>neomycin-colist-hc-thonzonium</i>)	Tier 3	
<i>fluocinolone acetonide otic oil 0.01 %</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<i>hydrocortisone-acetic acid otic solution 1-2 %</i>	Tier 1	
<i>neomycin-polymyxin-hc otic solution 1 %</i>	Tier 1	
<i>neomycin-polymyxin-hc otic suspension 3.5-10000-1</i>	Tier 1	
<i>ofloxacin otic solution 0.3 %</i>	Tier 1	

2025 Pharmacy Drug Guide - Aetna Health Exchange Plan - California PPO

The formulary is updated the first week of each month.

Tier 1=Most generic and low-cost preferred brand | Tier 2=Preferred Brand and Non-Preferred Generic |

Tier 3=Non-Preferred Brands | Tier 4=Specialty | PA=Prior Authorization | ST=Step Therapy |

QL=Quantity Limits | AL=Age Limits | PH=Preventive Health | OAC=Oral Anti-Cancer Drugs | DCN=Drug

Coverage Note | QLR=QL Restriction based on Age

02/01/2025

Index

<i>abacavir sulfate</i>	25	<i>allopurinol</i>	18	ARISTADA.....	58
<i>abacavir sulfate-lamivudine</i>	28	<i>almotriptan malate</i>	66	ARISTADA INITIO.....	58
<i>abiraterone acetate</i>	37	ALOCRI.....	113	<i>armodafinil</i>	70
<i>acamprosate calcium</i>	51	<i>alogliptin benzoate</i>	74	ARNUITY ELLIPTA.....	122
<i>acarbose</i>	73	<i>alogliptin-metformin hcl</i>	74	<i>asenapine maleate</i>	58
ACCU-CHEK AVIVA PLUS....	91	ALOMIDE.....	113	Ashlyna.....	80
ACCU-CHEK GUIDE TEST....	91	<i>alose tron hcl</i>	101	<i>aspirin adult low strength</i>	24
ACCU-CHEK SMARTVIEW ...	91	<i>alprazolam</i>	52	<i>aspirin-dipyridamole er</i>	107
ACCU-CHEK SMARTVIEW		ALPRAZOLAM INTENSOL....	52	ASTAGRAF XL.....	111
CONTROL		Altavera.....	80	<i>atazanavir sulfate</i>	26
.....	91	<i>alyacen 1/35</i>	80	<i>atenolol</i>	46
ACCU-CHEK SOFTCLIX		<i>alyacen 7/7/7</i>	80	<i>atenolol-chlorthalidone</i>	46
LANCETS		<i>amantadine hcl</i>	57	<i>atomoxetine hcl</i>	63
.....	91	<i>ambrisentan</i>	50	<i>atorvastatin calcium</i>	45
<i>acebutolol hcl</i>	46	<i>amcinonide</i>	126	<i>atovaquone</i>	34
<i>acetaminophen-codeine</i>	19, 23	Amethyst.....	80	<i>atovaquone-proguanil hcl</i>	25
<i>acetazolamide</i>	48	<i>amiloride hcl</i>	48	<i>atropine sulfate</i>	116
<i>acetazolamide er</i>	48	<i>amiloride-hydrochlorothiazide</i> ..	49	Aubra Eq.....	80
<i>acetic acid</i>	129	<i>amiodarone hcl</i>	44	Aurovela 1.5/30.....	80
<i>acetylcysteine</i>	120	<i>amitriptyline hcl</i>	53	Aurovela 1/20.....	80
<i>acitretin</i>	125	<i>amlodipine besy-benazepril hcl</i> ..	42	Aurovela 24 Fe.....	80
ACTEMRA.....	108	<i>amlodipine besylate</i>	47	Aurovela Fe 1.5/30.....	80
ACTEMRA ACTPEN.....	108	<i>amlodipine besylate-valsartan</i> ...	43	Aurovela Fe 1/20.....	80
ACTIMMUNE.....	111	<i>amlodipine-atorvastatin</i>	47	AUTOLET PLATFORMS.....	92
ACUVAIL.....	115	<i>amlodipine-olmesartan</i>	43	AUVELITY.....	53
<i>acyclovir</i>	30, 128	<i>ammonium lactate</i>	128	Aviane.....	80
<i>adalimumab-adaz</i>	108	<i>amoxapine</i>	53	<i>avidoxy</i>	35
<i>adapalene</i>	123	<i>amoxicill-clarithro-lansopraz</i> ..	103	Ayuna.....	80
<i>adapalene-benzoyl peroxide</i>	123	<i>amoxicillin</i>	35	AZASITE.....	114
<i>adefovir dipivoxil</i>	33	<i>amoxicillin-pot clavulanate</i>	35	<i>azathioprine</i>	111
ADEMPAS.....	50	<i>amoxicillin-pot clavulanate er</i> ...	35	<i>azelaic acid</i>	128
AEROCHAMBER PLUS		<i>amphetamine-dextroamphet er</i> ..	63	<i>azelastine hcl</i>	113, 117
FLOW VU		<i>amphetamine-</i>		<i>azelastine-fluticasone</i>	117
.....	121	<i>dextroamphetamine</i>		<i>azithromycin</i>	32
Afirmelle.....	79	.....	63	Azurette.....	80
AFTERA.....	79	<i>ampicillin</i>	35	<i>bacitracin</i>	114
AFTERPILL.....	79	<i>anagrelide hcl</i>	107	<i>bacitracin-polymyxin b</i>	114
AIMOVIG.....	66	<i>anastrozole</i>	37	<i>bacitra-neomycin-polymyxin-</i>	
AJOVY.....	66	ANNOVERA.....	80	<i>hc</i>	
AKYNZEO.....	99	ANORO ELLIPTA.....	117	.....	114
<i>ala-cort</i>	125	APOKYN.....	57	<i>baclofen</i>	69
<i>albendazole</i>	24	<i>apraclonidine hcl</i>	116	<i>balsalazide disodium</i>	100
<i>albuterol sulfate</i>	118	<i>aprepitant</i>	99	Balziva.....	80
<i>albuterol sulfate hfa</i>	118	Apri.....	80	BARACLUDGE.....	33
<i>alclometasone dipropionate</i>	125	APTIVUS.....	25	BASAGLAR KWIKPEN.....	75
<i>alcohol prep</i>	91	Aranelle.....	80	BASAGLAR TEMPO PEN.....	75
ALECENSA.....	38	ARANESP (ALBUMIN FREE)		BAXDELA.....	32
<i>alendronate sodium</i>	79	.....	107		
<i>alfuzosin hcl er</i>	104	ARCALYST.....	111		
ALINIA.....	34	<i>arformoterol tartrate</i>	118		
<i>aliskiren fumarate</i>	48	<i>aripiprazole</i>	58		

BD VEO INSULIN SYRINGE U/F	<i>buprenorphine hcl-naloxone hcl</i>	<i>cephalexin</i>	92	32
.....	.....	CERDELGA	65	94
BELSOMRA	<i>bupropion hcl</i>	<i>cevimeline hcl</i>	42	129
<i>benazepril hcl</i>	<i>bupropion hcl er (smoking det)</i>	Charlotte 24 Fe	42	81
<i>benazepril-hydrochlorothiazide</i>	<i>bupropion hcl er (sr)</i>	Chateal Eq	24	81
<i>benznidazole</i>	<i>bupropion hcl er (xl)</i>	CHEMET	119	79
<i>benzonatate</i>	<i>buspirone hcl</i>	CHEMSTRIP 9	123	92
<i>benzoyl peroxide-erythromycin</i>	<i>butorphanol tartrate</i>	<i>chlordiazepoxide hcl</i>	77	52
<i>benzphetamine hcl</i>	<i>cabergoline</i>	<i>chlordiazepoxide-amitriptyline</i>	57	71
<i>benztropine mesylate</i>	CABOMETYX	<i>chlorhexidine gluconate</i>	113	129
<i>bepotastine besilate</i>	<i>calcipotriene</i>	<i>chloroquine phosphate</i>	96	25
<i>betaine</i>	<i>calcipotriene-betameth diprop</i>	<i>chlorpromazine hcl</i>	126	59
<i>betamethasone dipropionate</i>	<i>calcitonin (salmon)</i>	<i>chlorthalidone</i>	.....	49
<i>betamethasone dipropionate aug</i>	<i>calcitriol</i>	<i>chlorzoxazone</i>	.....	69
.....	<i>calcium acetate</i>	<i>cholestyramine</i>	126	44
<i>betamethasone valerate</i>	<i>calcium acetate (phos binder)</i>	<i>cholestyramine light</i>	126	44
BETASERON	CALQUENCE	<i>chorionic gonadotropin</i>	68	93
<i>betaxolol hcl</i>	Camila	<i>ciclopirox</i>	46, 113	124
<i>bethanechol chloride</i>	Camrese	<i>ciclopirox olamine</i>	104	124
BETIMOL	Camrese Lo	<i>cilostazol</i>	113	107
BETOPTIC-S	<i>candesartan cilexetil</i>	CIMDUO	113	28
BEVESPI AEROSPHERE	<i>candesartan cilexetil-hctz</i>	<i>cimetidine</i>	117	100
<i>bexarotene</i>	<i>capecitabine</i>	<i>cimetidine hcl</i>	41, 128	100
<i>bicalutamide</i>	CAPLYTA	<i>cinacalcet hcl</i>	37	79
BIJUVA	CAPRELSA	CIPRO	94	32
BIKTARVY	<i>captopril</i>	<i>ciprofloxacin hcl</i>	28	32, 114, 129
<i>bisoprolol fumarate</i>	<i>carbamazepine</i>	<i>ciprofloxacin-dexamethasone</i>	47	129
<i>bisoprolol-hydrochlorothiazide</i>	<i>carbamazepine er</i>	<i>ciprofloxacin-fluocinolone pf</i>	46	129
Blisovi 24 Fe	<i>carbidopa</i>	<i>citalopram hydrobromide</i>	80	54
Blisovi Fe 1.5/30	<i>carbidopa-levodopa</i>	<i>clarithromycin</i>	81	32
Blisovi Fe 1/20	<i>carbidopa-levodopa er</i>	<i>clarithromycin er</i>	81	32
<i>bosentan</i>	<i>carbidopa-levodopa- entacapone</i>	<i>clemastine fumarate</i>	50	118
BREO ELLIPTA	<i>carbinoxamine maleate</i>	CLENPIQ	122	101
<i>briellyn</i>	CARDURA XL	CLEOCIN	81	105
<i>brimonidine tartrate</i>	<i>carglumic acid</i>	CLEVER CHOICE HOLDING CHAMBER	116, 128	.....
<i>brimonidine tartrate-timolol</i>	<i>carisoprodol</i>	.....	114	121
<i>brinzolamide</i>	<i>carteolol hcl</i>	CLIMARA PRO	115	94
<i>bromfenac sodium (once-daily)</i>	Cartia Xt	<i>clindamycin hcl</i>	115	34
.....	<i>carvedilol</i>	<i>clindamycin palmitate hcl</i>	115	34
<i>bromocriptine mesylate</i>	<i>carvedilol phosphate er</i>	<i>clindamycin phos-benzoyl perox</i>	57	.....
<i>budesonide</i>	CAYA	.....	100, 122	123
<i>budesonide er</i>	CAYSTON	<i>clindamycin phosphate</i>	100	105, 123
<i>budesonide-formoterol fumarate</i>	<i>cefaclor</i>	<i>clobazam</i>	122	60
.....	<i>cefadroxil</i>	<i>clobetasol propionate</i>	122	126
<i>bumetanide</i>	<i>cefdinir</i>	<i>clobetasol propionate e</i>	49	126
<i>buprenorphine</i>	<i>cefixime</i>	<i>clocortolone pivalate</i>	23, 24	126
<i>buprenorphine hcl</i>	<i>cefpodoxime proxetil</i>	<i>clomipramine hcl</i>	71	52
	<i>cefprozil</i>	<i>clonazepam</i>		60
	<i>cefuroxime axetil</i>	<i>clonidine</i>		49
	<i>celecoxib</i>	<i>clonidine hcl</i>		49

<i>clopidogrel bisulfate</i>	107	<i>dasatinib</i>	38	<i>difluprednate</i>	115
<i>clorazepate dipotassium</i>	60	Dasetta 1/35.....	81	<i>digoxin</i>	48
<i>clotrimazole</i>	124, 129	Dasetta 7/7/7.....	81	<i>dihydroergotamine mesylate</i>	66
<i>clotrimazole-betamethasone</i>	124	Daysee.....	81	DILANTIN.....	60
<i>clozapine</i>	59	DAYVIGO.....	65	<i>diltiazem hcl</i>	48
COARTEM.....	25	Deblitane.....	81	<i>diltiazem hcl er</i>	47, 48
<i>codeine sulfate</i>	19	<i>deferiprone</i>	79	<i>diltiazem hcl er beads</i>	47
<i>colchicine</i>	18	DELSTRIGO.....	28	<i>diltiazem hcl er coated beads</i>	47
<i>colchicine-probenecid</i>	18	Delyla.....	82	<i>dilt-xr</i>	48
<i>colestipol hcl</i>	44	<i>demeclocycline hcl</i>	35	<i>dimethyl fumarate</i>	68
COMPLERA.....	28	DEPO-ESTRADIOL.....	95	<i>dimethyl fumarate starter pack</i> ..	68
Compro.....	99	DEPO-SUBQ PROVERA 104... 82		DIPENTUM.....	100
<i>condoms</i>	81	DESCOVY.....	29	<i>diphenhydramine hcl</i>	118
CONTRACE.....	78	<i>desipramine hcl</i>	54	<i>diphenoxylate-atropine</i>	98
CORLANOR.....	49	<i>desloratadine</i>	118	<i>dipyridamole</i>	107
CORTISPORIN-TC.....	129	<i>desmopressin ace spray refrig</i> ... 98		<i>disopyramide phosphate</i>	44
COSENTYX.....	108	<i>desmopressin acetate</i>	98	<i>disulfiram</i>	51
COSENTYX (300 MG DOSE).108		<i>desmopressin acetate spray</i>	98	DIURIL.....	49
COSENTYX SENSOREADY		<i>desogestrel-ethinyl estradiol</i> 82		<i>divalproex sodium</i>	61
(300 MG)		<i>desonide</i>	126	<i>divalproex sodium er</i>	60
.....	108	<i>desoximetasone</i>	126	<i>dofetilide</i>	44
COSENTYX SENSOREADY		<i>desvenlafaxine succinate er</i>.....54		Dolishale.....	82
PEN		<i>dexamethasone</i>	93	<i>donepezil hcl</i>	52
.....	108	DEXAMETHASONE		DOPTELET.....	108
COSENTYX UNOREADY.....	108	INTENSOL		<i>dorzolamide hcl</i>	115
CREON.....	102	.....	93	<i>dorzolamide hcl-timolol mal</i>	114
CRESEMBA.....	25	<i>dexamethasone sodium</i>		DOVATO.....	29
CRINONE.....	97	<i>phosphate</i>		<i>doxazosin mesylate</i>	104
<i>cromolyn sodium</i>	102, 113, 120	.....	115	<i>doxepin hcl</i>	54, 65, 125
CROTAN.....	128	DEXCOM G6 RECEIVER.....	92	<i>doxercalciferol</i>	98
Cryselle-28.....	81	DEXCOM G6 SENSOR.....	92	<i>doxycycline hyclate</i>	35
CURAE.....	81	DEXCOM G6 TRANSMITTER 92		<i>doxycycline monohydrate</i>	36
<i>cvs ivermectin lice treatment</i> ... 128		DEXCOM G7 RECEIVER.....	92	<i>doxylamine-pyridoxine</i>	99
<i>cvs lice treatment</i>	128	DEXCOM G7 SENSOR.....	92	<i>dronabinol</i>	99
<i>cyanocobalamin</i>	113	<i>dexmethylphenidate hcl</i>	63	<i>drospiren-eth estrad-levomefol</i> ..82	
Cyclafem 1/35.....	81	<i>dexmethylphenidate hcl er</i>	63	<i>drospirenone-ethinyl estradiol</i> ...82	
Cyclafem 7/7/7.....	81	<i>dextroamphetamine sulfate</i>	63	DROXIA.....	108
<i>cyclobenzaprine hcl</i>	70	<i>dextroamphetamine sulfate er</i> ...63		DUAVEE.....	95
<i>cyclophosphamide</i>	36	DIASTIX.....	92	<i>duloxetine hcl</i>	55
<i>cycloserine</i>	30	<i>diazepam</i>	60	<i>dutasteride</i>	104
<i>cyclosporine</i>	111, 116	Diazepam Intensol.....	60	<i>dutasteride-tamsulosin hcl</i>.....104	
<i>cyclosporine modified</i>	111	<i>diclofenac potassium</i>	18	<i>econazole nitrate</i>	124
<i>cyproheptadine hcl</i>	118	<i>diclofenac sodium</i>	18, 115, 128	ECONTRA ONE-STEP.....	82
Cyred Eq.....	81	<i>diclofenac sodium er</i>	18	EDURANT.....	26
CYSTAGON.....	96	<i>diclofenac-misoprostol</i>	19	<i>efavirenz</i>	26
CYSTARAN.....	116	<i>dicloxacillin sodium</i>	35	<i>efavirenz-emtricitab-tenofo df</i> ... 29	
<i>dalfampridine er</i>	68	<i>dicyclomine hcl</i>	98	<i>efavirenz-emtricitab-tenofovir</i> ... 29	
<i>danazol</i>	93	<i>diethylpropion hcl</i>	78	<i>efavirenz-lamivudine-tenofovir</i> .. 29	
<i>dantrolene sodium</i>	70	<i>diethylpropion hcl er</i>	78	Effer-K.....	112
<i>dapsone</i>	34	DIFICID.....	32	ELESTRIN.....	95
<i>darifenacin hydrobromide er</i> ... 105		<i>diflorasone diacetate</i>	126	<i>eletriptan hydrobromide</i>	66
<i>darunavir</i>	26	<i>diflunisal</i>	24	ELIGARD.....	37

Elinest.....	82	<i>estradiol-norethindrone acet</i>	95	FLEXICHAMBER CHILD	
ELIQUIS.....	106	<i>eszopiclone</i>	65	MASK/SMALL	
ELIQUIS DVT/PE STARTER		<i>ethacrynic acid</i>	49	.....	121
PACK		<i>ethambutol hcl</i>	30	<i>fluconazole</i>	25
.....	106	<i>ethosuximide</i>	61	<i>fludrocortisone acetate</i>	93
ELITE-OB.....	112	<i>ethynodiol diac-eth estradiol</i>	82	<i>flunisolide</i>	121
ELLA.....	82	<i>etodolac</i>	18	<i>fluocinolone acetonide</i>	127, 129
ELMIRON.....	105	<i>etodolac er</i>	18	<i>fluocinolone acetonide body</i> ...	127
Eluryng.....	82	<i>etonogestrel-ethinyl estradiol</i> ...	82	<i>fluocinolone acetonide scalp</i> ...	127
EMCYT.....	36	<i>etoposide</i>	42	<i>fluocinonide</i>	127
EMGALITY.....	66	<i>etravirine</i>	26	<i>fluorouracil</i>	124
EMGALITY (300 MG DOSE)...	66	EUCRISA.....	125	<i>fluoxetine hcl</i>	55
<i>emtricitabine</i>	26	EVAMIST.....	95	<i>fluphenazine hcl</i>	59
<i>emtricitabine-tenofovir df</i>	29	<i>everolimus</i>	39, 111	<i>flurbiprofen</i>	18
EMTRIVA.....	26	EVOTAZ.....	29	<i>flurbiprofen sodium</i>	115
EMVERM.....	24	EVRYSDI.....	67	<i>fluticasone furoate-vilanterol</i> ..	123
Emzahn.....	82	<i>exemestane</i>	37	<i>fluticasone propionate</i>	121, 127
<i>enalapril maleate</i>	42	<i>ezetimibe</i>	44	<i>fluticasone-salmeterol</i>	123
<i>enalapril-hydrochlorothiazide</i> ...	42	<i>ezetimibe-simvastatin</i>	45	<i>fluvastatin sodium</i>	45
ENBREL.....	109	Falmina.....	82	<i>fluvastatin sodium er</i>	45
ENBREL MINI.....	109	<i>famciclovir</i>	30	<i>fluvoxamine maleate</i>	52
ENBREL SURECLICK.....	109	<i>famotidine</i>	100	<i>fluvoxamine maleate er</i>	52
ENCARE.....	104	FANAPT.....	59	<i>folic acid</i>	113
Endocet.....	19	FANAPT TITRATION PACK...	59	<i>fondaparinux sodium</i>	106
Enilloring.....	82	FC2 FEMALE CONDOM.....	82	<i>formoterol fumarate</i>	118
<i>enoxaparin sodium</i>	106	<i>febuxostat</i>	18	FOSAMAX PLUS D.....	79
Enpresse-28.....	82	<i>felbamate</i>	61	<i>fosamprenavir calcium</i>	26
Enskyce.....	82	<i>felodipine er</i>	48	<i>fosfomycin tromethamine</i>	24
<i>entacapone</i>	58	FEMCAP.....	83	<i>fosinopril sodium</i>	42
<i>entecavir</i>	33	FEMLYV.....	83	<i>fosinopril sodium-hctz</i>	42
ENTRESTO.....	49	<i>fenofibrate</i>	45	FOSRENOL.....	96
<i>enulose</i>	101	<i>fenofibrate micronized</i>	45	FRAGMIN.....	106
EPCLUSA.....	33	<i>fenofibric acid</i>	45	<i>frovatriptan succinate</i>	66
EPIDIOLEX.....	61	<i>fenoprofen calcium</i>	18	<i>furosemide</i>	49
<i>epinastine hcl</i>	113	<i>fentanyl</i>	19	Fyavolv.....	95
<i>epinephrine</i>	117	<i>fentanyl citrate</i>	19	FYLNETHRA.....	107
Epitol.....	61	FERRIPROX.....	79	<i>gabapentin</i>	61
<i>eplerenone</i>	42	FERRIPROX TWICE-A-DAY...	79	<i>galantamine hydrobromide</i> ..	52, 53
<i>ergotamine-caffeine</i>	66	<i>fesoterodine fumarate er</i>	105	<i>galantamine hydrobromide er</i> ...	52
<i>erlotinib hcl</i>	38, 39	FETZIMA.....	55	<i>gatifloxacin</i>	114
Errin.....	82	FETZIMA TITRATION.....	55	GAVILYTE-C.....	101
<i>ery</i>	123	FIASP.....	75	Gavilyte-G.....	101
Ery-Tab.....	32	FIASP FLEXTOUCH.....	75	<i>gemfibrozil</i>	45
<i>erythromycin</i>	114, 123	FIASP PENFILL.....	75	Gemmily.....	83
<i>erythromycin base</i>	32	FIASP PUMPCART.....	75	<i>generlac</i>	101
<i>erythromycin ethylsuccinate</i>	32	FINACEA.....	128	Gengraf.....	111
<i>escitalopram oxalate</i>	55	<i>finasteride</i>	104	GENOTROPIN.....	94
<i>esomeprazole magnesium</i>	103	<i>fingolimod hcl</i>	68	GENOTROPIN MINIQUICK...	94
Estarylla.....	82	Finzala.....	83	<i>gentamicin sulfate</i>	114, 124
<i>estazolam</i>	65	<i>flecainide acetate</i>	44	GENVOYA.....	29
<i>estradiol</i>	95			<i>glatiramer acetate</i>	68
<i>estradiol valerate</i>	95			Glatopa.....	68

GLEOSTINE.....	36	<i>hydroxychloroquine sulfate</i>	110	<i>itraconazole</i>	25
<i>glimepiride</i>	77	<i>hydroxyurea</i>	41	<i>ivabradine hcl</i>	49
<i>glipizide</i>	77	<i>hydroxyzine hcl</i>	118	<i>ivermectin</i>	24
<i>glipizide er</i>	77	<i>hydroxyzine pamoate</i>	118	Jaimiess.....	83
<i>glipizide-metformin hcl</i>	74	HYQVIA.....	111	JAKAFI.....	39
<i>glucagon emergency</i>	94	HYRIMOZ.....	109	Jantoven.....	106
<i>glycopyrrolate</i>	98	HYRIMOZ-CROHNS/UC		JANUMET.....	74
GLYXAMBI.....	77	STARTER		JANUMET XR.....	74
<i>goodsense aspirin</i>	24	.....	109	JANUVIA.....	74
<i>goodsense nicotine</i>	72	HYRIMOZ-PED<40KG		JARDIANCE.....	77
<i>granisetron hcl</i>	99	CROHN STARTER		Jasmiel.....	83
<i>griseofulvin microsize</i>	25	.....	109	Jencycla.....	83
<i>griseofulvin ultramicrosize</i>	25	HYRIMOZ-PED>/=40KG		Jinteli.....	95
<i>guaifenesin-codeine</i>	119	CROHN START		Jolessa.....	83
<i>guanfacine hcl</i>	49	.....	109	Joyeaux.....	83
<i>guanfacine hcl er</i>	63	HYRIMOZ-PLAQUE		Juleber.....	84
GYNAZOLE-1.....	105	PSORIASIS START		JULUCA.....	29
HAEGARDA.....	111	.....	109	Junel 1.5/30.....	84
Hailey 1.5/30.....	83	<i>ibandronate sodium</i>	79	Junel 1/20.....	84
Hailey 24 Fe.....	83	IBRANCE.....	39	Junel Fe 1.5/30.....	84
Hailey Fe 1.5/30.....	83	<i>ibuprofen</i>	18	Junel Fe 1/20.....	84
Hailey Fe 1/20.....	83	<i>icatibant acetate</i>	111	Junel Fe 24.....	84
<i>halobetasol propionate</i>	127	Iclevia.....	83	Kaitlib Fe.....	84
Haloette.....	83	<i>icosapent ethyl</i>	46	Kalliga.....	84
<i>haloperidol</i>	59	ILEVRO.....	115	KALYDECO.....	119, 120
<i>haloperidol lactate</i>	59	<i>imatinib mesylate</i>	39	Kariva.....	84
HARVONI.....	33	IMBRUVICA.....	39	Kelnor 1/35.....	84
Heather.....	83	<i>imipramine hcl</i>	55	Kelnor 1/50.....	84
<i>heparin sodium (porcine)</i>	106	<i>imipramine pamoate</i>	55	KERENDIA.....	43
<i>heparin sodium (porcine) pf</i>	106	<i>imiquimod</i>	124	<i>ketoconazole</i>	124, 125
HER STYLE.....	83	Incassia.....	83	<i>ketorolac tromethamine</i>	18, 115
HUMULIN R U-500		<i>indapamide</i>	49	KETOSTIX.....	92
(CONCENTRATED)		INLYTA.....	39	Kionex.....	97
.....	75	INTELENCE.....	26	Klor-Con.....	112
HUMULIN R U-500		INTRAROSA.....	96	Klor-Con 10.....	112
KWIKPEN	75	Introvale.....	83	Klor-Con M15.....	112
<i>hydralazine hcl</i>	50	IOPIDINE.....	116	KLOXXADO.....	71
<i>hydrochlorothiazide</i>	49	<i>ipratropium bromide</i>	117	Kurvelo.....	84
<i>hydrocod poli-chlorphe poli er</i>	119	<i>ipratropium-albuterol</i>	117	KYLEENA.....	84
<i>hydrocodone bitartrate er</i>	20	<i>irbesartan</i>	43	<i>labetalol hcl</i>	47
<i>hydrocodone bit-homatrop mbr</i>		<i>irbesartan-hydrochlorothiazide</i>	43	<i>lacosamide</i>	61
.....	119	ISENTRESS.....	26	LACRISERT.....	116
<i>hydrocodone-acetaminophen</i>	20	ISENTRESS HD.....	26	<i>lactulose</i>	101
<i>hydrocodone-ibuprofen</i>	20	Isibloom.....	83	LAGEVRIO.....	30
<i>hydrocortisone</i>	93, 100, 127	<i>isoniazid</i>	30	<i>lamivudine</i>	26, 27, 33
<i>hydrocortisone (perianal)</i>	103	<i>isosorb dinitrate-hydralazine</i>	49	<i>lamivudine-zidovudine</i>	29
<i>hydrocortisone butyrate</i>	127	<i>isosorbide dinitrate</i>	50	<i>lamotrigine</i>	61
<i>hydrocortisone valerate</i>	127	<i>isosorbide mononitrate</i>	50	<i>lamotrigine er</i>	61
<i>hydrocortisone-acetic acid</i>	130	<i>isosorbide mononitrate er</i>	50	<i>lamotrigine starter kit-blue</i>	61
<i>hydromet</i>	119	<i>isotretinoin</i>	123	<i>lamotrigine starter kit-green</i>	61
<i>hydromorphone hcl</i>	20	<i>isradipine</i>	48	<i>lamotrigine starter kit-orange</i> ...	61
<i>hydromorphone hcl er</i>	20	ITOVEBI.....	39	<i>lancets</i>	92

<i>lancing device</i>	92	<i>levonorgest-eth estradiol-iron</i>	85	LYNPARZA.....	41
<i>lansoprazole</i>	103	<i>levonorgestrel</i>	85	LYSODREN.....	38
Larin 1.5/30.....	84	<i>levonorgestrel-ethinyl estrad</i>	85	Lyza.....	86
Larin 1/20.....	84	<i>levonorg-eth estrad triphasic</i>	85	<i>malathion</i>	128
Larin 24 Fe.....	84	Levora 0.15/30 (28).....	85	<i>maraviroc</i>	27
Larin Fe 1.5/30.....	84	<i>levorphanol tartrate</i>	21	<i>marlissa</i>	86
Larin Fe 1/20.....	85	<i>levothyroxine sodium</i>	97	MARPLAN.....	55
<i>latanoprost</i>	116	Levoxyl.....	97	MATULANE.....	36
Layolis Fe.....	85	<i>lice treatment</i>	128	Matzim La.....	48
Leena.....	85	<i>lidocaine</i>	127, 128	MAVENCLAD (10 TABS).....	68
<i>leflunomide</i>	110	<i>lidocaine hcl</i>	128, 129	MAVENCLAD (4 TABS).....	68
LENVIMA (10 MG DAILY DOSE)	40	<i>lidocaine hcl urethral/mucosal</i>	128	MAVENCLAD (5 TABS).....	68
.....	40	<i>lidocaine viscous hcl</i>	129	MAVENCLAD (6 TABS).....	68
LENVIMA (12 MG DAILY DOSE)	40	<i>lidocaine-prilocaine</i>	128	MAVENCLAD (7 TABS).....	68
.....	40	LILETTA (52 MG).....	85	MAVENCLAD (8 TABS).....	68
LENVIMA (14 MG DAILY DOSE)	40	<i>linezolid</i>	34	MAVENCLAD (9 TABS).....	69
.....	40	LINZESS.....	101	MAYZENT.....	69
LENVIMA (18 MG DAILY DOSE)	40	<i>liothyronine sodium</i>	97	MAYZENT STARTER PACK..	69
.....	40	<i>liraglutide</i>	74	<i>meclizine hcl</i>	99
LENVIMA (20 MG DAILY DOSE)	40	<i>lisdexamphetamine dimesylate</i>	64	<i>meclofenamate sodium</i>	18
.....	40	<i>lisinopril</i>	42	MEDROL.....	93
LENVIMA (24 MG DAILY DOSE)	40	<i>lisinopril-hydrochlorothiazide</i> ...	42	<i>medroxyprogesterone acetate</i>	86, 97
.....	40	<i>lithium</i>	67	<i>mefenamic acid</i>	18
LENVIMA (4 MG DAILY DOSE)	40	<i>lithium carbonate</i>	67	<i>mefloquine hcl</i>	25
.....	40	<i>lithium carbonate er</i>	67	<i>megestrol acetate</i>	38, 97
LENVIMA (8 MG DAILY DOSE)	40	LO LOESTRIN FE.....	85	MEKINIST.....	40
.....	40	Loestrin 1.5/30 (21).....	85	<i>meloxicam</i>	18
Lessina.....	85	Loestrin 1/20 (21).....	85	<i>memantine hcl</i>	53
<i>letrozole</i>	38	Loestrin Fe 1.5/30.....	85	<i>memantine hcl er</i>	53
<i>leucovorin calcium</i>	41	Loestrin Fe 1/20.....	85	MENEST.....	95
LEUKERAN.....	36	<i>lofexidine hcl</i>	71	<i>meprobamate</i>	52
<i>leuprolide acetate</i>	38	Lojaimiess.....	86	<i>mercaptopurine</i>	36
<i>levabuterol hcl</i>	118	<i>loperamide hcl</i>	98	Merzee.....	86
<i>levabuterol tartrate</i>	118	<i>lopinavir-ritonavir</i>	29	<i>mesalamine</i>	100, 101
LEVEMIR.....	76	<i>lorazepam</i>	52	<i>mesalamine er</i>	100
LEVEMIR FLEXPEN.....	76	LORBRENA.....	40	<i>mesalamine-cleanser</i>	101
<i>levetiracetam</i>	61	Loryna.....	86	MESNEX.....	41
<i>levetiracetam er</i>	61	<i>losartan potassium</i>	43	<i>metaxalone</i>	70
<i>levobunolol hcl</i>	113	<i>losartan potassium-hctz</i>	43	<i>metformin hcl</i>	74
<i>levocetirizine dihydrochloride</i> ..	118	<i>loteprednol etabonate</i>	115	<i>metformin hcl er</i>	74
<i>levofloxacin</i>	32, 33	<i>lovastatin</i>	45	<i>methadone hcl</i>	21
Levonest.....	85	Low-Ogestrel.....	86	Methadone Hcl Intensol.....	21
<i>levonorgest-eth est & eth est</i>	85	<i>loxapine succinate</i>	59	Methadose.....	21
<i>levonorgest-eth estrad 91-day</i>	85	Lo-Zumandimine.....	86	<i>methamphetamine hcl</i>	64
		<i>lubiprostone</i>	101	<i>methazolamide</i>	49
		LUCEMYRA.....	71	<i>methenamine hippurate</i>	34
		<i>luliconazole</i>	124	<i>methimazole</i>	97
		LUMIGAN.....	116	<i>methocarbamol</i>	70
		<i>lurasidone hcl</i>	59	<i>methotrexate sodium</i>	36, 110
		Lutera.....	86	<i>methoxsalen rapid</i>	125
		LYBALVI.....	59	<i>methscopolamine bromide</i>	98
		Lyleq.....	86		

<i>methsuximide</i>	61	<i>mycophenolate sodium</i>	111	NITRO-DUR.....	50
<i>methyldopa</i>	50	MYRBETRIQ.....	105	<i>nitrofurantoin</i>	34
<i>methylphenidate hcl</i>	64	<i>na sulfate-k sulfate-mg sulf</i>	101	<i>nitrofurantoin macrocrystal</i>	34
<i>methylphenidate hcl er</i>	64	<i>nabumetone</i>	19	<i>nitrofurantoin monohyd macro</i>	34
<i>methylphenidate hcl er (cd)</i>	64	<i>nadolol</i>	47	<i>nitroglycerin</i>	50, 128
<i>methylphenidate hcl er (la)</i>	64	<i>naftifine hcl</i>	124	NIVESTYM.....	107
<i>methylphenidate hcl er (osm)</i>	64	<i>naloxone hcl</i>	71	<i>nizatidine</i>	100
<i>methylprednisolone</i>	93	<i>naltrexone hcl</i>	71	Nora-Be.....	87
<i>metoclopramide hcl</i>	99	<i>naproxen</i>	19	NORDIPEN 5 INJECTION	
<i>metolazone</i>	49	<i>naratriptan hcl</i>	66	DEVICE	
<i>metoprolol succinate er</i>	47	NARCAN.....	71	.....	94
<i>metoprolol tartrate</i>	47	NATACYN.....	114	NORDIPEN DELIVERY	
<i>metoprolol-</i>		NATAZIA.....	87	SYSTEM	
<i>hydrochlorothiazide</i>	46	<i>nateglinide</i>	77	.....	94
<i>metronidazole</i>	34, 105, 128	NAYZILAM.....	61	NORDITROPIN FLEXPEN.....	94
Mibelas 24 Fe.....	86	<i>nebivolol hcl</i>	47	<i>norelgestromin-eth estradiol</i>	87
<i>miconazole 3</i>	105	Necon 0.5/35 (28).....	87	<i>norethin ace-eth estrad-fe</i>	87
Microgestin 1.5/30.....	86	<i>nefazodone hcl</i>	55	<i>norethindrone</i>	87
Microgestin 1/20.....	86	<i>neomycin sulfate</i>	24	<i>norethindrone acetate</i>	97
Microgestin Fe 1.5/30.....	86	<i>neomycin-bacitracin zn-</i>		<i>norethindrone acet-ethinyl est</i>	87
Microgestin Fe 1/20.....	86	<i>polymyx</i>		<i>norethindrone-eth estradiol</i>	95
<i>midodrine hcl</i>	50	.....	115	<i>norethindron-ethinyl estrad-fe</i>	87
MIFEPREX.....	96	<i>neomycin-polymyxin-dexameth</i>		<i>norethin-eth estradiol-fe</i>	87
<i>mifepristone</i>	96	.....	114	<i>norgestimate-eth estradiol</i>	87
<i>miglitol</i>	74	<i>neomycin-polymyxin-</i>		<i>norgestim-eth estrad triphasic</i>	87
Mili.....	86	<i>gramicidin</i>		Norlyroc.....	87
Mimvey.....	95	.....	115	NORPACE CR.....	44
<i>minocycline hcl</i>	36	<i>neomycin-polymyxin-hc</i>	114, 130	Nortrel 0.5/35 (28).....	87
<i>minoxidil</i>	50	NEUPRO.....	58	Nortrel 1/35 (21).....	87
MIRCERA.....	107	NEVANAC.....	115	Nortrel 7/7/7.....	88
MIRENA (52 MG).....	86	<i>nevirapine</i>	27	<i>nortriptyline hcl</i>	55, 56
<i>mirtazapine</i>	55	<i>nevirapine er</i>	27	NORVIR.....	27
<i>misoprostol</i>	102	NEW DAY.....	87	NOVOFINE PEN NEEDLE.....	92
<i>modafinil</i>	70	NEXIUM.....	103	NOVOLIN 70/30.....	76
<i>moexipril hcl</i>	42	NEXLETOL.....	44	NOVOLIN 70/30 FLEXPEN.....	76
<i>mometasone furoate</i>	121, 127	NEXPLANON.....	87	NOVOLIN N.....	76
Mono-Linyah.....	86	NEXTSTELLIS.....	87	NOVOLIN N FLEXPEN.....	76
<i>montelukast sodium</i>	120	<i>niacin er (antihyperlipidemic)</i>	46	NOVOLIN R.....	76
<i>morphine sulfate</i>	21, 22	<i>nicardipine hcl</i>	48	NOVOLIN R FLEXPEN.....	76
<i>morphine sulfate (concentrate)</i>	21	<i>nicotine</i>	72	NOVOLOG.....	76
<i>morphine sulfate er</i>	21	<i>nicotine polacrilex</i>	72	NOVOLOG FLEXPEN.....	76
MOTOFEN.....	98	<i>nicotine step 3</i>	72	NOVOLOG MIX 70/30.....	76
MOUNJARO.....	75	NICOTROL.....	72	NOVOLOG MIX 70/30	
MOVANTIK.....	102	NICOTROL NS.....	73	FLEXPEN	
<i>moxifloxacin hcl</i>	33, 114	<i>nifedipine er</i>	48	.....	76
<i>moxifloxacin hcl (2x day)</i>	114	<i>nifedipine er osmotic release</i>	48	NOVOLOG PENFILL.....	76
MULTAQ.....	44	Nikki.....	87	NUBEQA.....	38
<i>mupirocin</i>	124	<i>nimodipine</i>	48	NUCALA.....	121, 122
MY CHOICE.....	86	<i>nisoldipine er</i>	48	Nyamyc.....	124
MY WAY.....	87	<i>nitazoxanide</i>	34	Nylia 1/35.....	88
MYALEPT.....	96	<i>nitisinone</i>	94	Nylia 7/7/7.....	88
<i>mycophenolate mofetil</i>	111	NITRO-BID.....	50	<i>nystatin</i>	25, 124, 125, 129

<i>nystatin-triamcinolone</i>	125	OPTIONS GYNOL II	<i>pentoxifylline er</i>	107
Nystop	125	CONTRACEPTIVE	<i>perindopril erbumine</i>	42
NYVEPRIA	107	.....	Periogard	129
Ocella	88	Oralone	<i>permethrin</i>	129
<i>octreotide acetate</i>	73	ORAVIG	<i>perphenazine</i>	59
ODEFSEY	30	ORENCIA	<i>perphenazine-amitriptyline</i> ..	71, 72
ODOMZO	41	ORENCIA CLICKJECT	<i>phendimetrazine tartrate</i>	78
OFEV	121	ORENITRAM	<i>phenelzine sulfate</i>	56
<i>ofloxacin</i>	33, 115, 130	ORENITRAM MONTH 1	<i>phenobarbital</i>	62
<i>olanzapine</i>	59	ORENITRAM MONTH 2	<i>phenoxybenzamine hcl</i>	50
<i>olmesartan medoxomil</i>	43	ORENITRAM MONTH 3	<i>phentermine hcl</i>	78
<i>olmesartan medoxomil-hctz</i>	43	ORFADIN	<i>phenytoin</i>	62
<i>olmesartan-amlodipine-hctz</i>	43	ORLISSA	<i>phenytoin sodium extended</i>	62
<i>olopatadine hcl</i>	113, 118	ORKAMBI	PHEXXI	104
OLUMIANT	109	<i>orphenadrine citrate er</i>	Philith	88
<i>omega-3-acid ethyl esters</i>	46	Orsythia	PHOSPHOLINE IODIDE	116
<i>omeprazole</i>	103	<i>oseltamivir phosphate</i>	Physiolyte	116
<i>omeprazole-sodium</i>		OSPHERA	Physiosol Irrigation	116
<i>bicarbonate</i>		OTEZLA	PIFELTRO	27
.....	103	<i>oxaprozin</i>	<i>pilocarpine hcl</i>	116, 129
OMNARIS	121	<i>oxazepam</i>	<i>pimozide</i>	72
OMNIFLEX DIAPHRAGM	88	<i>oxcarbazepine</i>	Pimtree	88
OMNIPOD 5 DEXG7G6		<i>oxiconazole nitrate</i>	<i>pindolol</i>	47
INTRO GEN 5		<i>oxybutynin chloride</i>	<i>pioglitazone hcl</i>	76
.....	92	<i>oxybutynin chloride er</i>	<i>pioglitazone hcl-glimepiride</i>	77
OMNIPOD 5 DEXG7G6 PODS		<i>oxycodone hcl</i>	<i>pioglitazone hcl-metformin hcl</i> ..	77
GEN 5		<i>oxycodone hcl er</i>	<i>pirfenidone</i>	121
.....	92	<i>oxycodone-acetaminophen</i> ..	<i>piroxicam</i>	19
OMNIPOD 5 G7 INTRO (GEN		<i>oxymorphone hcl</i>	PLEGRIDY	69
5)		<i>oxymorphone hcl er</i>	PLEGRIDY STARTER PACK ..	69
.....	92	Pacerone	PLENVU	102
OMNIPOD 5 G7 PODS (GEN		<i>paliperidone er</i>	<i>podofilox</i>	128
5)		<i>pantoprazole sodium</i>	Polycin	115
.....	92	PARAGARD	<i>polyethylene glycol 3350</i>	102
OMNIPOD CLASSIC PODS		INTRAUTERINE COPPER	<i>polymyxin b-trimethoprim</i>	115
(GEN 3)		.....	POMALYST	37
.....	92	<i>paricalcitol</i>	PONVORY	69
OMNIPOD DASH INTRO		<i>paromomycin sulfate</i>	PONVORY STARTER PACK ..	69
(GEN 4)		<i>paroxetine hcl</i>	Portia-28	88
.....	92	<i>paroxetine hcl er</i>	<i>posaconazole</i>	25
OMNIPOD DASH PDM (GEN		PAXLOVID (150/100)	<i>potassium chloride</i>	112
4)		PAXLOVID (300/100)	<i>potassium chloride crys er</i>	112
.....	92	PEDIATRIC PANDA MASK ..	<i>potassium chloride er</i>	112
OMNIPOD DASH PODS		<i>peg 3350-kcl-na bicarb-nacl</i> ...	<i>potassium citrate er</i>	105
(GEN 4)		<i>peg-3350/electrolytes</i>	<i>pramipexole dihydrochloride</i>	58
.....	92	PEGASYS	<i>pramipexole dihydrochloride er</i> ..	58
<i>ondansetron</i>	99	<i>peg-kcl-nacl-nasulf-na asc-c</i> ...	<i>prasugrel hcl</i>	108
<i>ondansetron hcl</i>	99	PEG-PREP	<i>pravastatin sodium</i>	45
OPCICON ONE-STEP	88	<i>penciclovir</i>	<i>praziquantel</i>	24
OPILL	88	<i>penicillamine</i>	<i>prazosin hcl</i>	43
OPTION 2	88	<i>penicillin v potassium</i>	PRECISION XTRA KETONE ..	92
		<i>pentamidine isethionate</i>	<i>prednisolone</i>	93

<i>prednisolone acetate</i>	115	<i>rasagiline mesylate</i>	58	SEREVENT DISKUS.....	119
<i>prednisolone sodium phosphate</i>	93, 115	REACT.....	88	<i>sertraline hcl</i>	56
<i>prednisone</i>	93, 94	Reclipsen.....	88	Setlakin.....	88
PREDNISON INTENSOL.....	93	REGANEX.....	129	<i>sevelamer carbonate</i>	96
<i>pregabalin</i>	62	RELENZA DISKHALER.....	31	Sharobel.....	88
PREMARIN.....	96	REMODULIN.....	51	SHUR-SEAL	
Prevalite.....	44	<i>repaglinide</i>	77	CONTRACEPTIVE	
Previfem.....	88	REPATHA.....	46	.....	104
PREZCOBIX.....	30	REPATHA PUSHTRONEX		SIGNIFOR.....	96
PREZISTA.....	27	SYSTEM		<i>sildenafil citrate</i>	51
PRIFTIN.....	30	.....	46	<i>silodosin</i>	104
<i>primaquine phosphate</i>	25	REPATHA SURECLICK.....	46	<i>silver sulfadiazine</i>	124
<i>primidone</i>	62	RETACRIT.....	107	SIMBRINZA.....	114
<i>probenecid</i>	18	REVLIMID.....	37	Simliya.....	88
<i>prochlorperazine</i>	99	REXULTI.....	59	Simpesse.....	89
<i>prochlorperazine maleate</i>	99	REYATAZ.....	27	<i>simvastatin</i>	45
Proctozone-Hc.....	103	<i>ribavirin</i>	31, 33	<i>sirolimus</i>	111
<i>progesterone</i>	97	<i>rifabutin</i>	30	SIRTURO.....	30
<i>promethazine hcl</i>	99, 100	<i>rifampin</i>	30	SKLICE.....	129
<i>promethazine vc</i>	119	<i>riluzole</i>	51	SKYLA.....	89
<i>promethazine-codeine</i>	119	<i>rimantadine hcl</i>	31	SKYRIZI.....	110
<i>promethazine-dm</i>	119	RINVOQ.....	110	SKYRIZI PEN.....	110
Promethegan.....	100	RINVOQ LQ.....	110	<i>sleep-aid</i>	65
PROMETHEGAN.....	100	<i>risedronate sodium</i>	79	SLYND.....	89
<i>propafenone hcl</i>	44	<i>risperidone</i>	59, 60	<i>sm lice treatment</i>	129
<i>propafenone hcl er</i>	44	<i>ritonavir</i>	27	<i>sm nicotine</i>	73
<i>proparacaine hcl</i>	116	<i>rivastigmine</i>	53	<i>sodium chloride</i>	121, 129
<i>propranolol hcl</i>	47	<i>rivastigmine tartrate</i>	53	<i>sodium fluoride</i>	112
<i>propranolol hcl er</i>	47	Rivelsa.....	88	<i>sodium phenylbutyrate</i>	98
<i>propylthiouracil</i>	97	RIVIVE.....	71	<i>solifenacin succinate</i>	105
<i>protriptyline hcl</i>	56	<i>rizatriptan benzoate</i>	66, 67	SOLUVITA.....	112
<i>pseudoeph-bromphen-dm</i>	119	<i>roflumilast</i>	120	SOMATULINE DEPOT.....	73
PULMOZYME.....	120	<i>ropinirole hcl</i>	58	SOMAVERT.....	73
<i>pyrazinamide</i>	30	<i>rosuvastatin calcium</i>	45	<i>sotalol hcl</i>	44
<i>pyridostigmine bromide</i>	70	<i>rufinamide</i>	62	<i>sotalol hcl (af)</i>	44
<i>pyridostigmine bromide er</i>	70	RUKOBIA.....	27	SOVALDI.....	33, 34
<i>pyrimethamine</i>	34	RUXIENCE.....	37	<i>spinosad</i>	129
QSYMIA.....	78	RYBELSUS.....	75	SPIRIVA RESPIMAT.....	117
<i>quetiapine fumarate</i>	59	RYCLORA.....	118	<i>spironolactone</i>	43
<i>quetiapine fumarate er</i>	59	RYDAPT.....	40	<i>spironolactone-hctz</i>	49
<i>quinapril hcl</i>	42	SANCUSO.....	100	SPRAVATO (56 MG DOSE).....	56
<i>quinapril-hydrochlorothiazide</i>	42	SANDIMMUNE.....	111	SPRAVATO (84 MG DOSE).....	56
<i>quinine sulfate</i>	25	<i>sapropterin dihydrochloride</i>	96	Sprintec 28.....	89
QULIPTA.....	66	SAVELLA.....	65	SPRYCEL.....	40
QVAR REDHALER.....	122	SAVELLA TITRATION PACK.....	65	Sps (Sodium Polystyrene Sulf)...	97
<i>rabeprazole sodium</i>	103	SAXENDA.....	78	SPS (SODIUM	
<i>raloxifene hcl</i>	96	<i>sb lice treatment</i>	129	POLYSTYRENE SULF)	
<i>ramelteon</i>	65	<i>scopolamine</i>	100	.....	97
<i>ramipril</i>	42	SECUADO.....	60	Sronyx.....	89
<i>ranolazine er</i>	50	<i>selegiline hcl</i>	58	Ssd.....	124
		<i>selenium sulfide</i>	125	STELARA.....	110
		SELZENTRY.....	27	STIVARGA.....	40

STRIBILD.....	30	<i>temozolomide</i>	36	TRESIBA.....	76
STRIVERDI RESPIMAT.....	119	<i>tenofovir disoproxil fumarate</i>	28	TRESIBA FLEXTOUCH.....	76
SUBLOCADE.....	24	<i>terazosin hcl</i>	104	<i>tretinoin</i>	41, 124
SUCRAID.....	102	<i>terbinafine hcl</i>	25	<i>tretinoin microsphere</i>	124
<i>sucralfate</i>	102	<i>terbutaline sulfate</i>	119	<i>tretinoin microsphere pump</i>	124
SUFLAVE.....	102	<i>terconazole</i>	106	<i>triamcinolone acetonide</i>	
<i>sulconazole nitrate</i>	125	<i>teriflunomide</i>	69	.....	121, 127, 129
<i>sulfacetamide sodium</i>	115	<i>testosterone</i>	73	<i>triamterene</i>	49
<i>sulfacetamide sodium (acne)</i> ...	123	<i>testosterone cypionate</i>	73	<i>triamterene-hctz</i>	49
<i>sulfacetamide-prednisolone</i>	114	<i>testosterone enanthate</i>	73	<i>triazolam</i>	65
<i>sulfadiazine</i>	24	<i>tetrabenazine</i>	68	Tri-Estarylla.....	89
<i>sulfamethoxazole-trimethoprim</i>	35	<i>tetracycline hcl</i>	36	<i>trifluoperazine hcl</i>	60
SULFAMYLON.....	124	THALOMID.....	37	<i>trifluridine</i>	115
<i>sulfasalazine</i>	101	<i>theophylline</i>	123	<i>trihexyphenidyl hcl</i>	58
<i>sulindac</i>	19	<i>theophylline er</i>	123	TRIKAFTA.....	120
<i>sumatriptan</i>	67	<i>thioridazine hcl</i>	60	Tri-Legest Fe.....	89
<i>sumatriptan succinate</i>	67	<i>thiothixene</i>	60	Tri-Linyah.....	89
<i>sumatriptan succinate refill</i>	67	<i>tiagabine hcl</i>	62	Tri-Lo-Estarylla.....	89
<i>sumatriptan-naproxen sodium</i> ..	67	Tilia Fe.....	89	Tri-Lo-Marzia.....	89
<i>sunitinib malate</i>	41	<i>timolol maleate</i>	47, 113, 114	Tri-Lo-Mili.....	89
SUNLENCA.....	27	<i>timolol maleate (once-daily)</i>	113	Tri-Lo-Sprintec.....	89
SUNOSI.....	70	<i>tinidazole</i>	24	<i>trimethobenzamide hcl</i>	100
SUTAB.....	102	<i>tiotropium bromide</i>		<i>trimethoprim</i>	35
Syeda.....	89	<i>monohydrate</i>		Tri-Mili.....	90
SYMDEKO.....	120	.....	117	<i>trimipramine maleate</i>	57
SYMLINPEN 120.....	74	Tis-U-Sol.....	116	TRINTELLIX.....	57
SYMLINPEN 60.....	74	TIVICAY.....	28	Tri-Sprintec.....	90
SYMTUZA.....	30	TIVICAY PD.....	28	TRIUMEQ.....	30
SYNAREL.....	93	<i>tizanidine hcl</i>	70	<i>triumeq pd</i>	30
SYNJARDY.....	77	TOBRADEX.....	114	Trivora (28).....	90
SYNJARDY XR.....	77	TOBRADEX ST.....	114	Tri-Vylibra.....	90
SYNTHROID.....	97	<i>tobramycin</i>	115, 120	Tri-Vylibra Lo.....	90
TABLOID.....	36	<i>tobramycin-dexamethasone</i>	114	<i>tropicamide</i>	116
<i>tacrolimus</i>	112, 125	TODAY SPONGE.....	104	<i>trospium chloride</i>	105
<i>tadalafil</i>	104	<i>tolterodine tartrate</i>	105	<i>trospium chloride er</i>	105
<i>tadalafil (pah)</i>	51	<i>tolterodine tartrate er</i>	105	TRULICITY.....	75
TAFINLAR.....	41	<i>tolvaptan</i>	96	TUKYSA.....	41
<i>tafluprost (pf)</i>	116	<i>topiramate</i>	62	Turqoz.....	90
TAGRISSO.....	41	<i>toremifene citrate</i>	38	TWIRLA.....	90
TAKE ACTION.....	89	<i>torse mide</i>	49	TYBLUME.....	90
<i>tamoxifen citrate</i>	38	<i>tramadol hcl</i>	23	TYBOST.....	28
<i>tamsulosin hcl</i>	104	<i>tramadol hcl er</i>	23	Tydemy.....	90
Tarina 24 Fe.....	89	<i>tramadol-acetaminophen</i>	23	TYMLOS.....	79
Tarina Fe 1/20 Eq.....	89	<i>trandolapril</i>	42	TYVASO.....	51
<i>tasimelteon</i>	65	<i>trandolapril-verapamil hcl er</i>	42	TYVASO REFILL KIT.....	51
Taysofy.....	89	<i>tranexamic acid</i>	107	TYVASO STARTER KIT.....	51
<i>tazarotene</i>	125	<i>tranylcypromine sulfate</i>	56	UBRELVY.....	66
TAZORAC.....	125	<i>travoprost (bak free)</i>	116	Unithroid.....	97
<i>telmisartan</i>	43	<i>trazodone hcl</i>	56	<i>urinary pain relief</i>	105
<i>telmisartan-amlodipine</i>	43	TRECTOR.....	30	<i>ursodiol</i>	102
<i>telmisartan-hctz</i>	43	TRELEGY ELLIPTA.....	117	<i>valacyclovir hcl</i>	31
<i>temazepam</i>	65	<i>treprostinil</i>	51	<i>valganciclovir hcl</i>	31

<i>valproic acid</i>	62	WIDE-SEAL DIAPHRAGM 60	90
<i>valsartan</i>	44	WIDE-SEAL DIAPHRAGM 65	90
<i>valsartan-hydrochlorothiazide</i> ...	43	WIDE-SEAL DIAPHRAGM 70	91
<i>vancomycin hcl</i>	35	WIDE-SEAL DIAPHRAGM 75	91
<i>varenicline tartrate</i>	73	WIDE-SEAL DIAPHRAGM 80	91
<i>varenicline tartrate (starter)</i>	73	WIDE-SEAL DIAPHRAGM 85	91
VARUBI (180 MG DOSE).....	100	WIDE-SEAL DIAPHRAGM 90	91
VCF VAGINAL CONTRACEPTIVE	104	WIDE-SEAL DIAPHRAGM 95	91
VELIVET.....	90	Wymzya Fe.....	91
VELPHORO.....	97	XARELTO.....	106
VEMLIDY.....	33	XARELTO STARTER PACK.	106
VENCLEXTA.....	36	XCOPRI.....	62
VENCLEXTA STARTING PACK	36	XCOPRI (250 MG DAILY DOSE)	62
<i>venlafaxine hcl</i>	57	XCOPRI (350 MG DAILY DOSE)	62
<i>venlafaxine hcl er</i>	57	XIFAXAN.....	35
VENTAVIS.....	51	XOLAIR.....	122
<i>verapamil hcl</i>	48	XTANDI.....	38
<i>verapamil hcl er</i>	48	Xulane.....	91
VERZENIO.....	41	XULTOPHY.....	75
Vestura.....	90	YOSPRALA.....	108
V-GO 20.....	93	Yuvaferm.....	96
V-GO 30.....	93	Zafemy.....	91
V-GO 40.....	93	<i>zafirlukast</i>	120
VICTOZA.....	75	<i>zaleplon</i>	65
Vienna.....	90	Zarah.....	91
<i>vigabatrin</i>	62	ZEJULA.....	41
<i>vilazodone hcl</i>	57	ZENPEP.....	103
VIOKACE.....	103	Zenzedi.....	64
<i>viorele</i>	90	ZEPBOUND.....	78
VIRACEPT.....	28	ZERVIAE.....	113
VIREAD.....	28	<i>zidovudine</i>	28
VISTOGARD.....	41	<i>zileuton er</i>	120
<i>vitamin d (ergocalciferol)</i>	113	<i>ziprasidone hcl</i>	60
VITRAKVI.....	41	ZITHROMAX.....	32
VIVITROL.....	71	<i>zolmitriptan</i>	67
Volnea.....	90	<i>zolpidem tartrate</i>	65
VOLTAREN ARTHRITIS PAIN	128	<i>zolpidem tartrate er</i>	65
<i>voriconazole</i>	25	<i>zonisamide</i>	62
VOSEVI.....	34	ZONTIVITY.....	108
VRAYLAR.....	60	Zovia 1/35 (28).....	91
VTAMA.....	125	Zumandimine.....	91
Vyfemla.....	90	ZURZUVAE.....	57
Vylibra.....	90		
<i>warfarin sodium</i>	106		
WEGOVY.....	78		
Wera.....	90		