Your prescription benefit updates

Utilization Management changes
Effective January 1, 2026

We offer a full suite of utilization management (UM) strategies to help ensure you receive clinically effective medications that also make the best use of your pharmacy benefit dollar.

This is a list of UM changes made to your formulary.

In this update, brand-name medications are shown in UPPERCASE (for example, CLOBEX). Generic medications are shown in lowercase (for example, clobetasol).

New Prior Authorization (PA)^

The following medication requires a PA review for coverage. This means we need more information from your doctor to see if this medication is covered by your plan.

Therapeutic use	Medication name
Central Nervous System: Analgesics	methadone soln 5 mg/5 mL, methadone soln 10 mg/5 mL
Central Nervous System: Antidepressants	RALDESY SOLN 10 MG/ML (trazodone)*

Step Therapy (ST)

The following medications have been added to a step therapy program. This means you must try a lower-cost medication (step 1) before a higher-cost medication (step 2) is covered.

Therapeutic use	Requested medication	New or revised trial medications (step requirement)
Central Nervous System: Alzheimer's Agents	NAMZARIC (memantine/donepezil)*	Both of the following generics: memantine and donepezil OR generic memantine/ donepezil capsule
Central Nervous System: Insomnia Agents	DAYVIGO (lemborexant)* QUVIVIQ (daridorexant)*	Any two of the following generics: doxepin, eszopiclone, ramelteon, triazolam, temazepam, zaleplon, zolpidem IR/ER AND preferred brand: Belsomra
Dermatology: Topical Immunomodulators	VTAMA CREAM 1% (tapinarof) ZORYVE CREAM 0.3% (roflumilast)	Any one of the following topical generics: alclometasone, amcinonide, betamethasone, clobetasol, clocortolone, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide, flurandrenolide, fluticasone, halcinonide, halobetasol, hydrocortisone, mometasone, prednicarbate, triamcinolone, pramoxine-HC, calcipotriene-betamethasone, tacrolimus, pimecrolimus, calcipotrine, calcitrol, tazarotene
Generic First: Various	APTIOM (eslicarbazepine)* BRILINTA (ticagrelor)* ENTRESTO TAB (sacubitril/valsartan)* ESTROGEL (estradiol)*	Generic equivalent
Endocrinology: Glucose Meters and Strips	All other brands that are not Contour, Freestyle or Precision#	Contour AND any one of the following: Freestyle or Precision

*Excluded on premium

^can apply to both brand and generic

This ST does not apply to premium

Quantity Limits (QL)^

The following medications have a new or revised quantity limit. Your plan provides coverage for quantities up to the amount shown. A prior authorization review may be required to determine if your plan covers additional quantities of these medications.

Therapeutic use	Medication name	New or revised quantity limit
Endocrinology & Metabolism: Androgens (Injectable)	AVEED INJ 750 MG/3 ML (testosterone)	1 vial (3 mL) per 70 days
	AZMIRO INJ 200 MG/ML (testosterone)	4 syringes per 28 days
	DEPO-TESTOSTERONE INJ 100 MG/ML (testosterone)*	1 vial (10 mL) per 28 days
	DEPO-TESTOSTERONE INJ 200 MG/ML (testosterone)*	1 vial (10 mL) per 28 days
	TESTONE CIK KIT 200 MG/ML (testosterone)*	4 kits per 28 days
	TESTOSTERONE CYPIONATE INJ 200 MG/ML (testosterone)*	4 vials (1 mL/each) per 28 days
	testosterone enanthate inj 200 mg/mL*	1 vial (5 mL) per 28 days
	XYOSTED INJ (testosterone)*	4 syringes per 28 days
Endocrinology & Metabolism: Androgens (Oral)	JATENZO*, KYZATREX, TLANDO*, UNDECATREX* CAP (testosterone)	4 capsules per day
	KYZATREX CAP 100 MG (testosterone)	7 capsules per day
	METHITEST TAB 10 MG (testosterone)	20 tablets per day
	methyltestosterone cap 10 mg	20 capsules per day
Endocrinology & Metabolism: Androgens (Topical)	ANDROGEL GEL PUMP 1.62% (testosterone)	2 bottles (75 gm/each) per 30 days
	FORTESTA GEL PUMP 10 MG/ ACTUATION (testosterone)	2 bottles (60 gm/each) per 30 days
	NATESTO NASAL GEL PUMP 5.5 MG (testosterone)*	3 bottles (7.32 gm/each) per 30 days
	TESTIM, VOGELXO GEL 1% (50 MG) (testosterone)*	2 packets per day
	testosterone gel 1% (25 mg)	4 packets per day
	testosterone gel 1.62% (20.25 mg)	4 packets per day
	testosterone gel 1.62% (40.5 mg)	2 packets per day
	testosterone soln 30 mg/actuation	2 bottles (90 mL/each) per 30 days
	VOGELXO GEL PUMP 1% (testosterone)*	4 bottles (75 gm/each) per 30 days
Ophthalmology: Dry Eye	CEQUA SOLN 0.09% (cyclosporine)	2 vials per day
	EYSUVIS SUSP 0.25% (loteprednol)	1 bottle (8.3 mL) per 30 days
	RESTASIS EMULSION 0.05% (cyclosporine)	2 vials per day or 1 bottle per 30 days
	VEVYE SOLN 0.1% (cyclosporine)*	1 bottle (2 mL) per 30 days
	XIIDRA SOLN 5% (lifitegrast)	2 vials per day

*Excluded on premium

^can apply to both brand and generic

This ST does not apply to premium

When differences between this list and your benefit plan documents exist, please refer to the information included in your benefit plan documents. This is not a complete list of your covered medications. Please review your benefit plan documents for information on what medications are covered by your plan.

Questions?

Call the number on your member ID card.

Visit your plan's website on your member ID card to:

- Find a participating retail pharmacy by ZIP code.
- Look up possible lower-cost medication alternatives.
- Compare medication pricing and options.