



January 2024

There are upcoming changes to your plan's drug coverage — and we want to be sure you're ready

Starting **January 1, 2024**, you'll see changes to the drugs your **Advanced Control Plan-Aetna** covers. It's important that you review the changes in the chart enclosed. Talk to your doctor about how these changes might impact you.

Find out how to keep your costs low

If the status of your current drug is changing, you may pay more for refilling them on or after **January 1, 2024**. So, we want to make sure you understand your options and what to do next.

What to do if your drugs are changing

Talk to your doctor to find out if changing to a preferred drug is right for you. If they agree, have them send a new prescription to your pharmacy so it's ready for you to fill **January 1, 2024**.

Your doctor may decide it's best for you to stay on your current drug. If so, they can ask for medical exception. Or you can call us at the number on your member ID card to request one. If approved, you'll still pay your plan copay or cost-share, after you meet your plan's deductible or out-of-pocket requirements.

Need more support? We're here to help.

- Visit the website listed on your member ID card to view your current plan details.
- Call us at the number on your member ID card.

Changes beginning January 1, 2024

On or after this date, log in to your member website. Here, you can search for and estimate the cost of your drug(s). You can also find options that may cost you less. Keep in mind, these costs will depend on several things, like where you are with your deductible.

The changes listed in this chart are based on your plan information as of the date of this letter.

UPPER CASE = brand-name drug

lower case = generic drug

Drug Name	Change(s)
ACCU-CHEK FASTCLIX LANCETDEVICE KIT (NDC* 65702048110 only)	Moving to preferred brand tier
ACCU-CHEK FASTCLIX LANCETS (NDC* 65702028810 only)	Moving to preferred brand tier
ACCU-CHEK SAFE-T-PRO LANCETS (NDC* 50924095120 only)	Moving to preferred brand tier
ACCU-CHEK SOFTCLIX (NDC* 75537000971 only)	Moving to preferred brand tier
ACCU-CHEK SOFTCLIX LANCETDEVICE KIT (NDC* 65702040010 only)	Moving to preferred brand tier
ACCU-CHEK SOFTCLIX LANCETS (NDC* 50924097110 only)	Moving to preferred brand tier
ACCU-CHEK SOFTCLIX LANCETS (NDC* 65702012410 only)	Moving to preferred brand tier
ACCU-CHEK SOFTCLIX LANCETS (NDC* 65702015610 only)	Moving to preferred brand tier
ADVAIR DISKUS	Non-formulary; not covered. Covered options include: fluticasone propionate/salmeterol (except certain NDCs), Wixela Inhub, Breo Ellipta
AIMOVIG	Non-formulary; not covered. Covered options include: Ajovy, Emgality, Qulipta
AMJEVITA	Non-formulary; not covered. Covered options include: Adalimumab-ADAZ, Hyrimoz, Humira
APLENZIN	Non-formulary; not covered. Covered options include: bupropion, bupropion ER (except 450 mg tab)
ARAZLO	Non-formulary; not covered. Covered options include: adapalene 0.1% gel, adapalene-benzoyl peroxide, benzoyl peroxide-erythromycin, clindamycin 1% swab, clindamycin-benzoyl peroxide 1.2%/2.5%, dapsone, ery pad, erythromycin, sulfacetamide, tretinoin cream, tretinoin 0.01% and 0.025% gel, tretinoin microsphere gel, Aklief, Differin 1% gel, Epiduo, Epiduo Forte, Onexton, Twyneo, Winlevi
AVSOLA	Drug list addition (preferred specialty); Preauthorization required; Step therapy required; Quantity limits apply. Covered up to 5 vials every 42 days

Drug Name	Change(s)
BASAGLAR KWIKPEN	Non-formulary; not covered. Covered options include: Lantus, Lantus Solostar
BASAGLAR TEMPO PEN	Non-formulary; not covered. Covered options include: Lantus, Lantus Solostar
BESREMI	Drug list addition (preferred specialty)
BYOOVIZ	Drug list addition (preferred specialty); Preauthorization required
CETROTIDE	Non-formulary; not covered. Covered options include: brand Ganirelix (NDC 78206-0138-xx)
CIMERLI	Moving to preferred specialty tier; Preauthorization required
COPAXONE	Non-formulary; not covered. Covered options include: glatiramer, Copaxone 40 mg, dimethyl fumarate DR, fingolimod, teriflunomide, Avonex, Betaseron, Kesimpta, Mayzent, Rebif, Tysabri, Vumerity, Zeposia
DULERA	Drug list addition (non-preferred); Quantity limits apply. Covered up to 1 package every 25 days
DYSPORT	Moving to preferred specialty tier
EDURANT	Non-formulary; not covered. Covered options include: etravirine
epinephrine auto injectors (NDC* 00093598519 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 00093598527 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 00093598619 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 00093598627 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 49502010101 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 49502010102 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 49502010201 only)	Non-formulary drug (Other NDCs covered)
epinephrine auto injectors (NDC* 49502010202 only)	Non-formulary drug (Other NDCs covered)
EPIPEN 2-PAK (NDC* 49502050001 only)	Non-formulary drug (Other NDCs covered)
EPIPEN 2-PAK (NDC* 49502050002 only)	Non-formulary drug (Other NDCs covered)
EPIPEN-JR 2-PAK	Non-formulary; not covered. Covered options include: epinephrine (except Mylan and Teva brands), Auvi-Q
EVOTAZ	Moving to non-preferred brand tier
EYLEA	Non-formulary; not covered. Covered options include: Byooviz, Cimerli
fluticasone propionate / salmeterol	Quantity limits apply. Covered up to 1 package every 25 days

Drug Name	Change(s)
fluticasone propionate / salmeterol diskus (NDC* 66993058497 only)	Non-formulary drug (Other NDCs covered)
fluticasone propionate / salmeterol diskus (NDC* 66993058597 only)	Non-formulary drug (Other NDCs covered)
fluticasone propionate / salmeterol diskus (NDC* 66993058697 only)	Non-formulary drug (Other NDCs covered)
FOLLISTIM AQ	Drug list addition (preferred specialty); Preauthorization required
fyremadel	Non-formulary; not covered. Covered options include: brand Ganirelix (NDC 78206-0138-xx)
GAMMAGARD LIQUID	Preauthorization required
GAMMAKED	Preauthorization required
GAMUNEX-C	Preauthorization required
GANIRELIX ACETATE	Moving to preferred specialty tier
ganirelix acetate generic	Non-formulary; not covered. Covered options include: brand Ganirelix (NDC 78206-0138-xx)
GENOTROPIN	Non-formulary; not covered. Covered options include: Humatrope, Norditropin
GENOTROPIN MINIQUICK	Non-formulary; not covered. Covered options include: Humatrope, Norditropin
GONAL-F	Non-formulary; not covered. Covered options include: Follistim AQ
GONAL-F RFF	Non-formulary; not covered. Covered options include: Follistim AQ
GONAL-F RFF REDIJECT	Non-formulary; not covered. Covered options include: Follistim AQ
HUMATROPE	Drug list addition (preferred specialty); Preauthorization required
ILARIS	Moving to non-preferred specialty tier
INTELENCE	Non-formulary; not covered. Covered options include: etravirine
IRESSA	Non-formulary; not covered. Covered options include: gefitinib, erlotinib
isotretinoin cap 25mg	Non-formulary; not covered. Covered options include: isotretinoin 20mg, 30mg, 40mg
isotretinoin cap 35mg	Non-formulary; not covered. Covered options include: isotretinoin 20mg, 30mg, 40mg
JANUMET	Drug list addition (preferred); Step therapy required
JANUMET XR	Drug list addition (preferred); Step therapy required
JANUVIA	Drug list addition (preferred); Step therapy required
JENTADUETO	Non-formulary; not covered. Covered options include: Janumet, Janumet XR
JENTADUETO XR	Non-formulary; not covered. Covered options include: Janumet, Janumet XR
KALETRA	Non-formulary; not covered. Covered options include: atazanvir, darunavir, lopinavir-ritonavir

Drug Name	Change(s)
KRAZATI	Moving to preferred specialty tier
LANTUS (NDC* 00088222033 only)	Drug list addition (preferred)
LANTUS SOLOSTAR (NDC* 00088221900 only)	Drug list addition (preferred)
LANTUS SOLOSTAR (NDC* 00088221901 only)	Drug list addition (preferred)
LANTUS SOLOSTAR (NDC* 00088221905 only)	Drug list addition (preferred)
LEVEMIR	Non-formulary; not covered. Covered options include: Lantus, Lantus Solostar
LEVEMIR FLEXPEN	Non-formulary; not covered. Covered options include: Lantus, Lantus Solostar
LEVEMIR FLEXTOUCH	Non-formulary; not covered. Covered options include: Lantus, Lantus Solostar
LORBRENA	Non-formulary; not covered. Covered options include: Alecensa, Alunbrig
LUCENTIS	Non-formulary; not covered. Covered options include: Byooviz, Cimerli
LUMAKRAS	Moving to preferred specialty tier
LUMRYZ	Moving to preferred specialty tier
MULTAQ	Drug list addition (preferred)
NEXAVAR	Non-formulary; not covered. Covered options include: sorafenib, sunitinib, Cabometyx, Inlyta, Lenvima
NORVIR	Non-formulary; not covered. Covered options include: ritonavir
OCTAGAM	Non-formulary; not covered
OPZELURA	Moving to preferred brand tier
PHEBURANE	Moving to preferred specialty tier
PREZCOBIX	Moving to non-preferred brand tier
PREZISTA	Non-formulary; not covered. Covered options include: atazanavir, darunavir
RETIN-A MICRO	Non-formulary; not covered. Covered options include: adapalene 0.1% gel, adapalene-benzoyl peroxide, benzoyl peroxide-erythromycin, clindamycin 1% swab, clindamycin-benzoyl peroxide 1.2%/2.5%, dapsone, ery pad, erythromycin, sulfacetamide, tretinoin cream, tretinoin 0.01% and 0.025% gel, tretinoin microsphere gel, Aklief, Differin 1% gel, Epiduo, Epiduo Forte, Onexton, Twyneo, Winlevi
RETIN-A MICRO PUMP	Non-formulary; not covered. Covered options include: adapalene 0.1% gel, adapalene-benzoyl peroxide, benzoyl peroxide-erythromycin, clindamycin 1% swab, clindamycin-benzoyl peroxide 1.2%/2.5%, dapsone, ery pad, erythromycin, sulfacetamide, tretinoin cream, tretinoin 0.01% and 0.025% gel, tretinoin microsphere gel, Aklief, Differin 1% gel, Epiduo, Epiduo Forte, Onexton, Twyneo, Winlevi

Drug Name	Change(s)
REYATAZ	Non-formulary; not covered. Covered options include: atazanavir, darunavir
SYMBICORT	Non-formulary; not covered. Covered options include: fluticasone propionate/salmeterol (except certain NDCs), Wixela Inhub, Breo Ellipta
TADLIQ	Moving to preferred specialty tier; Preauthorization required; Quantity limits apply. Covered up to 300mL every 30 days
TRADJENTA	Non-formulary; not covered. Covered options include: Januvia
tretinoin microsphere	Non-formulary; not covered. Covered options include: adapalene 0.1% gel, adapalene-benzoyl peroxide, benzoyl peroxide-erythromycin, clindamycin 1% swab, clindamycin-benzoyl peroxide 1.2%/2.5%, dapsone, ery pad, erythromycin, sulfacetamide, tretinoin cream, tretinoin 0.01% and 0.025% gel, tretinoin microsphere gel, Akliief, Differin 1% gel, Epiduo, Epiduo Forte, Onexton, Twyneo, Winlevi
TRIPTODUR	Non-formulary; not covered. Covered options include: Fensolvi, LUPRON DEPOT PED
WELLBUTRIN XL	Non-formulary; not covered. Covered options include: bupropion, bupropion ER (except 450 mg tab)
wixela inhub	Quantity limits apply. Covered up to 1 package every 25 days
XEMBIFY	Drug list addition (non-preferred specialty); Preauthorization required
XEOMIN	Moving to preferred specialty tier
XTAMPZA ER	Non-formulary; not covered. Covered options include: fentanyl transdermal, methadone (except oral concentrate), morphine ER, oxycodone ER
XYREM	Non-formulary; not covered. Covered options include: Lumryz, Xywav, Wakix
ZIEXTENZO INJ 6/0.6M	Non-formulary; not covered. Covered options include: FYLNETRA, NYVEPRIA
ZIOPTAN	Moving to non-preferred brand tier

* Drug products are identified by unique numerical product identifiers, called National Drug Codes (NDC), which identify the manufacturer, strength, dosage form, formulation and package size.

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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.

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.

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Policy forms issued in Missouri include: AL HGrpPol 07, AL SG HGrpPol-1A 01, HI HGrpAg 05, HI GrpAgAmend-2022 01, HO HGrpPol 04, HO GrpPolAmend-2022 01, HI SG HGrpAg-1A 01. AL IVL HPOL-1A-2023-EPO-HIX 02, AL IVL SOB 1A EPO HIX 02R2, AL IVL HPOL-1A-2023-EPO 02, AL IVL SOB 1A EPO 02R1.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, 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 a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also 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, 800-537-7697 (TDD).

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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 လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အိၣ်အဂီၢ်,ကိးဘၣ်လီၤတၢ်စိနီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၢ် (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 ṇan kwe, kwōn kallok nōmba eo ilo kaat in ID eo am.
Micronesia-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
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.

