



July 1, 2025

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

Starting **July 1, 2025** 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 **July 1, 2025**. 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 **July 1, 2025**.

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.

\* In accordance with state law or insurer policies, changes to drug coverage are not effective for commercial fully insured plans (including HMOs) in **Iowa, Louisiana, New York, Texas**, and in most circumstances **Connecticut and Vermont**, until the plans' renewal date. Additional state specific disclaimers for **Maryland, Tennessee and Washington** are listed later within this document.

## Changes beginning July 1, 2025

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. Some drugs listed may require prior authorization. For more drug coverage information, view your formulary plan on the website listed on your member ID card.

**UPPER CASE** = brand-name drug

**lower case** = generic drug

| <b>Drug Name</b>  | <b>Change(s)</b>  |
|---|---|
| ACCU-CHEK SAFE-T-PRO PLUSLANCETS (NDC 50924007920 only) | Moving to preferred brand tier  |
| ADALIMUMAB-ADAZ SOLN AUTO-INJECTOR                      | Moving to preferred specialty tier  |
| apomorphine hydrochloride                               | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 20 cartridges every 30 days |
| ARALAST NP  | Drug list addition (preferred specialty); Preauthorization required   |
| CLIMARA PRO   | Non-formulary; not covered. Covered options include: COMBIPATCH   |
| CREXONT   | Moving to preferred brand tier  |
| CRINONE   | Drug list addition (preferred)  |
| deflazacort sus 22.75mg                                 | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 52 ml every 30 days         |
| deflazacort tab 18mg                                    | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days       |
| deflazacort tab 30mg                                    | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days       |
| deflazacort tab 36mg                                    | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days       |
| deflazacort tab 6mg                                     | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 60 tabs every 30 days       |
| DIVIGEL   | Non-formulary; not covered. Covered options include: estradiol  |
| ENDOMETRIN  | Non-formulary; not covered. Covered options include: CRINONE  |
| EVAMIST   | Non-formulary; not covered. Covered options include: estradiol  |

| <b>Drug Name</b>    | <b>Change(s)</b>  |
|---------------------|---|
| FULPHILA            | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 syringes every 28 days  |
| FYLNETRA            | Non-formulary; not covered. Covered options include: FULPHILA   |
| GLASSIA             | Drug list addition (preferred specialty); Preauthorization required   |
| HYRIMOZ (by Sandoz) | Non-formulary; not covered. Covered options include: Ankylosing Spondylitis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, AVSOLA, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), REMICADE IV, RINVOQ Crohn's Disease: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, AVSOLA, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis & Sandoz), REMICADE IV, RINVOQ, SKYRIZI SC, STELARA SC, TREMFYA SC, YESINTEK SC Hidradenitis Suppurativa: ADALIMUMAB-ADAZ, ADALIMUMAMB-FKJP, COSENTYX SC, Hyrimoz (by Cordavis) Non-Radiographic Axial Spondyloarthritis: CIMZIA SC, COSENTYX SC, RINVOQ Psoriasis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, AVSOLA, BIMZELX, HYRIMOZ (by Cordavis), OTEZLA, PYZCHIVA SC (by Cordavis & Sandoz), REMICADE IV, SKYRIZI SC, SOTYKTU, STELARA SC, TREMFYA SC, YESINTEK SC Psoriatic Arthritis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, AVSOLA, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, PYZCHIVA SC (by Cordavis & Sandoz), REMICADE IV, RINVOQ, SKYRIZI SC, STELARA SC, TREMFYA SC, YESINTEK SC Rheumatoid Arthritis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, AVSOLA, ENBREL, HYRIMOZ (by Cordavis), KEVZARA, ORENCIA CLICKJECT, ORENCIA SC, REMICADE IV, RINVOQ, XELJANZ, XELJANZ XR Ulcerative Colitis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, AVSOLA, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis & Sandoz), REMICADE IV, RINVOQ, SKYRIZI SC, STELARA SC, TREMFYA SC, VELSIPITY, YESINTEK SC, ZEPOSIA All other conditions: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENBREL, HYRIMOZ (by Cordavis) |
| icosapent ethyl     | Non-formulary; not covered. Covered options include: VASCEPA  |
| IQIRVO              | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days   |
| ivermectin cream    | Drug list addition (preferred generic); Preauthorization required   |
| JATENZO             | Non-formulary; not covered. Covered options include: testosterone gel (except authorized generics for TESTIM and VOGELXO), testosterone solution, NATESTO   |

| <b>Drug Name</b>   | <b>Change(s)</b>  |
|--|---|
| LIBERVANT  | Drug list addition (preferred); Quantity limits apply. Covered up to 10 pouches every 25 days   |
| mifepristone 300 mg  | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 120 tabs every 30 days  |
| NYVEPRIA   | Non-formulary; not covered. Covered options include: FULPHILA   |
| OCALIVA  | Non-formulary; not covered. Covered options include: IQIRVO   |
| OCREVUS INJ 300 / 10ML   | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 vials every 168 days  |
| OCREVUS INJ ZUNOVO   | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 168 days   |
| ONETOUCH ULTRA STRIPS, ONETOUCH VERIO STRIPS, ONETOUCH LANCETS & LANCING DEVICES | Non-formulary; not covered. Covered options include: ACCU-CHEK AVIVA PLUS STRIPS, ACCU-CHEK GUIDE STRIPS, ACCU-CHEK SMARTVIEW STRIPS, ACCU-CHEK LANCETS & LANCING DEVICES |
| OTREXUP  | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 4 injections every 28 days                                      |
| PROLASTIN-C  | Non-formulary; not covered. Covered options include: ARALAST NP, GLASSIA, ZEMAIRA   |
| PYZCHIVA INJ 45 / 0.5ML  | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 84 days   |
| PYZCHIVA INJ 90MG / ML   | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 56 days   |
| RASUVO   | Non-formulary; not covered. Covered options include: methotrexate, OTREXUP  |
| SIMPONI ARIA   | Not covered under pharmacy benefit. May be covered under the medical benefit  |
| SOOLANTRA  | Non-formulary; not covered. Generic version of drug covered   |
| SYNAGIS  | Non-formulary; not covered  |
| TEZSPIRE   | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 28 days   |
| tiopronin dr   | Drug list addition (preferred specialty); Preauthorization required   |
| VASCEPA  | Drug list addition (preferred)  |
| venxxiva   | Drug list addition (preferred specialty); Preauthorization required   |
| WILATE   | Moving to preferred specialty tier  |
| XHANCE   | Moving to preferred brand tier  |

| <b>Drug Name</b>                | <b>Change(s)</b>  |
|---------------------------------|---|
| XYOSTED                         | Non-formulary; not covered. Covered options include: testosterone gel (except authorized generics for TESTIM and VOGELXO), testosterone solution, NATESTO |
| YESINTEK INJ 45 / 0.5ML SYRINGE | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 84 days                         |
| YESINTEK INJ 45 / 0.5ML VIAL    | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 84 days                            |
| YESINTEK INJ 90MG / ML          | Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 56 days                         |
| ZEMAIRA                         | Moving to preferred specialty tier; Preauthorization required   |
| ZEPBOUND                        | Non-formulary; not covered. Covered options include: orlistat, QSYMIA, SAXENDA, WEGOVY  |

Information is subject to change.

Your plan may not cover certain drugs to treat conditions such as infertility, erectile dysfunction and weight loss.

For fully insured plans (including HMOs) in **Maryland**, changes in prior authorization requirements for previously authorized **immune globulin (human) and drugs used in the treatment of a mental disorder** may not apply on reauthorization under certain conditions.

For fully insured plans in **Washington**, certain changes to **drugs prescribed for the treatment of a serious mental illness** may not apply until the plans' renewal date under certain conditions.

For fully insured plans in **Tennessee**, certain changes to **drugs previously authorized** may not apply until the plans' renewal date under certain conditions.

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 by 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.

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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**Policy forms issued in Oklahoma include:**

AL HGrpPol 07 AL HCOC 12, AL HSOB 10, AL HSOBNM 10, HI HGrpAg 07, HC HCOC 11, HC HSOB 10.

**Policy forms issued in Missouri include:**

AL HGrpPol 07, AL GrpPolAmend-2024 01, HI HGrpAg 07, HO HGrpPol 05. AL IVL HPOL-1A-2024-EPO-HIX 03, AL IVL SOB 1A EPO HIX 03, AL IVL HPOL-1A-2024-EPO 03, AL IVL SOB 1A EPO 03.

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](mailto: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 ugwo obula, kpoo nomba no 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<br>လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အိၣ်အဂီၢ်,ကိးဘၣ်လီၤတဲၣ်နီၣ်ဂံၢ်လၢအိၣ်လၢနနီၣ်ဂီၢ် (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 ئاگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بو تو، پەڕه‌ندی بکه به ژماره‌ی سه‌ر ئای دی (ID) کارتی 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 wōñean ñan 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 | ដើម្បីទទួលបានសេវាកម្មភាសាដែលគិតថ្លៃសម្រាប់លោកអ្នក 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.  |

