Your prescription benefit updates

Utilization Management changes
Effective Jan. 1, 2024

At Optum Rx, 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).

Optum Rx®

Prior Authorization (PA)

The following medication requires a PA for coverage. This means we need more information from your doctor to see if you can get coverage for your medication.

Therapeutic use	Medication name
Electrolyte & Renal Agents: Vasopressin Analog	NOCDURNA (desmopressin)

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	Step 2 medication	Step 1 medication
Cardiology: Statins	ROSZET*, EZETIMIBE-ROSUVASTATIN* (ezetimibe/ rosuvastatin)	Generic ezetimibe and any one of the following generics: atorvastatin, fluvastatin, fluvastatin ER, lovastatin, pravastatin, rosuvastatin, simvastatin
Central Nervous System: ADHD Agents	AZSTARYS (serdexmethylphenidate/ dexmethylphenidate), JORNAY PM (methylphenidate)	Any one of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Central Nervous System: ADHD Agents	ADDERALL XR (amphetamine/ dextroamphetamine) ADZENYS XR-ODT* (amphetamine) APTENSIO XR (methylphenidate) CONCERTA (methylphenidate) COTEMPLA XR-ODT* (methylphenidate) DAYTRANA* (methylphenidate), DESOXYN* (methamphetamine) DEXEDRINE* (dextroamphetamine) DYANAVEL XR* (amphetamine), EVEKEO* (amphetamine) EVEKEO ODT (amphetamine) FOCALIN* (dexmethylphenidate), FOCALIN XR* (dexmethylphenidate), METHYLIN SOLN (methylphenidate), MYDAYIS* (amphetamine/dextroamphetamine), PROCENTRA (dextroamphetamine), QUILLICHEW ER* (methylphenidate), QUILLIVANT* (methylphenidate), RELEXXII, METHYLPHENIDATE ER (methylphenidate), RITALIN*(methylphenidate), RITALIN LA*(methylphenidate), VYVANSE CAP* (lisdexamfetamine) VYVANSE CHEW* (lisdexamfetamine) XELSTRYM* (dextroamphetamine) ZENZEDI* (dextroamphetamine)	Any three of the following generics: amphetamine-dextroamphetamine IR/ER, dexmethylphenidate IR/ER, dextroamphetamine SR/IR, methylphenidate IR/ER
Central Nervous System: Antidepressants	AUVELITY*[C] (dextromethorphan/bupropion)	Any three of the following generics: bupropion, citalopram, desvenlafaxine ER, duloxetine, escitalopram, fluoxetine, mirtazapine, paroxetine, paroxetine ER, sertraline tab or solution, venlafaxine, venlafaxine ER
Gastrointestinal: Constipation Agents	RELISTOR* (methylnaltrexone)	Any one of the following generics: lactulose, polyethylene glycol AND any one of the following preferred brands: Movantik, Symproic AND generic lubiprostone
Gastrointestinal: Constipation Agents	TRULANCE* (plecanatide)	Any one of the following generics: lactulose, polyethylene glycol AND preferred brand Linzess AND generic lubiprostone
Gastrointestinal: Irritable Bowel Syndrome	PENTASA* (mesalamine)	Generic mesalamine AND preferred brand Apriso

*Medication is excluded on the Premium PDL.
^Applies to brand and generic products.
[C]Allows for continuation of therapy.

Therapeutic use	Step 2 medication	Step 1 medication
Gastrointestinal: Irritable Bowel Syndrome	LIALDA* (mesalamine)	Preferred brand Apriso
Respiratory: Inhaled Corticosteroids	ALVESCO* (ciclesonide), ARMONAIR DIGIHALER* (fluticasone), ASMANEX TWISTHALER* (mometasone), ASMANEX HFA* (mometasone), FLOVENT HFA* (fluticasone), FLUTICASONE HFA*, FLOVENT DISKUS* (fluticasone), PULMICORT FLEXHALER* (budesonide)	Both of the following preferred brands: Arnuity Ellipta, Qvar Redihaler
Respiratory: Long-Acting Bronchodilator Combinations	ADVAIR DISKUS* (fluticasone/salmeterol), AIRDUO DIGIHALER* (fluticasone/salmeterol), AIRDUO RESPICLICK* (fluticasone/salmeterol), FLUTICASONE/SALMETEROL* DULERA* (mometasone/formoterol)	Any two of the following preferred brands: Advair HFA, Breo Ellipta, Symbicort
Respiratory: Long-Acting Bronchodilator Combinations	generic fluticasone-salmeterol diskus WIXELA INHUB	Any one of the following preferred brands: Advair HFA, Breo Ellipta, Symbicort
Generic First Step: Various	LATUDA* (lurasidone), PYLERA (bismuth subcitrate/metronidazole/tetracycline)	Generic equivalent

Quantity Limits^ (QL)

The following medications have a new or revised quantity limit that will be covered. If your medication includes a quantity limit, this means there is a new limit to the amount of the drug(s) below that will be covered.

Therapeutic use	Medication name	New or revised quantity limit
Central Nervous System: Analgesics (opioid)	DILAUDID (hydromorphone) 1 mg/mL	10 mL per day up to 7 days for treatment naive, 18 mL per day for treatment experienced
Central Nervous System: Analgesics (opioid)	DILAUDID (hydromorphone) 2 mg	5 tablets per day up to 7 days for treatment naive, 9 tablets per day for treatment experienced
Central Nervous System: Analgesics (opioid)	DILAUDID (hydromorphone) 4 mg	2 tablets per day up to 7 days for treatment naive, 4 tablets per day for treatment experienced
Central Nervous System: Analgesics (opioid)	hydromorphone suppository 3 mg	3 suppositories per day up to 7 days for treatment naive, 6 suppositories per day for treatment experienced
Central Nervous System: Analgesics (opioid)	QDOLO* (tramadol) 5 mg/mL	50 mL per day up to 7 days for treatment naive, 80 mL per day for treatment experienced
Central Nervous System: Analgesics (opioid)	tramadol 50 mg	5 tablets per day up to 7 days for treatment naive, 8 tablets per day for treatment experienced
Central Nervous System: Analgesics (opioid)	tramadol 100 mg	2 tablets per day up to 7 days for treatment naive, 4 tablets per day for treatment experienced
Central Nervous System: Analgesics (opioid)	tramadol/acetaminophen 37.5/325 mg	6 tablets per day up to 7 days for treatment naive, 8 tablets per day for treatment experienced

When differences between this list and your benefit plan exist, the benefit plan documents rule.
This is not a complete list of your covered medications. Please review your benefit plan for full details.

*Medication is excluded on the Premium PDL.
^Applies to brand and generic products.
[C]Allows for continuation of therapy.

Questions?

Call the number on your member ID card.

Visit your plan's website on your member ID card or log on to the Optum Rx app to:

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

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