RXSENSE®

2022 Open Select Formulary

Effective Date: July 1, 2022

For the most current list of covered medications or if you have 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.

Therapeutic use	Step 1 medication	Step 2 medication	Quantity limit
Diabetes bundle			
Basal Insulin	Both of the following:: LANTUS, TOUJEO	BASAGLAR, SEMGLEE, INSULIN GLARGINE, LEVEMIR, TRESIBA	None
Dipeptidyl Peptidase-4 Inhibitors & Combinations	Any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin	JANUMET, JANUMET XR, JANUVIA, JENTADUETO, JENTADUETO XR, TRADJENTA	None
	Any one of the following: JANUMET*, JANUMET XR*, JANUVIA*	ALOGLIPTIN[G], ALOGLIPTIN-METFORMIN[G], ALOGLIPTIN-PIOGLITAZONE[G], KAZANO, KOMBIGLYZE XR, NESINA, ONGLYZA, OSENI	None
Rapid-Acting Insulin	Any of the following: HUMALOG, LYUMJEV	INSULIN ASPART[G], INSULIN LISPRO[G], INSULIN LISPRO JR [G], INSULIN ASPART PROTAMINE/INSULIN ASPART[G], NOVOLOG RELION, NOVOLOG RELION FLEXPEN, NOVOLOG RELION 70/30, NOVOLOG MIX FLEX RELION, NOVOLOG	None

* These preferred products may need additional step therapy requirements.

[G] Authorized Brand Alternative.

Continued

Therapeutic use	Step 1 medication	Step 2 medication	Quantity limit
Sodium-Glucose Co-Transporter-2 (SGLT2) Inhibitors & Combinations	Any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin OR Any one of the following: captopril, enalapril, lisinopril, quinapril, ramipril, fosinopril, trandolapril, perindopril, candesartan, valsartan, losartan, bisoprolol, carvedilol ir, carvedilol er, metoprolol er, spironolactone, eplerenone, ENTRESTO	FARXIGA, JARDIANCE	None
	Any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin	GLYXAMBI, SYNJARDY, SYNJARDY XR, TRIJARDY XR, XIGDUO XR	None
	SEGLUROMET, STEGLATRO, STEGLUJAN	INVOKAMET, INVOKAMET XR, INVOKANA, QTERN, FARXIGA*, XIGDUO XR*	None
Glucagon-Like Peptide-1 Agonists	Any one of the following: metformin, metformin ER, glipizide-metformin, glyburide-metformin, pioglitazone-metformin, TRULICITY, VICTOZA	BYDUREON	4 pens/vials/28 days
		BYDUREON BCISE	4 syringes/28 days
		BYETTA	1 pen injector/30 days
		OZEMPIC 4 mg/3 mL	1 pen/28 days
		OZEMPIC 2 mg/1.5 mL	2 pens/28 days
		RYBELSUS	1 tab/day
		RYBELSUS 3 mg	60 tabs/365 days
		ADLYXIN	2 pens/28 days
		ADLYXIN STARTER PACK	2 packs/365 days

* These preferred products may need additional step therapy requirements.

Continued

Therapeutic use	Step 1 medication	Step 2 medication	Quantity limit	
Blood Glucose Meters & Strips	CONTOUR NEXT	ACCU-CHECK, ACCUTREND, AT LAST, BAYER, BLULINK, CVS ADVANCED, EASYMAX, EASYPLUS, EMBRACE, EXACTECH, FREESTYLE, FORA GD50, FORTISCARE, GENSTRIP, GLUCOCORD, GMATE, KROGER, LIBERTY, NEUTEK, ON CALL, OPTIUM, POGO, PRECISION, QUINTET, RIGHTEST, TRUETEST, RELION, REVEAL, SUPREME, TRUE METRIX, TRUETRACK, ULTIMA, UNISTRIP, ONETOUCH	Blood Glucose Test Strips	300 strips/ 30 days
Respiratory bundle				
Pulmonary Anti-Inflammatory Inhalers	Any two of the following: ARNUITY ELLIPTA, FLOVENT	ALVESCO	2 inhalers/30 days	
		ARMONAIR	1 inhaler/30 days	
		ASMANEX	1 inhaler/30 days	
		PULMICORT FLEXHALER	2 inhalers/30 days	
		QVAR REDIHALER	2 inhalers/30 days	
	INCRUSE	SPIRIVA RESPIMAT	1 inhaler/30 days	
		TUDORZA PRESSAIR	1 inhaler/30 days	
Pulmonary Anti-Inflammatory/ Long-Acting Beta Agonist	Both of the following: ADVAIR, BREO ELLIPTA	AIRDUO	1 inhaler/30 days	
		DULERA	1 inhaler/30 days	
		SYMBICORT	1 inhaler/30 days	
Combination Inhalers		FLUTICASONE/ SALMETEROL[G]	1 inhaler/30 days	
Topical Acne Treatment	Any one of the following: EPIDUO FORTE, ONEXTON	ACANYA, BENZACLIN, BENZACLIN PUMP, BENZAMYCIN, VELTIN, ZIANA	None	
Rosacea	Any one of the following: azelaic acid gel, FINACEA FOAM, SOOLANTRA	FINACEA GEL NORITATE ZILXI	None	
	Any one of the following: metronidazole gel, FINACEA FOAM, SOOLANTRA	METROGEL	None	

[G] Authorized Brand Alternative.

Continued

Therapeutic use	Step 1 medication	Step 2 medication	Quantity limit
Gastroenterology bundle			
Constipation Agents	Any one of the following: lactulose, polyethylene glycol AND Any one of the following: LINZESS*, SYMPROIC*	AMITIZA	2 caps/day
		LUBIPROSTONE[G]	2 caps/day
		MOVANTIK*	1 tab/day
	Any one of the following: lactulose, polyethylene glycol AND LINZESS*	TRULANCE	1 tab/day
		MOTEGRITY	1 tab/day
	Any one of the following: lactulose, polyethylene glycol	LINZESS	1 cap/day
		MOVANTIK	1 tab/day
		SYMPROIC	1 tab/day
	Any one of the following generics: lactulose, polyethylene glycol AND Any one of the following: MOVANTIK*, SYMPROIC*	RELISTOR TABLET	3 tabs/day
		RELISTOR INJECTION	1 vial or syringe/day
Pancreatic Enzymes	Both of the following: CREON, ZENPEP	PANCREAZE PERTZYE VIOKACE	None
Inflammatory Bowel Disease	APRISO	ASACOL HD DELZICOL	None

Focused prior authorization with quantity limits program

The following medications require a prior authorization (PA) for coverage. This means we need more information from your doctor to see if you can get coverage for your medication.

Therapeutic use	Targeted drugs	Quantity limit	
Respiratory bundle			
Pulmonary Anti-Inflammatory/ Long-Acting Beta Agonist Combination Inhalers	Preferred Agents: BUDESONIDE-FORMOTEROL[G] Non-preferred Agents: SYMBICORT	BUDESONIDE-FORMOTEROL[G]	1 inhaler/30 days

* These preferred products may need additional step therapy requirements.

[G] Authorized Brand Alternative.

Continued

Therapeutic use	Targeted drugs	Quantity limit	
Miscellaneous bundle			
Long-Acting Opioids	Preferred Agents: buprenorphine patch, fentanyl patch, hydrocodone ER, methadone tab, morphine sulfate ER, OXYMORPHONE ER, BELBUCA, HYSINGLA ER, OXYCONTIN*, XTAMPZA ER* Non-preferred Agents: ARYMO ER, BUTRANS, DURAGESIC, KADIAN, MORPHABOND ER, MS CONTIN, NUCYNTA ER, ZOHYDRO ER, HYDROMORPHONE ER[G], OXYCODONE ER[G]	ARYMO ER	3 tabs/day
		BELBUCA	2 films/day
		BUTRANS	4 patch/28 days
		DURAGESIC	15 patch/30 days
		DURAGESIC 75 mcg/hr	30 patch/30 days
		DURAGESIC 100 mcg/hr	30 patch/30 days
		HYDROCODONE ER	2 caps/day
		HYDROMORPHONE ER	2 tabs/day
		HYDROCODONE ER 50 mg	4 caps/day
		HYSINGLA ER	1 tab/day
		KADIAN	2 caps/day
		MORPHABOND ER	2 tabs/day
		MORPHINE BEADS ER	1 cap/day
		MORPHINE BEADS ER 120 mg	2 caps/day
		MS CONTIN	3 tabs/day
		NUCYNTA ER	2 tabs/day
		OXYCONTIN	4 tabs/day
		OXYCODONE ER	4 tabs/day
		OXYMORPHONE ER	4 tabs/day
		XTAMPZA ER	4 caps/day
		ZOHYDRO ER	2 caps/day
		ZOHYDRO ER 50 mg	4 caps/day
Constipation Agents	Preferred Agents: lactulose, polyethylene glycol, LINZESS Non-preferred Agents: ZELNORM	ZELNORM	2 tabs/day

Focused specialty prior authorization with quantity limits program

The following medications require a prior authorization (PA) for coverage. This means we need more information from your doctor to see if you can get coverage for your medication.

Therapeutic use	Targeted drugs	Quantity limit
Growth hormones		
	Preferred Agents: NUTROPIN Non-preferred Agents: GENOTROPIN, HUMATROPE, OMNITROPE, SAIZEN, SKYTROFA, ZOMACTON NORDITROPIN	None

* These preferred products may need additional step therapy requirements.

[G] Authorized Brand Alternative.

Continued

Therapeutic use	Targeted drugs	Quantity limit	
Hepatitis C			
	Preferred Agents: EPCLUSA, HARVONI, MAVYRET, VOSEVI Non-preferred Agents: LEDIPASVIR-SOFOSBUVIR[G], SOFOSBUVIR-VELPATASVIR[G], SOVALDI, VIEKIRA, ZEPATIER	HARVONI 90-400 mg	1 tab/day
		HARVONI 45-200 mg	2 tabs/day
		HARVONI PELLET PAK 45-200 MG	2 packets/day
		HARVONI PELLET PAK 33.75-150 mg	1 packet/day
		SOVALDI	1 tab/day
		SOVALDI PELLET PAK 150 mg	1 packet/day
		SOVALDI 200 mg	2 tabs/day
		SOVALDI PELLET PAK 200 mg	2 packets/day
		VIEKIRA	4 tabs/day
		EPCLUSA	1 tab/day
		EPCLUSA PELLET PAK 150-37.5 mg	1 packet/day
		EPCLUSA PELLET PAK 200-500 mg	2 packets/day
		MAVYRET PELLET PAK 50-20 mg	5 packets/day
		ZEPATIER	1 tab/day
		VOSEVI	1 tab/day
		MAVYRET	3 tabs/day
		LEDIPASVIR-SOFOSBUVIR[G]	1 tab/day
		SOFOSBUVIR-VELPATASVIR[G]	1 tab/day
Immuno-modulators			
	Preferred Agents: (Tier 2) AVSOLA,CIMZIA,HUMIRA, INFLECTRA, OTEZLA, RINVOQ, SKYRIZI, XELJANZ*, XELJANZ XR* (Tier 3) ACTEMRA*, ORENCIA*, TALTZ* Non-preferred Agents: COSENTYX, ENBREL, ILUMYA, KEVZARA, KINERET, OLUMIANT, REMICADE, RENFLEXIS, RITUXAN, SILIQ, TRUXIMA, SIMPONI, STELARA, TREMFYA	STELARA 45 mg/0.5 ml	1 unit/56 days
		STELARA 90 mg/1 ml	1 unit/56 days

* These preferred products may need additional step therapy requirements.

[G] Authorized Brand Alternative.

Continued

Therapeutic use	Targeted drugs	Quantity limit	
Infertility			
	Preferred Agents: FOLLISTIM AQ Non-preferred Agents: GONAL-F, GONAL-F RFF	None	
Multiple Sclerosis			
	Preferred Agents: (Tier 2) AVONEX, BAFIERTAM, BETASERON, COPAXONE/GLATOPA/ glatiramer, dimethyl fumarate, KESIMPTA, VUMERITY (Tier 3) AUBAGIO, GILENYA, MAYZENT, MAVENCLAD*, ZEPOSIA Non-preferred Agents: EXTAVIA, LEMTRADA, PLEGRIDY, PONVORY, TECFIDERA, REBIF*	AUBAGIO	1 tab/day
		AVONEX	1 kit/28 days
		BAFIERTAM	4 caps/day
		BETASERON	14 vials/28 days
		COPAXONE 20 mg	30 syringes/30 days
		GLATOPA	30 syringes/30 days
		glatiramer 20 mg	30 syringes/30 days
		COPAXONE 40 mg	12 syringes/28 days
		EXTAVIA	15 vials/30 days
		GILENYA	1 cap/day
		KESIMPTA	1 syringe/28 days
		MAYZENT 0.25 mg	4 tabs/day
		MAYZENT 2 mg	1 tab/day
		MAYZENT STARTER PACK	2 starter packs/365 days
		PLEGRIDY KIT	1 kit/30 days
		PLEGRIDY	2 pens/syr/28 days
		PONVORY	1 tab/day
		PONVORY STARTER PACK	2 starter packs/365 days
		REBIF TITRATION PACK	1 pack/year
		REBIF	12 syringes/28 days
		TECFIDERA STARTER PACK	2 packs/year
		TECFIDERA	2 caps/day
		VUMERITY 120 count	4 caps/day
		VUMERITY 106 count	212 caps/365 days
		ZEPOSIA	1 cap/day
		ZEPOSIA STARTER KIT	74 caps/365 days
		ZEPOSIA STARTER PACK	14 caps/365 days
Viscosupplements			
	Preferred Agents: DUROLANE, EUFLEXXA, GELSYN-3 Non-preferred Agents: HYALGAN, HYMOVIS, GEL-ONE, GENVISC 850, MONOVISC, ORTHOVISC, SODIUM HYALURONATE, SUPARTZ FX, SYNVISC, SYNVISC-ONE, TRILURON, TRIVISC, VISCO-3	None	

* These preferred products may need additional step therapy requirements.