



January 1, 2026

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

Starting **January 1, 2026** you'll see changes to the drugs your **Advanced Control Plan-Aetna: West Virginia** 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, 2026**. 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, 2026**.

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 **Arizona, Iowa, Minnesota, Louisiana, New York, North Dakota, 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 January 1, 2026

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

DRUG_NAME	CHANGES
abiraterone acetate	Moving to preferred generic tier
abirtega	Moving to preferred generic tier
ADBRY	Moving to non-preferred specialty tier
ALPROLIX	Non-formulary; not covered. Covered options include: BENEFIX, REBINYN
alyq	Moving to preferred generic tier
AMPYRA	Moving to non-preferred brand tier
APTIOM	Moving to non-preferred brand tier
AUSTEDO XR	Non-formulary; not covered. Covered options include: tetrabenazine, AUSTEDO, INGREZZA
AUSTEDO XR PATIENT TITRATION KIT	Non-formulary; not covered. Covered options include: tetrabenazine, AUSTEDO, INGREZZA
AUTOSOFT 30 INFUSION SET/23"/13MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT 30 INFUSION SET/43"/13MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT 90 INFUSION SET/23"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT 90 INFUSION SET/23"/9MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT 90 INFUSION SET/43"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT 90 INFUSION SET/43"/9MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT XC INFUSION SET/23"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES

DRUG_NAME	CHANGES
AUTOSOFT XC INFUSION SET/23"/9MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT XC INFUSION SET/32"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT XC INFUSION SET/43"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
AUTOSOFT XC INFUSION SET/43"/9MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
bexarotene	Moving to preferred generic tier
CIBINQO	Moving to preferred brand tier
CIMERLI	Moving to non-preferred specialty tier
cinacalcet hydrochloride	Moving to preferred generic tier
colchicine 0.6 mg	Drug list addition (preferred generic); Quantity limits apply. Covered up to 60 caps every 25 days
COPIKTRA	Non-formulary; not covered. Covered options include: BRUKINSA, CALQUENCE
dalfampridine er	Moving to preferred generic tier
dichlorphenamide	Moving to preferred generic tier
dimethyl fumarate	Moving to preferred generic tier
dimethyl fumarate starterpack	Moving to preferred generic tier
dofetilide	Moving to preferred generic tier
droxidopa	Moving to preferred generic tier
DYSPORT	Drug list addition (preferred specialty); Preauthorization required
ENTRESTO	Moving to non-preferred brand tier
ENTYVIO	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 56 days
ENTYVIO PEN	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 pens every 28 days
FILSPARI TAB 200MG	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 60 tabs every 30 days
FILSPARI TAB 400MG	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days
FYCOMPA	Moving to non-preferred brand tier
HETLIOZ	Moving to non-preferred brand tier
HETLIOZ LQ	Moving to non-preferred brand tier
HYCAMTIN	Moving to non-preferred brand tier

DRUG_NAME	CHANGES
IBTROZI	Moving to preferred specialty tier
INBRIJA	Moving to preferred brand tier
INGREZZA	Moving to preferred brand tier
JAKAFI	Moving to preferred specialty tier
KEYEYIS	Moving to non-preferred brand tier
LIVTENCITY	Moving to non-preferred brand tier
MENOPUR	Moving to non-preferred specialty tier
MITIGARE	Non-formulary; not covered. Covered options include: colchicine
MOBI 2ML CARTRIDGE	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
NEORAL	Moving to non-preferred brand tier
NUPLAZID	Moving to non-preferred brand tier
NUZYRA	Moving to non-preferred brand tier
ODACTRA	Moving to preferred brand tier
OFEV	Moving to preferred brand tier
OLUMIANT	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days
ONZETRA XSAIL	Non-formulary; not covered. Covered options include: naratriptan, rizatriptan, sumatriptan, zolmitriptan, NURTEC ODT, TOSYMRA, UBRELVY
ormalvi	Moving to preferred generic tier
ORTHOVISC	Drug list addition (preferred specialty); Preauthorization required
OSENVELT	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 28 days
OTEZLA	Moving to preferred brand tier
OTEZLA XR	Moving to preferred brand tier
OTEZLA/OTEZLA XR 28 DAY TREATMENT INITIATION PACK	Moving to preferred brand tier
OTREXUP	Moving to non-preferred specialty tier
penicillamine	Moving to preferred generic tier
REVLIMID	Non-formulary; not covered. Covered options include: lenalidomide
RINVOQ	Moving to preferred brand tier
RINVOQ LQ	Moving to preferred brand tier
SANDIMMUNE	Moving to non-preferred brand tier
SENSIPAR	Moving to non-preferred brand tier

DRUG_NAME	CHANGES
SUPARTZ FX	Non-formulary; not covered. Covered options include: DUROLANE, EUFLEXXA, GELSYN-3, ORTHOVISC
T:FLEX T:LOCK INSULIN CARTRIDGE 4.8ML	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
T:SLIM X2 3 ML CARTRIDGE	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TACLONEX	Moving to non-preferred brand tier
tadalafil	Moving to preferred generic tier
TADLIQ	Moving to preferred brand tier
TANDEM T:SLIM ASFT 30 PK10 23"	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TANDEM T:SLIM ASFT 30 PK14 23"	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TANDEM T:SLIM ASFT XC PK10 23"	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TANDEM T:SLIM ASFT XC PK14 23"	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TANDEM T:SLIM TRUSTL PK10 23"	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
tasimelteon	Moving to preferred generic tier
TAVNEOS	Moving to non-preferred brand tier
TEGSEDI	Moving to non-preferred specialty tier
teriflunomide	Moving to preferred generic tier
tetrabenazine	Moving to preferred generic tier
TIKOSYN	Moving to non-preferred brand tier
TOSYMRA	Drug list addition (preferred); Quantity limits apply. Covered up to 18 units every 25 days
TRUSTEEL INFUSION SET/23"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TRUSTEEL INFUSION SET/23"/8MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TRUSTEEL INFUSION SET/32"/6MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
TRUSTEEL INFUSION SET/32"/8MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES

DRUG_NAME	CHANGES
TURALIO	Drug list addition (non-preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 120 caps every 30 days
VANRAFIA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days
VARISOFT INFUSION SET/23"/13MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
VARISOFT INFUSION SET/23"/17MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
VARISOFT INFUSION SET/32"/13MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
VARISOFT INFUSION SET/43"/17MM	Non-formulary; not covered. Covered options include: OMNIPOD 5/ DASH, TWIIST INSULIN INFUSION PUMP AND SUPPLIES
VEMLIDY	Non-formulary; not covered. Covered options include: entecavir, lamivudine, tenofovir disoproxil fumarate
VEVYE	Drug list addition (preferred)
VUMERITY	Moving to preferred brand tier
VYNDAMAX	Moving to preferred brand tier
WAKIX	Moving to preferred brand tier
XDEMZY	Preauthorization required; Quantity limits apply. Covered up to 10ml every 6 weeks
XELJANZ	Moving to preferred brand tier
XELJANZ XR	Moving to preferred brand tier
XELODA	Moving to non-preferred brand tier
XEMBIFY	Moving to preferred specialty tier
XERMELO	Moving to non-preferred brand tier
XGEVA	Non-formulary; not covered. Covered options include: pamidronate 30 mg/10 mL and 90 mg/10 mL, zoledronic acid 4mg/5mL, OSENVELT
XIIDRA	Non-formulary; not covered. Covered options include: RESTASIS, VEVYE
XTANDI	Moving to preferred brand tier
YONSA	Moving to preferred brand tier
YUTREPIA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 140 capsules every 28 days
ZYDELIG	Non-formulary; not covered. Covered options include: BRUKINSA, CALQUENCE

Information is subject to change.

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

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. Each insurer has sole financial responsibility for its own products. Pharmacy benefits are administered by an affiliated pharmacy benefit manager, CVS Caremark. Aetna® is part of the CVS Health® family of companies.

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:

Medical Multiple: AL HGrpPol 09, AL HCOC 14, AL HSOB 12, AL HSOBNM 12.

HMO-POS Combo: HI HGrpAg 07, HI GrpAgAmend-2025 01, HC HCOC 13, HC HSOB 12.

Policy forms issued in Missouri include:

HMO: HI HGrpAg 07, HI GrpAgAmend-2025 01, HI HCOC 13, HI HSOB 12

POS: HO HGrpPol 05, HO POSRider 11

PPO: AL HGrpPol 07, AL GrpPolAmend-2024 01, AL GrpPolAmend-2025 01, AL HCOC-PPO 14, AL HSOB-PPO 12

EPO: AL HGrpPol 07, AL GrpPolAmend-2024 01, AL GrpPolAmend-2025 01, AL HCOC-EPO 14, AL HSOB-EPO 12

TC: AL HGrpPol 07, AL GrpPolAmend-2024 01, AL GrpPolAmend-2025 01, AL HCOC-TC 14, AL HSOB-TC 12

