



September 28, 2026

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

Starting **January 1, 2027** you'll see changes to the drugs your **Advanced Control Plan-Aetna: Federal and Postal Service Employees** 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, 2027**. 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, 2027**.

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, 2027**

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
ARMOUR THYROID	Non-formulary; not covered. Covered options include: levothyroxine tabs, liothyronine
ARNUITY ELLIPTA	Non-formulary; not covered. Covered options include: beclomethasone dipropionate HFA, ASMANEX HFA
ATTRUBY	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 112 tabs every 28 days
AUVI-Q	Moving to non-preferred brand tier
BILPREVDA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 28 days
BIMZELX INJ 160MG/ML	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 injections every 28 days
BIMZELX INJ 320MG/3	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 injection every 28 days

DRUG NAME	CHANGES
BOSULIF	Non-formulary; not covered. Covered options include: bosutinib, dasatinib, imatinib mesylate, nilotinib, SCEMBLIX
clotrimazole troche	Quantity limits removed
COPIKTRA	Non-formulary; not covered. Covered options include: BRUKINSA, CALQUENCE
CRINONE	Drug list addition (preferred brand)
cyclosporine 0.05% ophthalmic emulsion	Drug list addition (preferred generic)
DAWNZERA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 pen every 28 days
DESCOVY	Moving to non-preferred brand tier
DIFICID	Moving to non-preferred brand tier
doxycycline cap 40mg	Drug list addition (preferred generic)
ENDOMETRIN	Drug will no longer be covered without cost sharing for clients that have adopted the Affordable Care Act (ACA) Preventive Services Benefit. If covered by plan, cost sharing will apply
EPCLUSA	Non-formulary; not covered. Covered options include: MAVYRET
EPIPEN 2-PAK	Moving to non-preferred brand tier
ESTRACE	Non-formulary; not covered. Covered options include: estradiol oral tablet, conjugated estrogens oral tablet
ESTRACE VAG	Non-formulary; not covered. Generic version of drug covered
estradiol vaginal tab	Drug list addition (preferred generic)
EUCRISA	Preauthorization required; Quantity limits apply. Covered up to 60 g every 25 days
fluticasone furoate ellipta	Non-formulary; not covered. Covered options include: beclomethasone dipropionate HFA, ASMANEX HFA
FYCOMPA	Moving to non-preferred brand tier
GRALISE	Moving to non-preferred brand tier
HAEGARDA	Non-formulary; not covered. Covered options include: DAWNZERA, TAKHZYRO

DRUG NAME	CHANGES
HARVONI	Non-formulary; not covered. Covered options include: MAVYRET
HUMATROPE	Moving to non-preferred specialty tier
hydrocodone bitartrate/homatropine methylbromide	Moving to non-preferred generic tier
hydromet	Moving to non-preferred generic tier
HYMPAVZI	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 8 pens every 28 days
icosapent ethyl	Drug list addition (preferred generic)
INFLIXIMAB	Drug list addition (preferred specialty); Preauthorization required; Step therapy required; Quantity limits apply. Covered up to 5 vials every 42 days
INVEGA HAFYERA	Drug list addition (preferred brand)
INVEGA SUSTENNA	Moving to preferred brand tier
INVEGA TRINZA	Drug list addition (preferred brand)
LEDIPASVIR/SOFOSBUVIR	Drug list addition (non-preferred specialty)
LIPFENDRA	Drug list addition (preferred brand); Preauthorization required; Quantity limits apply. Covered up to 30 tabs every 30 days
LORBRENA	Moving to preferred specialty tier
LYBALVI	Drug list addition (non-preferred brand)
MAVYRET PAK 50-20MG	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 140 packets every 28 days
MAVYRET TAB 100-40MG	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 84 tabs every 28 days
MYRBETRIQ	Moving to non-preferred brand tier
NAMZARIC	Moving to non-preferred brand tier
NATESTO	Moving to non-preferred brand tier
NEMLUVIO	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 2 pens every 28 days
NUCYNTA	Moving to non-preferred brand tier

DRUG NAME	CHANGES
NUCYNTA ER	Moving to non-preferred brand tier
OPSUMIT	Non-formulary; not covered. Covered options include: ambrisentan, bosentan, macitentan
ORACEA	Non-formulary; not covered. Generic version of drug covered
ORENCIA INJ 50/0.4ML	Moving to non-preferred specialty tier
ORENCIA INJ 87.5/0.7ML	Moving to non-preferred specialty tier
OSENVELT	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 28 days
OSPOMYV	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 6 months
POMALYST	Non-formulary; not covered. Covered options include: pomalidomide
PRALUENT	Drug list addition (preferred brand); Preauthorization required; Quantity limits apply. Covered up to 2 pens every 28 days
PROLIA	Non-formulary; not covered. Covered options include: teriparatide, zoledronic acid, OSPOMYV, STOBOCLO, TYMLOS
REPATHA	Non-formulary; not covered. Covered options include: LIPFENDRA, PRALUENT
REPATHA PUSHTRONEX SYSTEM	Non-formulary; not covered. Covered options include: LIPFENDRA, PRALUENT
REPATHA SURECLICK	Non-formulary; not covered. Covered options include: LIPFENDRA, PRALUENT
RESTASIS	Non-formulary; not covered. Generic version of drug covered
RESTASIS MULTIDOSE	Non-formulary; not covered. Generic version of drug covered
SAXENDA	Moving to non-preferred brand tier
SOFOSBUVIR/VELPATASVIR	Drug list addition (non-preferred specialty)
SOVALDI	Non-formulary; not covered. Covered options include: MAVYRET
SPRAVATO 56MG DOSE	Moving to preferred specialty tier
SPRAVATO 84MG DOSE	Moving to preferred specialty tier

DRUG NAME	CHANGES
STELARA SC	Non-formulary; not covered. Covered options include: Crohn's Disease: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, YESINTEK SC; Psoriasis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, BIMZELX, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, PYZCHIVA SC (by Cordavis), SKYRIZI SC, SOTYKTU, TREMFYA SC, YESINTEK SC; Psoriatic Arthritis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, YESINTEK SC; Ulcerative Colitis: ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC, ZEPOSIA
STOBOCLO	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 syringe every 6 months
tetracycline hydrochloride	Quantity limits removed
TYRUKO	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 1 vial every 28 days
TYVASO	Non-formulary; not covered. Covered options include: YUTREPIA
TYVASO DPI INSTITUTIONAL KIT	Non-formulary; not covered. Covered options include: YUTREPIA
TYVASO DPI MAINTENANCE KIT	Non-formulary; not covered. Covered options include: YUTREPIA
TYVASO DPI TITRATION KIT	Non-formulary; not covered. Covered options include: YUTREPIA
TYVASO REFILL KIT	Non-formulary; not covered. Covered options include: YUTREPIA
TYVASO STARTER KIT	Non-formulary; not covered. Covered options include: YUTREPIA

DRUG NAME	CHANGES
VAGIFEM	Non-formulary; not covered. Generic version of drug covered
VASCEPA	Non-formulary; not covered. Generic version of drug covered
VEVYE	Drug list addition (preferred brand)
vilazodone hydrochloride	Drug list addition (preferred generic)
VOSEVI	Non-formulary; not covered. Covered options include: MAVYRET
VYVGART HYTRULO	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 4 syringes every 28 days
XELJANZ SOL 1MG/ML	Non-formulary; not covered. Covered options include: Psoriatic Arthritis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, RINVOQ, SKYRIZI SC, TREMFYA SC
XELJANZ TAB 10MG	Non-formulary; not covered. Covered options include: Ulcerative Colitis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC
XELJANZ TAB 5MG	Non-formulary; not covered. Covered options include: Ankylosing Spondylitis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), RINVOQ; Psoriatic Arthritis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, RINVOQ, SKYRIZI SC, TREMFYA SC; Rheumatoid Arthritis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENBREL, HYRIMOZ (by Cordavis), KEVZARA, ORENCIA CLICKJECT, ORENCIA SC, RINVOQ; Ulcerative Colitis:

DRUG NAME	CHANGES
	tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC
XELJANZ XR TAB 11MG	Non-formulary; not covered. Covered options include: Ankylosing Spondylitis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), RINVOQ; Psoriatic Arthritis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, COSENTYX SC, ENBREL, HYRIMOZ (by Cordavis), OTEZLA, OTEZLA XR, RINVOQ, SKYRIZI SC, TREMFYA SC; Rheumatoid Arthritis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENBREL, HYRIMOZ (by Cordavis), KEVZARA, ORENCIA CLICKJECT, ORENCIA SC, RINVOQ; Ulcerative Colitis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC
XELJANZ XR TAB 22MG	Non-formulary; not covered. Covered options include: Ulcerative Colitis: tofacitinib, tofacitinib ext-rel, ADALIMUMAB-ADAZ, ADALIMUMAB-FKJP, ENTYVIO SC, HYRIMOZ (by Cordavis), PYZCHIVA SC (by Cordavis), RINVOQ, SKYRIZI SC, TREMFYA SC, VELSIPITY, YESINTEK SC
XGEVA	Non-formulary; not covered. Covered options include: zoledronic acid, BILPREVDA, OSENVELT
YUTREPIA	Drug list addition (preferred specialty); Preauthorization required; Quantity limits apply. Covered up to 140 caps every 28 days
yuvaferm	Drug list addition (preferred generic)

DRUG NAME	CHANGES
ZORYVE	Drug list addition (preferred brand); Preauthorization required; Quantity limits apply. Covered up to 60 g every 25 days

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