
2024

SCAN Health Plan Formulary

List of Covered Drugs

SCAN Health Plan 處方藥一覽表

承保藥物清單



This formulary was updated on 03/01/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-800-559-3500 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

本處方藥一覽表更新於 03/01/2024。如需瞭解最新資訊或有其他疑問，請聯絡 SCAN Health Plan 會員服務部，電話：1-800-559-3500（聽障人士應致電 711），10 月 1 日至 3 月 31 日期間，服務時間為每週 7 天，上午 8 點至晚上 8 點。4 月 1 日至 9 月 30 日期間的服務時間為週一至週五，上午 8 點至晚上 8 點（節假日及營業時間之外收到的訊息將在一個工作日內回覆），或瀏覽 www.scanhealthplan.com。

SCAN Health Plan

2024 Formulary (List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

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This formulary was updated on 03/01/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-800-559-3500 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means SCAN Health Plan. When it refers to "plan" or "our plan," it means SCAN Affirm partnered with Included LGBTQ+ Health (HMO), SCAN Alta (HMO), SCAN Classic (HMO), SCAN Compass (HMO), SCAN Inspired by women for women (HMO), SCAN MyChoice (HMO), SCAN Navigate (HMO), SCAN Options (HMO), SCAN Prime (HMO), SCAN Venture (HMO), Scripps Classic offered by SCAN Health Plan (HMO), Scripps Signature offered by SCAN Health Plan (HMO), SCAN Balance (HMO C-SNP), SCAN Embrace (HMO I-SNP), SCAN Healthy at Home (HMO I-SNP), SCAN Heart First (HMO C-SNP), Scripps Heart First offered by SCAN Health Plan (HMO C-SNP) and SCAN Strive (HMO C-SNP).

This document includes a list of the drugs (formulary) for our plan which is current as of March 2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025, and from time to time during the year. You will receive notice when necessary.

You can get prescription drugs shipped to your home through our network mail-order delivery program. Express Scripts PharmacySM is one of our mail order pharmacies. You can fill your prescription medications at any of our network mail order pharmacies. Typically, you should expect to receive your prescription drugs within 14 days from the time that Express Scripts mail-order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact SCAN Health Plan's Member Services. For your mail order prescriptions, you have the option to sign up for an automatic refill program by contacting Express Scripts Pharmacy at 1-866-553-4125, 24 hours a day, 7 days a week. TTY users should call 711. You may opt out of automatic deliveries at any time.

SCAN Health Plan is an HMO plan with a Medicare contract. Enrollment in SCAN Health Plan depends on contract renewal.

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What is the SCAN Health Plan Formulary?

A formulary is a list of covered drugs selected by SCAN Health Plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. SCAN Health Plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a SCAN Health Plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled “How do I request an exception to the SCAN Health Plan’s Formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand-name drug currently on the formulary, or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the SCAN Health Plan’s Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain

available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of March, 2024. To get updated information about the drugs covered by SCAN Health Plan, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 57. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, "Cardiovascular Agents". If you know what your drug is used for, look for the category name in the list that begins on page number 57. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 94. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

SCAN Health Plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** SCAN Health Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from SCAN Health Plan before you fill your prescriptions. If you don't get approval, SCAN Health Plan may not cover the drug.
- **Quantity Limits:** For certain drugs, SCAN Health Plan limits the amount of the drug that SCAN Health Plan will cover. For example, SCAN Health Plan provides 30 tablets per prescription for BELSOMRA. This may be in addition to a standard one-month or three-month supply.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 57. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online a document that explain our prior authorization restriction. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask SCAN Health Plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, “How do I request an exception to the SCAN Health Plan’s formulary?” on page 5 for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that SCAN Health Plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by SCAN Health Plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by SCAN Health Plan.
- You can ask SCAN Health Plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the SCAN Health Plan’s Formulary?

You can ask SCAN Health Plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at lower cost-sharing level unless the drug is on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, SCAN Health Plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, SCAN Health Plan will only approve your request for an exception if the alternative drugs included on the plan’s formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tier, or utilization restriction exception. **When you request a formulary, tier, or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber’s supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply if you are not in a long-term care facility or a 31-day supply if you are a resident of a long-term care facility. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication if you are not in a long-term care facility or a 31-day supply of medication if you are a resident of a long-term care facility. After your first 30-day supply if you are not in a long-term care facility or a 31-day supply if you are a resident of a long-term care facility, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you are a current member transitioning to a different level of care, you may be prescribed medications not on our formulary or your ability to get your drugs may be limited. In these instances, you need to talk with your doctor about the appropriate alternative therapies available on our formulary. If there are no appropriate alternative therapies on our formulary, you or your doctor can request an exception and ask the plan to cover the drug or remove restrictions from the drug. While you are talking with your doctor to determine the course of action, you are eligible to receive a 30-day transition supply of the drug if you are moving from a long-term care facility or a hospital stay to home or a 31-day transition supply of the drug if you are moving from home or a hospital stay to a long-term care facility.

For more information

For more detailed information about your SCAN Health Plan prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about SCAN Health Plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit <http://www.medicare.gov>.

The charts below list what you will pay as your share of the costs for covered prescription drugs at our network pharmacies when you are in the Initial Coverage Stage.

Preferred cost-sharing is lower cost-sharing that may be available to you for certain covered Part D drugs at certain network pharmacies. For more information, please visit our online searchable Pharmacy Directory at www.scanhealthplan.com or call Member Services. Our contact information appears on the front and back cover pages.

Please refer to your Evidence of Coverage for information about the costs at Long-Term Care (LTC) pharmacies and out-of-network pharmacies.

If you receive "Extra Help," your share of the cost for covered prescription drugs may vary based on the level of "Extra Help" you receive. For more information about your drug costs, look at the "LIS Rider".

You won't pay more than \$35 for a one-month supply and no more than \$105 for a three-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Most adult Part D vaccines are covered by our plan at no cost to you.

SCAN Classic (HMO): Los Angeles and Orange Counties

SCAN Alta (HMO): San Diego County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): Riverside County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$9	\$18
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): San Bernardino County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$9	\$18
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): Santa Clara and San Francisco Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$10	\$20
2	Generic	\$0	\$0	\$12	\$24
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$42	\$106	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): Fresno and Madera Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): Stanislaus County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$40	\$100	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): Alameda County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$10	\$20
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$37	\$91	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): San Mateo County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$10	\$20
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$40	\$100	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Classic (HMO): Ventura County**SCAN Options (HMO):** Ventura County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$10	\$20
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$37	\$91	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Options (HMO): Santa Clara County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$10	\$20
2	Generic	\$0	\$0	\$17.50	\$35
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$40	\$100	\$45
4	Non-Preferred Drug	\$90	\$250	\$95	\$265
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Venture (HMO): Los Angeles, Orange, Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

Scripps Classic offered by SCAN Health Plan (HMO): San Diego County

Drug Tier	Tier Name	Retail				Mail Order	
		Preferred		Standard		Preferred	Standard
		30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$9	\$18	\$0	\$18
2	Generic	\$5	\$10	\$15	\$30	\$0	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35	\$85	\$55
		Other Drugs	\$42	\$106	\$47	\$121	\$106
4	Non-Preferred Drug	\$95	\$265	\$100	\$280	\$265	\$280
5	Specialty Tier	33%	N/A	33%	N/A	N/A	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33	\$33	\$33
We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.							

Scripps Signature offered by SCAN Health Plan (HMO): San Diego County

Drug Tier	Tier Name	Retail				Mail Order	
		Preferred		Standard		Preferred	Standard
		30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$9	\$18	\$0	\$18
2	Generic	\$3	\$6	\$12	\$24	\$0	\$24
3	Preferred Brand	Insulin	\$25	\$55	\$35	\$85	\$55
		Other Drugs	\$37	\$91	\$47	\$121	\$91
4	Non-Preferred Drug	\$95	\$265	\$100	\$280	\$265	\$280
5	Specialty Tier	33%	N/A	33%	N/A	N/A	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33	\$33	\$33
We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.							

Scripps Heart First offered by SCAN Health Plan (HMO C-SNP): San Diego County

Drug Tier	Tier Name	Retail				Mail Order	
		Preferred		Standard		Preferred	Standard
		30-day supply	100-day supply	30-day supply	100-day supply	100-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14	\$0	\$14
2	Generic	\$5	\$10	\$12	\$24	\$0	\$24
3	Preferred Brand	Insulin	\$25	\$55	\$35	\$85	\$55
		Other Drugs	\$42	\$106	\$47	\$121	\$106
4	Non-Preferred Drug	\$95	\$265	\$100	\$280	\$265	\$280
5	Specialty Tier	33%	N/A	33%	N/A	N/A	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Prime (HMO): Los Angeles and Orange Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$12	\$24
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Prime (HMO): Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$14	\$28
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Affirm (HMO): Los Angeles, Orange, Riverside and San Diego Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	25%	N/A	25%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Affirm (HMO): San Francisco County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$10	\$20
2	Generic	\$0	\$0	\$12	\$24
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	25%	N/A	25%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): Los Angeles and Orange Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$30	\$70	\$35
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): Stanislaus and Santa Clara Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$35	\$85	\$45
4	Non-Preferred Drug	\$85	\$235	\$95	\$265
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): Alameda and San Mateo Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$10	\$20
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$40	\$100	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$30	\$70	\$35
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): Fresno and Madera Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): San Diego County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$30	\$70	\$35
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Balance (HMO C-SNP): San Francisco County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$35	\$85	\$45
4	Non-Preferred Drug	\$85	\$235	\$95	\$265
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Heart First (HMO C-SNP): Orange and Los Angeles Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$9	\$18
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Heart First (HMO C-SNP): Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$14	\$28
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Heart First (HMO C-SNP): Alameda and San Mateo Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$10	\$20
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$40	\$100	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Heart First (HMO C-SNP): Santa Clara and Stanislaus Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$40	\$100	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Heart First (HMO C-SNP): Fresno and Madera Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Heart First (HMO C-SNP): San Francisco County

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$40	\$100	\$47
4	Non-Preferred Drug	\$90	\$250	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$0	\$0	\$0	\$0

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Embrace (HMO I-SNP): Los Angeles, Orange and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$0	\$0
2	Generic	\$0	\$0	\$0	\$0
3	Preferred Brand	Insulin	\$0	\$0	\$0
		Other Drugs	\$37	\$91	\$37
4	Non-Preferred Drug	\$99	\$277	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Healthy at Home (HMO I-SNP): Los Angeles, Orange, Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$15
2	Generic	\$0	\$0	\$12	\$36
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$42	\$126	\$47
4	Non-Preferred Drug	\$95	\$285	\$100	\$300
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Compass (HMO): Los Angeles, Orange, Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Inspired (HMO): Los Angeles and Orange Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$5	\$10
2	Generic	\$0	\$0	\$12	\$24
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN Navigate (HMO): Los Angeles, Orange, Riverside and San Bernardino Counties

Drug Tier	Tier Name	Retail & Mail Order			
		Preferred		Standard	
		30-day supply	100-day supply	30-day supply	100-day supply
1	Preferred Generic	\$0	\$0	\$7	\$14
2	Generic	\$0	\$0	\$15	\$30
3	Preferred Brand	Insulin	\$25	\$55	\$35
		Other Drugs	\$35	\$85	\$47
4	Non-Preferred Drug	\$95	\$265	\$100	\$280
5	Specialty Tier	33%	N/A	33%	N/A
6	Select Care Drugs	\$11	\$33	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic), Tier 2 (Generic), and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN MyChoice (HMO): Orange County

Drug Tier	Tier Name	Retail & Mail Order	
		30-day supply	100-day supply
1	Preferred Generic	\$0	\$0
2	Generic	\$0	\$0
3	Preferred Brand	Insulin	\$25
		Other Drugs	\$35
4	Non-Preferred Drug	\$70	\$190
5	Specialty Tier	33%	N/A
6	Select Care Drugs	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN MyChoice (HMO): San Diego County

Drug Tier	Tier Name	Retail & Mail Order	
		30-day supply	100-day supply
1	Preferred Generic	\$0	\$0
2	Generic	\$0	\$0
3	Preferred Brand	Insulin	\$25
		Other Drugs	\$35
4	Non-Preferred Drug	\$70	\$190
5	Specialty Tier	33%	N/A
6	Select Care Drugs	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

SCAN MyChoice (HMO): Alameda and San Mateo Counties

Drug Tier	Tier Name	Retail & Mail Order	
		30-day supply	100-day supply
1	Preferred Generic	\$0	\$0
2	Generic	\$0	\$0
3	Preferred Brand	Insulin	\$25
		Other Drugs	\$35
4	Non-Preferred Drug	\$70	\$190
5	Specialty Tier	33%	N/A
6	Select Care Drugs	\$11	\$33

We provide additional coverage of prescription drugs in Tier 1 (Preferred Generic) and Tier 3 (Preferred Brand – insulin only) in the Coverage Gap. Please refer to your Evidence of Coverage for more information about this coverage.

The chart below lists what you will pay as your share of the costs for covered prescription drugs at our network pharmacies when you are in the Initial Coverage Stage.

Please refer to your Evidence of Coverage for information about the costs at Long-Term Care (LTC) pharmacies and out-of-network pharmacies.

SCAN Strive (HMO C-SNP): Los Angeles, Orange, Riverside, San Bernardino, San Diego, Ventura, Santa Clara, Stanislaus, Fresno and Madera Counties

Members with no "Extra Help"	Members with "Extra Help"
Retail & Mail Order Pharmacies (one-, two- or three-month supply)	Retail & Mail Order Pharmacies (one-, two- or three-month supply)
You pay a 25% coinsurance of the total drug cost for all Part D prescription drugs covered on our Drug List, which begins on page 57.	You pay a \$0 copayment for all Part D prescription drugs covered on our Drug List, which begins on page 57.
You won't pay more than \$35 for a one-month supply and no more than \$105 for a three-month supply of each insulin product covered by our plan, even if you haven't paid your deductible. Most adult Part D vaccines are covered by our plan at no cost to you, even if you haven't paid your deductible.	You won't pay more than \$0 for a one-month through three-month supply of each insulin product covered by our plan. Most Part D vaccines are covered by our plan at no cost to you.
Some medications (e.g., Specialty drugs) are available for up to a one-month supply. To see which medications are available for an extended day supply, turn to page 57.	

SCAN Health Plan's Formulary

The formulary that begins on page 57 provides coverage information about the drugs covered by SCAN Health Plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 94.

The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., JANUVIA) and generic drugs are listed in lower-case italics (e.g., *metformin*).

The information in the Requirements/Limits column tells you if SCAN Health Plan has any special requirements for coverage of your drug.

- The symbol [PA] indicates that prior authorization applies.
- The symbol [B vs D] indicates that this drug may be covered under Medicare Part B or Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
- The symbol [QL] indicates that quantities dispensed are limited. To see the quantity limit amount for the formulary drugs with quantity limits, turn to the page 92.
- The symbol [LD] indicates that limited distribution applies. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Member Services at 1-800-559-3500 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.
- The symbol [EDS] indicates that this drug is available for an extended day supply (e.g., greater than a 30-day supply) at mail-order and many retail pharmacies.

SCAN Health Plan

2024 年處方藥一覽表（承保藥物清單）

請閱讀：本文件包含有關本計劃承保藥物的資訊

24429, 11

本處方藥一覽表更新於 03/01/2024。如需瞭解最新資訊或有其他疑問，請聯絡 SCAN Health Plan 會員服務部，電話：1-800-559-3500（聽障人士應致電 711），10 月 1 日至 3 月 31 日期間，服務時間為每週 7 天，上午 8 點至晚上 8 點。4 月 1 日至 9 月 30 日期間的服務時間為週一至週五，上午 8 點至晚上 8 點（節假日及營業時間之外收到的訊息將在一個工作日內回覆），或瀏覽 www.scanhealthplan.com。

現有會員請注意：本處方藥一覽表自去年以來已經變更。請查看此文件以確保其中仍包含您使用的藥物。

本藥物清單（處方藥一覽表）中，凡提述「我們」或「我們的」時，均指 SCAN Health Plan。凡提及「計劃」或「我們的計劃」時，是指 SCAN Affirm 與 Included LGBTQ+ Health 聯盟 (HMO)、SCAN Alta (HMO)、SCAN Classic (HMO)、SCAN Compass (HMO)、SCAN Inspired 女性專屬計劃 (HMO)、SCAN MyChoice (HMO)、SCAN Navigate (HMO)、SCAN Options (HMO)、SCAN Prime (HMO)、SCAN Venture (HMO)、Scripps Classic offered by SCAN Health Plan (HMO)、Scripps Signature offered by SCAN Health Plan (HMO)、SCAN Balance (HMO C-SNP)、SCAN Embrace (HMO I-SNP)、SCAN Healthy at Home (HMO I-SNP)，SCAN Heart First (HMO C-SNP)、Scripps Heart First offered by SCAN Health Plan (HMO C-SNP) 和 SCAN Strive (HMO C-SNP)。

本文件包含一份適用於我們計劃的藥物清單（處方藥一覽表），該清單最近更新於 2024 年 3 月。如需獲取最新的處方藥一覽表，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

您通常必須使用網絡內藥房才能享受處方藥福利。福利、處方藥一覽表、藥房網絡和/或共付額/共同保險可能會在 2025 年 1 月 1 日及一年中不時更改。必要時您會收到通知。

您可以要求透過網絡內郵購快遞計劃將處方藥送達您的家中。Express Scripts PharmacySM 是我們的郵購藥房之一。您可以在我們的任何網絡郵購藥房配取處方藥。一般而言，您可在 Express Scripts 郵購藥房接獲訂單後 14 天內收到您的處方藥。如果您在此時限內沒有收到您的處方藥，請聯絡 SCAN Health Plan 會員服務部。對於郵購處方藥，您可撥打 1-866-553-4125 聯絡 Express Scripts 藥房，選擇參加一項自動重配計劃，服務時間為每週 7 天，每天 24 小時。聽障人士可致電 711。您可以隨時取消自動配送。

SCAN Health Plan 是一項簽有 Medicare 合約的 HMO 計劃。能否參保 SCAN Health Plan 視合約續簽情況而定。

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什麼是 SCAN Health Plan 處方藥一覽表？

處方藥一覽表是 SCAN Health Plan 在諮詢保健服務提供者團隊後所選出的受保藥物清單，代表著高品質治療計劃中不可或缺的處方藥治療方案。只要具有醫療必需性，且於 SCAN Health Plan 網絡內藥房配藥，並遵守其他計劃規則，SCAN Health Plan 通常會承保列於處方藥一覽表中的藥物。要瞭解有關如何按您的處方配藥的更多資訊，請查閱您的《承保範圍說明書》。

處方藥一覽表（藥物清單）是否會變更？

大多數藥物的承保範圍在 1 月 1 日進行變更，但是我們可能會在一年之中添加或刪除藥物清單上的藥物、更改分攤費用層級或增設限制。進行變更時，我們必須遵守 Medicare 的規定。

今年可能會影響到您的變更：在下列情況中，您將受到當年承保範圍變更的影響：

- **新的普通藥。**如果我們計劃以新的普通藥取代某一品牌藥，而且這種普通藥將出現在相同或更低的分攤費用層級上，並具有相同或更少的限制，我們可能會立即將其從藥物清單上刪除。此外，在添加新的普通藥時，我們可能會決定保留我們藥物清單中的品牌藥，但會立即將其移至其他分攤費用層級或添加新的限制。如果您正在使用該品牌藥，我們可能不會在作出變更前提前通知您，但稍後我們會向您提供有關我們所做的具體變更的資訊。
 - 如果我們作出變更，您或您的處方醫生可以要求我們作出例外處理，並繼續為您承保該品牌藥。我們向您傳送的通知將詳細介紹如何申請例外處理，您可以在後文的「如何申請 SCAN Health Plan 處方藥一覽表例外」章節中查看更多資訊。
- **藥物下架。**若美國食品藥物管理局認為我們處方藥一覽表上的某種藥物不安全，或藥物製造商從市場中撤除該藥物，我們會立即從我們的處方藥一覽表上刪除該藥物，並向服用該藥物的會員發出通知。
- **其他變更。**我們可能會作出影響目前正在服用藥物的會員的其他變更。例如，我們可能會增加一種非新上市的普通藥來取代處方藥一覽表上現有的品牌藥，或者對品牌藥添加新的限制，或將其移至不同的分攤費用層級，或兩者兼而有之。我們也可能會根據新的臨床指南作出變更。如果我們從處方藥一覽表中移除了某些藥物，或對某個藥物新增了事先授權、數量限制和/或階段療法限制，或提高某個藥物的分攤費用層級，則我們必須在該變更生效前至少 30 天，或在會員要求重配該藥物時向受影響的會員發出通知（該名會員將收到 30 天份的藥物）。
 - 如果我們作出其他變更，您或您的開處方者可以要求我們作出例外處理，並繼續為您承保該品牌藥。我們向您傳送的通知將詳細介紹如何申請例外處理，您也可以在後文的「如何申請 SCAN Health Plan 處方藥一覽表例外」章節中查看更多資訊。

這些變更不會影響您當前正在服用的藥物。一般而言，若您正在服用年初享受承保的 2024 年處方藥一覽表上的藥物，我們不會在 2024 年承保年度中終止或減少此藥物的承保，除非出現上文所述情況。換言之，在承保年度的剩餘時間內，此藥物將以相同的分攤費用向使用此藥物的會員提供，且不設新的限制。對於不會影響您的變更，今年內您不會收到有關直接通知。然而，自明年的 1 月 1 日起，此類變更將會影響到您，因此務必檢查新的福利年度的藥物清單以瞭解藥物是否有任何變更。

隨附的處方藥一覽表更新於 2024 年 3 月。如需瞭解有關 SCAN Health Plan 承保藥物的最新資訊，請聯絡我們。我們的聯絡資訊載於封面和封底。

如何使用處方藥一覽表？

有兩種方法在處方藥一覽表中查找您所需的藥物：

病症

處方藥一覽表從 57 頁開始。本處方藥一覽表中的藥物依照其所治療的病症類別分類。例如，用來治療心臟病的藥物列在「心血管藥物」類別。如果您知道您的藥物的用途，請在從第 57 頁開始的清單中查找類別名稱。然後，在此類別名稱下查找所需的藥物。

按字母順序排列的清單

如果您不確定要查看哪個類別，您應該在第 94 頁開始的索引中查找您的藥物。該索引提供一份按字母順序排列的清單，其中有本文件包含的所有藥物。該索引中列有品牌藥和普通藥。請在該索引中查找所需的藥物。藥物旁邊註有頁碼，您可以在該頁查找承保範圍資訊。轉到該索引中所列的頁碼，在清單的第一欄即可找到所需的藥物名稱。

什麼是普通藥？

SCAN Health Plan 同時承保品牌藥和普通藥。普通藥由 FDA 批准為具有與品牌藥相同的活性成分。一般來說，普通藥的費用低於品牌藥。

對於我享受的承保範圍是否有任何限制？

某些承保藥物可能有其他要求或承保範圍限制。這些要求和限制可能包括：

- **事先授權：**對於某些藥物，SCAN Health Plan 要求您或您的醫生取得事先授權。這表示您需要在配藥前取得 SCAN Health Plan 的批准。如果您沒有取得批准，SCAN Health Plan 可能不會承保該藥物。
- **數量限制：**對於某些藥物，SCAN Health Plan 限制了 SCAN Health Plan 承保的藥物數量。例如，SCAN Health Plan 為每份 BELSOMRA 處方提供 30 片藥片。這可以另外附加在標準的一個月或三個月的供藥上。

您可以通過查看從第 57 頁開始的處方藥一覽表來瞭解您的藥物是否有任何其他要求或限制。您也可以流覽我們的網站以取得更多關於特定承保藥物限制的資訊。我們已在網上發佈了一份文件，解釋了我們的事先授權限制。您也可以要求我們寄一份給您。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

您可以要求 SCAN Health Plan 對此類限制或使用上限作出例外處理，或提供能夠治療您的病症的其他相似藥物清單。請參閱第 33 頁上的「如何申請 SCAN Health Plan 處方藥一覽表例外處理？」章節以瞭解如何申請例外處理。

若我的藥物不在此處方藥一覽表上，該怎麼辦？

如果您的藥物不在此處方藥一覽表（承保藥物清單）上，那麼您首先應該聯絡會員服務部，詢問您的藥物是否在承保範圍內。

如果您得知 **SCAN Health Plan** 不承保您的藥物，您有兩種選擇：

- 向會員服務部索要一份由 **SCAN Health Plan** 承保的相似藥物清單。收到該清單後，請出示給您的醫生看並要求開配 **SCAN Health Plan** 承保的類似藥物。
- 您可以要求 **SCAN Health Plan** 作出例外處理以便為您的藥物提供承保。請查看以下關於如何申請例外處理的資訊。

如何申請 **SCAN Health Plan** 處方藥一覽表例外處理？

您可以要求 **SCAN Health Plan** 對我們的承保規則作出例外處理。您可要求我們作出例外處理的類型有數種。

- 您可以要求我們承保一種藥物，即使它不在我們的處方藥一覽表上。如獲批准，此藥物將按預定分攤費用等級獲得承保，且您不得要求我們以更低的分攤費用等級提供此藥物。
- 除非此藥物屬於特殊級藥，否則您可要求我們按更低的分攤費用等級承保處方藥一覽表藥物。如獲批准，則可減少您必須為藥物支付的金額。
- 您可以要求我們撤銷對您的藥物的承保限制。例如，**SCAN Health Plan** 限制了某些藥物的承保數量。如果您的藥物有數量限制，則可以要求我們撤銷限制並承保更多數量。

通常情況下，只有在替代藥物處於計劃的處方藥一覽表上時，或是較低分攤費用的藥物或額外的使用限制對於治療您的病症無法達到相同的效果時，和/或可能造成副作用時，**SCAN Health Plan** 才會批准您申請的例外處理。

您應當與我們聯絡，要求我們做出針對處方藥一覽表、藥物等級，或使用限制例外處理的初始承保決定。在提出針對處方藥一覽表藥物等級或使用限制例外處理申請時，您應提交一份處方醫師或醫師的聲明來支持您的申請。通常，我們在收到處方醫師的支持聲明後，必須在 72 小時內做出決定。如果您或您的醫生認為等候 72 小時再作出決定會對您的健康造成嚴重傷害，您可以申請加急（快速）例外處理。如果您的加急申請獲得批准，我們在收到您的醫生或其他處方醫生的支持聲明後，必須在 24 小時內為您做出決定。

在向醫生提出變更藥物要求或提交例外處理申請之前，我應該做什麼？

無論是本計劃的新會員還是老會員，您可能正在使用我們處方藥一覽表上沒有的藥物。或者，您正在使用一種在我們處方藥一覽表上的藥物，但您在獲取該藥物時受到限制。例如，您在配藥之前可能要獲得我們的事先授權。您應當先和您的醫生談談，以決定您是否應該換用我們承保的適當藥物，或提出處方藥一覽表例外處理申請以使我們承保您使用的藥物。在您與醫生討論以確定何種措施適合您時，我們會在您成為計劃會員後的頭 90 天內針對某些情況為您的藥物提供承保。

如果您的所有藥物都不在我們的處方藥一覽表上，或您獲取藥物時受到限制，則我們將承保 30 天（您不住在長期護理機構時）或 31 天（您住在長期護理機構時）的臨時供藥。如果您的處方天數較短，我們將允許重配藥物，提供最多 30 天（您不住在長期護理機構時）或 31 天（您住在長期護理機構時）的供藥。在您獲得 30 天（您不住在長期護理機構時）或 31 天（您住在長期護理機構時）的供藥後，我們將不再為您支付這些藥物的費用，即使您成為計劃會員還不足 90 天。

如果您居住在長期護理機構且需要的藥物不在處方藥一覽表上，或您獲取藥物時受到限制，但您成為我們計劃的會員已超過 90 天，則在您尋求處方藥一覽表例外處理時，我們將會對該藥物承保 31 天份的緊急藥量。

如果您是過渡到另一個護理級別的現任會員，則給您開處的藥物可能會不在處方藥一覽表上，或您獲得藥物時可能會受到限制。若出現上述情況，您需要諮詢您的醫生來瞭解我們處方藥一覽表上是否有適當的替代療法。如果我們處方藥一覽表上沒有適當的替代療法，您或您的醫生可提出例外請求，要求本計劃承保您所用的藥物或解除對您所用藥物的限制。在您諮詢醫生以確定治療方案的同時，您將有資格獲得 30 天（您從長期護理機構或醫院搬回家時）或 31 天（您從家中或醫院搬到長期護理機構時）的過渡期供藥。

瞭解更多資訊

如需瞭解更多關於 SCAN Health Plan 處方藥保險的詳細資訊，請查閱您的承保範圍說明書及其他計劃資料。

如果您對 SCAN Health Plan 有任何疑問，請聯絡我們。我們的聯絡資訊連同最後更新處方藥一覽表的日期載於封面和封底。

如果您對 Medicare 處方藥保險有任何疑問，請致電 Medicare：

1-800-MEDICARE (1-800-633-4227) 獲取資訊，全天候服務。聽障人士應致電 1-877-486-2048。或瀏覽 <http://www.medicare.gov>。

下表列出了您在初始承保階段，在我們的網絡內藥房需要為承保範圍內的處方藥支付的分攤費用。

首選分攤費用是指在特定網絡內藥房為某些 D 部分承保藥物支付的較低分攤費用。如需瞭解更多資訊，請瀏覽我們線上的可搜尋「藥房目錄」，網址：www.scanhealthplan.com，或致電會員服務部。我們的聯絡資訊載於封面和封底。

如需瞭解長期護理 (LTC) 藥房和網絡外藥房費用的相關資訊，請參閱您的「承保範圍說明書」。

如果您接受「額外補助」，則您對承保的處方藥支付的分攤費用取決於您所接受的「額外補助」等級。如需瞭解更多有關藥物費用的資訊，請參見「**LIS 附則**」。

對於我們計劃承保的每種胰島素產品的一個月供應量，您支付的費用不會超過 \$35，三個月供應量的費用分攤費用也不會超過 \$105，無論其費用分攤等級如何。

大多數成人 D 部分疫苗由我們的計劃免費承保。

SCAN Classic (HMO)：洛杉磯郡和橘郡

SCAN Alta (HMO)：聖地牙哥郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 河濱郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$9	\$18
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 聖貝納迪諾

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$9	\$18
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 聖塔克拉拉郡和三藩市郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$10	\$20
2	普通藥	\$0	\$0	\$12	\$24
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$42	\$106	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 弗雷斯諾和馬德拉郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 斯坦尼斯勞斯郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$40	\$100	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 阿拉米達郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$10	\$20
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$37	\$91	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 聖馬刁郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$10	\$20
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$40	\$100	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Classic (HMO) : 文圖拉郡

SCAN Options (HMO) : 文圖拉郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$10	\$20
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$37	\$91	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Options (HMO) : 聖塔克拉拉郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$10	\$20
2	普通藥	\$0	\$0	\$17.50	\$35
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$40	\$100	\$45
4	非首選藥物	\$90	\$250	\$95	\$265
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Venture (HMO) : 洛杉磯郡、橘郡、河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

Scripps Classic offered by SCAN Health Plan (HMO) : 聖地牙哥郡

藥物等級	等級名稱	零售				郵購	
		首選		標準		首選	標準
		30 天份量	100 天份量	30 天份量	100 天份量	100 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$9	\$18	\$0	\$18
2	普通藥	\$5	\$10	\$15	\$30	\$0	\$30
3	首選品牌	胰島素	\$25	\$55	\$35	\$85	\$55
		其他藥物	\$42	\$106	\$47	\$121	\$106
4	非首選藥物	\$95	\$265	\$100	\$280	\$265	\$280
5	特殊級藥物	33%	不適用	33%	不適用	不適用	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33	\$33	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

Scripps Signature offered by SCAN Health Plan (HMO) : 聖地牙哥郡

藥物等級	等級名稱	零售				郵購	
		首選		標準		首選	標準
		30 天份量	100 天份量	30 天份量	100 天份量	100 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$9	\$18	\$0	\$18
2	普通藥	\$3	\$6	\$12	\$24	\$0	\$24
3	首選品牌	胰島素	\$25	\$55	\$35	\$85	\$55
		其他藥物	\$37	\$91	\$47	\$121	\$91
4	非首選藥物	\$95	\$265	\$100	\$280	\$265	\$280
5	特殊級藥物	33%	不適用	33%	不適用	不適用	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33	\$33	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

Scripps Heart First offered by SCAN Health Plan (HMO C-SNP) : 聖地牙哥郡

藥物等級	等級名稱	零售				郵購		
		首選		標準		首選	標準	
		30 天份量	100 天份量	30 天份量	100 天份量	100 天份量	100 天份量	
1	首選普通藥	\$0	\$0	\$7	\$14	\$0	\$14	
2	普通藥	\$5	\$10	\$12	\$24	\$0	\$24	
3	首選品牌	胰島素	\$25	\$55	\$35	\$85	\$55	\$85
		其他藥物	\$42	\$106	\$47	\$121	\$106	\$121
4	非首選藥物	\$95	\$265	\$100	\$280	\$265	\$280	
5	特殊級藥物	33%	不適用	33%	不適用	不適用	不適用	
6	選擇性護理藥物	\$0	\$0	\$0	\$0	\$0	\$0	

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Prime (HMO) : 洛杉磯郡和橘郡

藥物等級	等級名稱	零售和郵購				
		首選		標準		
		30 天份量	100 天份量	30 天份量	100 天份量	
1	首選普通藥	\$0	\$0	\$5	\$10	
2	普通藥	\$0	\$0	\$12	\$24	
3	首選品牌	胰島素	\$25	\$55	\$35	\$85
		其他藥物	\$35	\$85	\$47	\$121
4	非首選藥物	\$95	\$265	\$100	\$280	
5	特殊級藥物	33%	不適用	33%	不適用	
6	選擇性護理藥物	\$11	\$33	\$11	\$33	

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Prime (HMO) : 河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$14	\$28
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Affirm (HMO) : 洛杉磯郡、橘郡、河濱郡和聖地牙哥郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	25%	不適用	25%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Affirm (HMO) : 舊金山郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$10	\$20
2	普通藥	\$0	\$0	\$12	\$24
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	25%	不適用	25%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 洛杉磯郡和橘郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$9	\$18
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$30	\$70	\$35
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 斯坦尼斯勞斯郡和聖塔克拉拉郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$35	\$85	\$45
4	非首選藥物	\$85	\$235	\$95	\$265
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 阿拉米達郡和聖馬刁郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$10	\$20
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$40	\$100	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$9	\$18
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$30	\$70	\$85
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 弗雷斯諾和馬德拉郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$35	\$85	\$121
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 聖地牙哥郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$9	\$18
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$30	\$70	\$85
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Balance (HMO C-SNP) : 舊金山郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$35	\$85	\$115
4	非首選藥物	\$85	\$235	\$95	\$265
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Heart First (HMO C-SNP) : 橘郡和洛杉磯郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$9	\$18
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Heart First (HMO C-SNP) : 河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$14	\$28
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Heart First (HMO C-SNP) : 阿拉米達郡和聖馬刁郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$10	\$20
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$40	\$100	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Heart First (HMO C-SNP) : 聖克拉拉郡和斯坦尼斯勞斯郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$40	\$100	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Heart First (HMO C-SNP) : 弗雷斯諾和馬德拉郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Heart First (HMO C-SNP) : 舊金山郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$40	\$100	\$47
4	非首選藥物	\$90	\$250	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$0	\$0	\$0	\$0

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Embrace (HMO I-SNP) : 洛杉磯郡、橘郡和聖貝納迪諾

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$0	\$0
2	普通藥	\$0	\$0	\$0	\$0
3	首選品牌	胰島素	\$0	\$0	\$0
		其他藥物	\$37	\$91	\$91
4	非首選藥物	\$99	\$277	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Healthy at Home (HMO I-SNP) : 洛杉磯郡、橘郡、河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$15
2	普通藥	\$0	\$0	\$12	\$36
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$42	\$126	\$47
4	非首選藥物	\$95	\$285	\$100	\$300
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Compass (HMO) : 洛杉磯郡、橘郡、河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Inspired (HMO) : 洛杉磯郡和橘郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$5	\$10
2	普通藥	\$0	\$0	\$12	\$24
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN Navigate (HMO) : 洛杉磯郡、橘郡、河濱郡和聖貝納迪諾郡

藥物等級	等級名稱	零售和郵購			
		首選		標準	
		30 天份量	100 天份量	30 天份量	100 天份量
1	首選普通藥	\$0	\$0	\$7	\$14
2	普通藥	\$0	\$0	\$15	\$30
3	首選品牌	胰島素	\$25	\$55	\$35
		其他藥物	\$35	\$85	\$47
4	非首選藥物	\$95	\$265	\$100	\$280
5	特殊級藥物	33%	不適用	33%	不適用
6	選擇性護理藥物	\$11	\$33	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）、第 2 級處方藥（普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN MyChoice (HMO) : 橘郡

藥物等級	等級名稱	零售和郵購	
		30 天份量	100 天份量
1	首選普通藥	\$0	\$0
2	普通藥	\$0	\$0
3	首選品牌	胰島素	\$25
		其他藥物	\$35
4	非首選藥物	\$70	\$190
5	特殊級藥物	33%	不適用
6	選擇性護理藥物	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN MyChoice (HMO) : 聖地牙哥郡

藥物等級	等級名稱	零售和郵購	
		30 天份量	100 天份量
1	首選普通藥	\$0	\$0
2	普通藥	\$0	\$0
3	首選品牌	胰島素	\$25
		其他藥物	\$35
4	非首選藥物	\$70	\$190
5	特殊級藥物	33%	不適用
6	選擇性護理藥物	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

SCAN MyChoice (HMO) : 阿拉米達郡和聖馬刁郡

藥物等級	等級名稱	零售和郵購	
		30 天份量	100 天份量
1	首選普通藥	\$0	\$0
2	普通藥	\$0	\$0
3	首選品牌	胰島素	\$25
		其他藥物	\$35
4	非首選藥物	\$70	\$190
5	特殊級藥物	33%	不適用
6	選擇性護理藥物	\$11	\$33

在承保缺口階段，我們會對第 1 級處方藥（首選普通藥）和第 3 級處方藥（首選品牌藥，僅限胰島素藥物）提供額外承保。關於此承保範圍的資訊，請參閱「承保範圍說明書」。

下表列出了您在初始承保階段，在我們的網絡內藥房為承保處方藥支付的分攤費用。

如需瞭解長期護理 (LTC) 藥房和網絡外藥房費用的相關資訊，請參閱您的「承保範圍說明書」。

SCAN Strive (HMO C-SNP) : 洛杉磯郡、橘郡、河濱郡、聖貝納迪諾、聖地牙哥郡、文圖拉郡、聖塔克拉拉郡、斯坦尼斯勞斯郡、弗雷斯諾郡和馬德拉郡

沒有「額外補助」的會員	享有「額外補助」的會員
零售和郵購藥房 (一個月、兩個月或三個月的份量)	零售和郵購藥房 (一個月、兩個月或三個月的份量)
對於我們藥物清單（從第 57 頁開始）上承保的所有 D 部分處方藥，您需支付總藥費的 25% 共同保險。	您需為我們藥物清單（從第 57 頁開始）上承保的所有 D 部分處方藥支付 \$0 的共付額。
即使您尚未支付自付額，您也不會為我們計劃承保的每種胰島素產品的一個月供應量支付超過 \$35，為三個月供應量支付的費用也不會超過 \$105。 大多數成人 D 部分疫苗由我們的計劃承保，即使您尚未支付自付額，也不收取任何費用。	
某些藥物（例如特殊藥物）可提供長達一個月的供應量。要查看哪些藥物可用於延長天數供應，請轉到第 57 頁。	

SCAN Health Plan 處方藥一覽表

處方藥一覽表從第 57 頁開始，提供有關 SCAN Health Plan 承保藥物的承保範圍資訊。如果您在清單中查找藥物時遇到困難，請參閱從第 94 頁開始的索引。

圖表的第一欄列出了藥物名稱。品牌藥用大寫字母表示（例如 JANUVIA），普通藥用小寫斜體字母列出（例如 *metformin*）。

要求/限制欄中的資訊說明了 SCAN Health Plan 在承保您的藥物時是否有任何特殊要求。

- [PA] 表明適用於事先授權。
- [B vs D] 表明此藥物可能由 Medicare B 部分或 D 部分承保（視情況而定）。此時可能需要提交描述藥物用途與規定的資訊，以利裁決。
- [QL] 表明配發數量受限。要查看有數量限制的處方藥一覽表藥物的數量限制，請轉到第 92 頁。
- [LD] 表明配發受限。此處方藥可能只在某些藥房提供。如需瞭解更多資訊，請查看藥房目錄或致電會員服務部，電話：1-800-559-3500（聽障人士應致電 711），10 月 1 日至 3 月 31 日期間，服務時間為每週 7 天，上午 8 點至晚上 8 點。4 月 1 日至 9 月 30 日期間的服務時間為週一至週五，上午 8 點至晚上 8 點（節假日及營業時間之外收到的訊息將在一個工作日內回覆），或瀏覽 www.scanhealthplan.com。
- [EDS] 表示此藥物可在郵購和許多零售藥房獲得延長天數供藥（例如大於 30 天份量的供藥）。

FORMULARY DRUGS ARRANGED BY THERAPEUTIC CLASS

處方藥一覽表上的藥物按照治療類別排列

Formulary ID: 24429 (Version 11)

處方藥一覽表: 24429 (版本 11)

Updated: 3/2024

版本: 3/2024

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
ANALGESICS		
Opioid Analgesics, Long-acting		
fentanyl patches 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/hr & 100mcg/hr	3	[QL] [EDS]
methadone oral	2	[EDS]
morphine sulfate er tabs	3	[QL] [EDS]
OXYCODONE ER TABS	4	[QL] [EDS]
tramadol er tabs	3	[QL] [EDS]
Opioid Analgesics, Short-acting		
acetaminophen & codeine	2	[QL] [EDS]
butorphanol tartrate nasal	2	[QL] [EDS]
codeine sulfate	2	[EDS]
endocet	3	[QL] [EDS]
fentanyl citrate lozenges 200mcg	4	[PA] [EDS]
fentanyl citrate lozenges 400mcg, 600mcg, 800mcg, 1200mcg & 1600mcg	5	[PA]
hydrocodone & acetaminophen soln 7.5-325mg/15ml	2	[QL] [EDS]
hydrocodone & acetaminophen tabs 5-325mg, 7.5-325mg & 10-325mg	2	[QL] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
hydrocodone & ibuprofen	2	[QL] [EDS]
hydromorphone immediate-release oral soln & tabs	2	[EDS]
hydromorphone inj	3	[EDS]
morphine sulfate oral	2	[EDS]
oxycodone immediate-release	2	[EDS]
oxycodone oral soln	2	[EDS]
oxycodone & acetaminophen 2.5- 325mg, 5-325mg, 7.5- 325mg & 10-325mg	3	[QL] [EDS]
tramadol tab 50mg	2	[EDS]
tramadol ir tab 100mg	2	[QL] [EDS]
tramadol & acetaminophen	2	[QL] [EDS]
ANESTHETICS		
Local Anesthetics		
lidocaine ointment	4	[QL] [EDS]
lidocaine patch	3	[PA] [EDS]
lidocaine topical soln	2	[QL] [EDS]
lidocaine & prilocaine cream	3	[QL] [EDS]
lidocan III	3	[PA] [EDS]
ANTI-ADDICTION/SUBSTANCE ABUSE TREATMENT AGENTS		
Alcohol Deterrents/Anti-Craving		
acamprosate calcium dr	2	[EDS]
disulfiram	2	[EDS]

[PA] = Prior Authorization [B vs D] = B versus D [QL] = Quantity Limit

[LD] = Limited Distribution [EDS] = Extended Day Supply

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits	
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制	
Opioid Dependence						
buprenorphine sublingual tabs	1	[EDS]	naproxen tabs 250mg, 375mg & 500mg	1	[EDS]	
buprenorphine & naloxone sublingual film	2	[EDS]	naproxen dr tabs	1	[EDS]	
buprenorphine & naloxone sublingual tabs	2	[EDS]	naproxen sodium ir tabs	1	[EDS]	
naltrexone	1	[EDS]	piroxicam	2	[EDS]	
Opioid Reversal Agents						
KLOXXADO	3	[EDS]	sulindac	2	[EDS]	
naloxone inj	2	[EDS]	ANTIBACTERIALS			
naloxone nasal	2	[EDS]	Aminoglycosides			
Smoking Cessation Agents						
bupropion sr 150mg	2	[EDS]	amikacin inj	2	[EDS]	
NICOTROL INHALER	3	[EDS]	gentamicin cream 0.1% & oint 0.1%	2	[EDS]	
NICOTROL NASAL	3	[EDS]	gentamicin inj 40mg/ml	2	[EDS]	
varenicline starting month box	4	[EDS]	neomycin sulfate oral	2	[EDS]	
varenicline tartrate	4	[EDS]	paromomycin	3	[EDS]	
ANTI-INFLAMMATORY AGENTS			streptomycin inj	2	[EDS]	
Nonsteroidal Anti-inflammatory Drugs			tobramycin sulfate inj	2	[EDS]	
celecoxib	2	[EDS]	Antibacterials, Other			
diclofenac potassium tab 50mg	1	[EDS]	aztreonam inj	4	[EDS]	
diclofenac sodium dr	1	[EDS]	CLEOCIN VAGINAL SUPP	3	[EDS]	
diclofenac sodium er	1	[EDS]	clindamycin oral	2	[EDS]	
diflunisal	2	[EDS]	clindamycin phosphate inj	2	[EDS]	
etodolac	2	[EDS]	clindamycin phosphate/dextrose inj	2	[EDS]	
etodolac er	2	[EDS]	clindamycin vaginal cream	2	[EDS]	
ibu	1	[EDS]	colistimethate inj	2	[EDS]	
ibuprofen	1	[EDS]	daptomycin inj	5		
indometacin er	2	[EDS]	fosfomycin pack	4	[EDS]	
indometacin ir caps	2	[EDS]	linezolid inj	4	[EDS]	
ketorolac oral tabs	2	[EDS]	linezolid oral susp and tabs	4	[EDS]	
LODINE TABS	2	[EDS]	methenamine hippurate	2	[EDS]	
meloxicam tabs	1	[EDS]	metronidazole inj	2	[EDS]	
nabumetone	2	[EDS]	metronidazole oral	2	[EDS]	

[PA] = 事先授權 [B vs D] = B 與 D [QL] = 數量限制 [LD] = 限量分配 [EDS] = 延長天數供藥

您可以前往第 56 頁，找到本表中的符號和縮寫詞所代表含義的相關資訊。

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits	
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制	
<i>metronidazole topical</i>	3	[EDS]	Beta-lactam, Penicillins			
<i>metronidazole vaginal gel</i>	2	[EDS]	<i>amoxicillin</i>	1	[EDS]	
<i>nitrofurantoin caps</i>	2	[EDS]	<i>amoxicillin & clavulanate potassium</i>	2	[EDS]	
SIVEXTRO TABS & INJ	5		<i>amoxicillin & clavulanate potassium er</i>	2	[EDS]	
<i>tigecycline inj</i>	5		<i>ampicillin inj</i>	2	[EDS]	
<i>trimethoprim</i>	2	[EDS]	<i>ampicillin oral</i>	2	[EDS]	
<i>vancomycin caps</i>	4	[EDS]	<i>ampicillin & sulbactam inj 10-5gm, 2-1gm & 1-0.5gm</i>	2	[EDS]	
<i>vancomycin inj 500mg, 750mg, 1gm & 10gm</i>	3	[EDS]	BICILLIN L-A INJ	4	[EDS]	
<i>vancomycin oral soln 250mg/5ml</i>	4	[EDS]	<i>dicloxacillin sodium</i>	2	[EDS]	
<i>vandazole</i>	2	[EDS]	<i>nafcillin sodium inj</i>	4	[EDS]	
XIFAXAN TABS 200MG	3	[PA] [EDS]	<i>penicillin g inj 5 million units & 20 million units</i>	2	[EDS]	
XIFAXAN TABS 550MG	5	[PA]	<i>penicillin v potassium</i>	2	[EDS]	
Beta-lactam, Cephalosporins						
<i>cefaclor</i>	2	[EDS]	<i>piperacillin/tazobactam inj</i>	3	[EDS]	
<i>cefaclor er</i>	2	[EDS]	ZOSYN INJ	4	[EDS]	
<i>cefadroxil caps & tabs</i>	2	[EDS]	Carbapenems			
<i>cefazolin inj</i>	2	[EDS]	<i>cilastatin/imipenem inj</i>	2	[EDS]	
<i>cefdinir</i>	2	[EDS]	<i>ertapenem inj</i>	4	[EDS]	
<i>cefepime inj</i>	2	[EDS]	<i>meropenem inj</i>	4	[EDS]	
<i>cefixime caps</i>	3	[EDS]	Macrolides			
<i>cefixime susp</i>	4	[EDS]	<i>azithromycin tabs & oral susp bottle</i>	2	[EDS]	
<i>cefoxitin sodium</i>	2	[EDS]	<i>azithromycin inj</i>	2	[EDS]	
<i>cefpodoxime tabs</i>	2	[EDS]	<i>clarithromycin</i>	2	[EDS]	
<i>cefprozil</i>	2	[EDS]	<i>clarithromycin er</i>	2	[EDS]	
<i>ceftazidime inj</i>	2	[EDS]	DIFCID	5		
<i>ceftriaxone inj</i>	2	[EDS]	ERYTHROCIN LACTOBIONATE INJ	4	[EDS]	
<i>cefuroxime oral</i>	2	[EDS]	<i>erythrocin stearate</i>	3	[EDS]	
<i>cefuroxime inj</i>	2	[EDS]	<i>erythromycin caps & tabs</i>	3	[EDS]	
<i>cephalexin caps & tabs 250mg & 500mg</i>	1	[EDS]	<i>erythromycin dr</i>	3	[EDS]	
<i>cephalexin oral susp</i>	1	[EDS]				
<i>tazicef inj</i>	2	[EDS]				
TEFLARO INJ	5					
ZERBAXA INJ	5					

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits			
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制			
Quinolones								
ciprofloxacin in d5w inj	2	[EDS]	felbamate tabs 600mg	4	[EDS]			
ciprofloxacin tabs immediate-release 250mg, 500mg & 750mg	1	[EDS]	felbamate oral susp 600mg/5ml	5				
levofloxacin in d5w inj	2	[EDS]	FINTEPLA	5	[PA] [LD]			
levofloxacin oral soln	2	[EDS]	FYCOMPA	4	[EDS]			
levofloxacin tabs	1	[EDS]	levetiracetam er	2	[EDS]			
moxifloxacin inj	4	[EDS]	levetiracetam oral	2	[EDS]			
moxifloxacin oral	2	[EDS]	NAYZILAM	4	[EDS]			
ofloxacin oral	2	[EDS]	roweepra 500mg	2	[EDS]			
Sulfonamides								
sulfacetamide sodium topical lotion 10%	2	[EDS]	SPRITAM	4	[EDS]			
sulfadiazine tabs	4	[EDS]	valproic acid oral caps & soln	2	[EDS]			
sulfamethoxazole & trimethoprim tabs	1	[EDS]	XCOPRI TABS	5				
sulfamethoxazole & trimethoprim ds tabs	1	[EDS]	XCOPRI MAINTENANCE PACK	5				
sulfamethoxazole & trimethoprim oral susp	2	[EDS]	XCOPRI TITRATION PACK 12.5-25MG	4	[EDS]			
Tetracyclines								
demeclocycline	4	[EDS]	XCOPRI TITRATION PACK 50-100MG, & 150-200MG	5				
doxy 100 inj	2	[EDS]	ZTALMY SUSP	5	[LD]			
doxycycline immediate-release tabs, caps & oral susp	2	[EDS]	Calcium Channel Modifying Agents					
minocycline ir	2	[EDS]	CELONTIN	4	[EDS]			
tetracycline	3	[EDS]	ethosuximide	2	[EDS]			
ANTICONVULSANTS			methsuximide	4	[EDS]			
Anticonvulsants, Other			Gamma-aminobutyric Acid (GABA) Augmenting Agents					
BRIVIACT ORAL SOLN	4	[EDS]	clobazam	4	[EDS]			
BRIVIACT TABS	5		clonazepam	2	[EDS]			
EPIDIOLEX	5	[PA] [LD]	clonazepam odt	2	[EDS]			
EPRONTIA	4	[EDS]	DIACOMIT	5	[PA]			
felbamate tabs 400mg	2	[EDS]	DIAZEPAM RECTAL GEL	3	[EDS]			
			divalproex sodium dr	2	[EDS]			
			divalproex sodium er	2	[EDS]			
			gabapentin caps, tabs & oral soln	2	[EDS]			
			phenobarbital elixir & tabs	2	[EDS]			

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您可以前往第 56 頁，找到本表中的符號和縮寫詞所代表含義的相關資訊。

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
pregabalin	2	[EDS]
primidone tabs 50mg & 250mg	2	[EDS]
PRIMIDONE TABS 125MG	3	[EDS]
SYMPAZAN 5MG	4	[EDS]
SYMPAZAN 10MG & 20MG	5	
tiagabine	4	[EDS]
VALTOCO	4	[EDS]
vigabatrin	5	[LD]
vigadronе	5	[LD]
vigpoder	5	[LD]
Sodium Channel Agents		
APTIOM	5	
carbamazepine tabs, chewable tabs & oral susp	2	[EDS]
carbamazepine er tabs & caps	3	[EDS]
DILANTIN CAPS	3	[EDS]
DILANTIN INFATABS	3	[EDS]
DILANTIN SUSP	3	[EDS]
epitol	2	[EDS]
lacosamide oral	4	[EDS]
oxcarbazepine tabs	2	[EDS]
oxcarbazepine susp	4	[EDS]
phenytek	2	[EDS]
phenytoin suspension & chewable tabs	2	[EDS]
phenytoin er	2	[EDS]
phenytoin oral susp	2	[EDS]
rufinamide	4	[EDS]
TEGRETOL	3	[EDS]
TEGRETOL XR	3	[EDS]
TRILEPTAL	4	[EDS]
ZONISADE	4	[EDS]
zonisamide	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
ANTIDEMENTIA AGENTS		
Antidementia Agents, Other		
ergoloid mesylates	3	[PA] [EDS]
Cholinesterase Inhibitors		
donepezil tabs 5mg & 10mg	2	[EDS]
donepezil odt	2	[EDS]
galantamine tabs	2	[EDS]
galantamine er caps	2	[EDS]
galantamine soln	4	[EDS]
rivastigmine caps	3	[EDS]
rivastigmine patches	4	[EDS]
N-methyl-D-aspartate (NMDA) Receptor Antagonists		
memantine hcl immediate release	2	[EDS]
memantine hcl soln	2	[EDS]
memantine hcl titration pack	2	[EDS]
ANTIDEPRESSANTS		
Antidepressants, Other		
AUVELITY	5	
bupropion hcl tabs	2	[EDS]
bupropion sr	2	[EDS]
bupropion xl 150mg & 300mg	2	[EDS]
bupropion xl 450mg	3	[EDS]
FORFIVO XL	3	[EDS]
mirtazapine	1	[EDS]
mirtazapine odt	1	[EDS]
nefazodone	2	[EDS]
perphenazine & amitriptyline	2	[EDS]
trazodone	1	[EDS]
TRINTELLIX	4	[EDS]
ZURZUVAE	5	[PA]
Monoamine Oxidase Inhibitors		
EMSAM	5	
MARPLAN	4	[EDS]
phenelzine	2	[EDS]
tranylcypromine	4	[EDS]

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits			
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制			
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin & Norepinephrine Reuptake Inhibitors)								
citalopram tabs	1	[EDS]	doxepin oral soln	2	[EDS]			
citalopram oral soln	2	[EDS]	imipramine hcl tabs	2	[EDS]			
DESVENLAFAKINE ER	4	[EDS]	nortriptyline	2	[EDS]			
desvenlafaxine succinate er	3	[EDS]	protriptyline	3	[EDS]			
escitalopram	2	[EDS]	trimipramine maleate	2	[EDS]			
FETZIMA	4	[EDS]	ANTIEMETICS					
FETZIMA TITRATION PACK	4	[EDS]	Antiemetics, Other					
fluoxetine hcl caps 10mg, 20mg & 40mg	2	[EDS]	compro	2	[EDS]			
fluoxetine hcl tabs 10mg & 20mg	2	[EDS]	meclizine	2	[EDS]			
fluoxetine hcl oral soln	2	[EDS]	prochlorperazine oral	2	[EDS]			
fluvoxamine	2	[EDS]	prochlorperazine suppositories	2	[EDS]			
fluvoxamine er	4	[EDS]	promethazine suppositories	3	[EDS]			
paroxetine hcl ir tabs	1	[EDS]	promethazine syrup	2	[EDS]			
paroxetine hcl er	2	[EDS]	promethazine tabs	2	[EDS]			
paroxetine hcl susp	4	[EDS]	promethegan	3	[EDS]			
sertraline tabs	1	[EDS]	scopolamine patch	3	[EDS]			
sertraline oral soln	2	[EDS]	Emetogenic Therapy Adjuncts					
VENLAFAKINE BESYLATE ER TAB 112.5MG	4	[EDS]	aprepitant caps 80mg & 125mg	4	[PA] [EDS]			
venlafaxine ir tabs	2	[EDS]	aprepitant pack	4	[PA] [EDS]			
venlafaxine hcl er tabs	3	[EDS]	dronabinol	4	[PA] [EDS]			
venlafaxine hcl er caps	2	[EDS]	granisetron oral	2	[PA] [B vs D] [EDS]			
vilazodone	3	[EDS]	ondansetron odt	2	[PA] [B vs D] [EDS]			
Tricyclics								
amitriptyline	2	[EDS]	ondansetron oral soln	2	[PA] [B vs D] [EDS]			
amoxapine	2	[EDS]	ondansetron tabs 4mg & 8mg	2	[PA] [B vs D] [EDS]			
clomipramine	4	[EDS]	ANTIFUNGALS					
desipramine	2	[EDS]	Antifungals					
doxepin caps	2	[EDS]	ABELCET INJ	4	[PA] [B vs D] [EDS]			
AMBI SOME INJ	5	[PA] [B vs D]						
amphotericin b inj	2	[PA] [B vs D] [EDS]						
amphotericin b liposome inj	5	[PA] [B vs D]						
caspofungin inj 50mg	5							

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您可以前往第 56 頁，找到本表中的符號和縮寫詞所代表含義的相關資訊。

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
<i>caspofungin inj 70mg</i>	4	[EDS]
<i>clotrimazole cream 1%</i>	2	[EDS]
<i>clotrimazole topical soln 1%</i>	2	[EDS]
<i>clotrimazole troche</i>	2	[EDS]
<i>CRESEMBA ORAL</i>	5	[PA]
<i>econazole nitrate</i>	4	[EDS]
<i>fluconazole in sodium chloride inj</i>	2	[EDS]
<i>fluconazole oral</i>	2	[EDS]
<i>flucytosine</i>	5	
<i>griseofulvin microsize</i>	2	[EDS]
<i>itraconazole</i>	4	[EDS]
<i>ketoconazole cream, shampoo & tabs</i>	2	[EDS]
<i>nyamyc</i>	2	[EDS]
<i>nystatin</i>	2	[EDS]
<i>nystop</i>	2	[EDS]
<i>posaconazole dr tabs</i>	5	[PA]
<i>posaconazole suspension</i>	4	[PA] [EDS]
<i>terbinafine</i>	2	[EDS]
<i>terconazole</i>	2	[EDS]
<i>voriconazole inj</i>	5	[PA]
<i>voriconazole oral suspension</i>	5	
<i>voriconazole tabs</i>	4	[EDS]
ANTIGOUT AGENTS		
Antigout Agents		
<i>allopurinol tabs 100mg & 300mg</i>	1	[EDS]
<i>COLCHICINE CAPS</i>	4	[EDS]
<i>colchicine tabs</i>	3	[EDS]
<i>febuxostat</i>	3	[EDS]
<i>probenecid</i>	2	[EDS]
<i>probenecid & colchicine</i>	2	[EDS]
ANTIMIGRAINE AGENTS		
Antimigraine Agents, Other		
<i>UBRELVY</i>	3	[PA] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
Ergot Alkaloids		
<i>caffeine-ergotamine</i>	3	[EDS]
<i>dihydroergotamine mesylate nasal</i>	5	
<i>migergot suppository</i>	4	[EDS]
Prophylactic		
<i>AIMOVIG INJ</i>	3	[PA] [EDS]
<i>EMGALITY INJ</i>	3	[PA] [EDS]
<i>NURTEC ODT</i>	3	[PA] [EDS]
<i>QULIPTA TABS</i>	3	[PA] [EDS]
<i>topiramate immediate-release</i>	2	[EDS]
Serotonin (5-HT) Receptor Agonist		
<i>naratriptan</i>	2	[EDS]
<i>rizatriptan</i>	2	[EDS]
<i>rizatriptan odt</i>	2	[EDS]
<i>sumatriptan nasal</i>	4	[EDS]
<i>sumatriptan succinate inj</i>	4	[EDS]
<i>sumatriptan succinate tabs</i>	2	[EDS]
<i>zolmitriptan nasal soln 5mg</i>	4	[EDS]
<i>zolmitriptan tabs</i>	3	[EDS]
<i>zolmitriptan odt</i>	3	[EDS]
<i>ZOMIG NASAL 2.5MG</i>	4	[EDS]
ANTIMYASTHENIC AGENTS		
Parasympathomimetics		
<i>pyridostigmine soln</i>	4	[EDS]
<i>pyridostigmine tabs 60mg</i>	3	[EDS]
<i>pyridostigmine er tabs 180mg</i>	4	[EDS]
ANTIMYCOBACTERIALS		
Antimycobacterials, Other		
<i>dapsone tabs</i>	3	[EDS]
<i>rifabutin</i>	4	[EDS]
Antituberculars		
<i>ethambutol</i>	2	[EDS]
<i>isoniazid</i>	2	[EDS]

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Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制
PRIFTIN	4	[EDS]
<i>pyrazinamide</i>	2	[EDS]
<i>rifampin oral and inj</i>	2	[EDS]
<i>rifampin inj</i>	2	[EDS]
SIRTURO	5	
TRECATOR	4	[EDS]
ANTINEOPLASTICS		
Alkylating Agents		
cyclophosphamide	3	[PA] [B vs D] [EDS]
GLEOSTINE	4	[EDS]
LEUKERAN	4	[EDS]
MATULANE	5	
VALCHLOR	5	[PA]
Antiandrogens		
<i>abiraterone acetate</i>	5	[PA]
<i>bicalutamide</i>	2	[EDS]
ERLEADA	5	[PA]
<i>nilutamide</i>	5	
NUBEQA	5	[PA] [LD]
XTANDI	5	[PA]
YONSA	5	[PA]
Antiangiogenic Agents		
FOTIVDA	5	[PA] [LD]
<i>lenalidomide</i>	5	[PA] [LD]
POMALYST	5	[PA] [LD]
QINLOCK	5	[PA] [LD]
TABRECTA	5	[PA]
THALOMID	5	[PA]
Antiestrogens/Modifiers		
EMCYT	3	[EDS]
SOLTAMOX	3	[EDS]
<i>tamoxifen</i>	2	[EDS]
<i>toremifene citrate</i>	5	
Antimetabolites		
<i>hydroxyurea</i>	2	[EDS]
<i>mercaptopurine</i>	2	[EDS]
PURIXAN	5	
TABLOID	4	[EDS]

Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制
Antineoplastics, Other		
AKEEGA	5	[PA] [LD]
BESREMI INJ	5	[PA] [LD]
GAVRETO	5	[PA] [LD]
IDHIFA	5	[PA] [LD]
INREBIC	5	[PA] [LD]
KRAZATI	5	[PA]
LONSURF	5	[PA]
LUMAKRAS	5	[PA]
LYTGOBI TABS	5	[PA] [LD]
NINLARO	5	[PA]
ONUREG	5	[PA]
ORSERDU TABS	5	[PA]
PEMAZYRE	5	[PA] [LD]
RETEVMO	5	[PA] [LD]
ROZLYTREK	5	[PA]
TAZVERIK	5	[PA] [LD]
TUKYSA	5	[PA] [LD]
VONJO	5	[PA]
XPOVIO	5	[PA] [LD]
Aromatase Inhibitors, 3rd Generation		
<i>anastrozole</i>	2	[EDS]
<i>exemestane</i>	3	[EDS]
<i>letrozole</i>	2	[EDS]
Enzyme Inhibitors		
BALVERSA	5	[PA]
ZOLINZA	5	[PA]
Molecular Target Inhibitors		
AUGTYRO	5	[PA]
ALECENSA	5	[PA]
ALUNBRIG	5	[PA]
ALUNBRIG	5	[PA]
INITIATION PACK		
AYVAKIT	5	[PA] [LD]
BOSULIF	5	[PA]
BRAFTOVI	5	[PA] [LD]
BRUKINSA	5	[PA] [LD]
CABOMETYX	5	[PA]
CALQUENCE	5	[PA] [LD]
CAPRELSA	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
COMETRIQ	5	[PA]	RYDAPT	5	[PA]
COPIKTRA	5	[PA] [LD]	SCEMBLIX	5	[PA]
COTELLIC	5	[PA]	sorafenib	5	[PA]
DAURISMO	5	[PA]	SPRYCEL	5	[PA]
ERIVEDGE	5	[PA]	STIVARGA	5	[PA]
<i>erlotinib</i>	5	[PA]	<i>sunitinib malate</i>	5	[PA]
everolimus tabs 2.5mg, 5mg, 7.5mg & 10mg	5	[PA]	TAFINLAR	5	[PA]
everolimus tabs for suspension 2mg, 3mg & 5mg	5	[PA]	TAGRISSO	5	[PA]
EXKIVITY	5	[PA] [LD]	TALZENNA	5	[PA]
FRUZAQLA	5	[PA]	TASIGNA	5	[PA]
<i>gefitinib</i>	5	[PA]	TEPMETKO	5	[PA] [LD]
GILOTrif	5	[PA]	TIBSOVO	5	[PA]
IBRANCE	5	[PA]	TRUQAP	5	[PA]
ICLUSIG	5	[PA]	TURALIO	5	[PA] [LD]
<i>imatinib</i>	5	[PA]	VENCLEXTA TABS 10MG & 50MG	3	[PA] [EDS]
IMBRUVICA	5	[PA]	VENCLEXTA TABS 100MG	5	[PA]
INLYTA	5	[PA]	VENCLEXTA STARTING PACK	5	[PA]
INQOVI	5	[PA]	VERZENIO	5	[PA] [LD]
IRESSA	5	[PA]	VITRAKVI	5	[PA] [LD]
JAKAFI	5	[PA]	VIZIMPRO	5	[PA]
JAYPIRCA TABS	5	[PA]	VOTRIENT	5	[PA]
KISQALI	5	[PA]	WELIREG	5	[PA] [LD]
KISQALI FEMARA CO-PACK	5	[PA]	XALKORI	5	[PA]
<i>lapatinib</i>	5	[PA]	XOSPATA	5	[PA] [LD]
LENVIMA	5	[PA]	VANFLYTA	5	[PA]
LORBRENA	5	[PA]	ZEJULA	5	[PA] [LD]
LYNPARZA	5	[PA]	ZELBORAF	5	[PA]
MEKINIST	5	[PA]	ZYDELIG	5	[PA]
MEKTOVI	5	[PA] [LD]	ZYKADIA TABS	5	[PA]
NERLYNX	5	[PA] [LD]	Retinoids		
ODOMZO	5	[PA]	<i>bexarotene</i>	5	[PA]
OJJAARA	5	[PA]	PANRETIN	5	
<i>pazopanib</i>	5	[PA]	<i>tretinoiin caps</i>	5	
PIQRAY	5	[PA]	Treatment Adjuncts		
REZLIDHIA CAPS	5	[PA]	<i>leucovorin oral</i>	2	[EDS]
RUBRACA	5	[PA] [LD]	MESNEX TABS	4	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
ANTIPARASITICS					
Anthelmintics					
<i>albendazole</i>	4	[EDS]	<i>carbidopa</i>	4	[EDS]
<i>ivermectin tabs</i>	2	[EDS]	<i>carbidopa & levodopa ir, er, odt</i>	2	[EDS]
Antiprotozoals					
<i>atovaquone susp</i>	4	[EDS]	Monoamine Oxidase B (MAO-B) Inhibitors		
<i>atovaquone/proguanil</i>	2	[EDS]	<i>rasagiline</i>	4	[EDS]
<i>chloroquine</i>	2	[EDS]	<i>selegiline</i>	2	[EDS]
<i>COARTEM</i>	3	[EDS]	ANTIPSYCHOTICS		
<i>hydroxychloroquine tab 200mg</i>	2	[EDS]	1st Generation/Typical		
<i>mefloquine</i>	2	[EDS]	<i>chlorpromazine oral</i>	4	[EDS]
<i>NEBUPENT NEBULIZER</i>	4	[PA] [B vs D] [EDS]	<i>fluphenazine oral</i>	2	[EDS]
<i>nitazoxanide</i>	5		<i>fluphenazine decanoate inj</i>	2	[EDS]
<i>pentamidine inhalation soln</i>	3	[PA] [B vs D] [EDS]	<i>fluphenazine inj</i>	2	[EDS]
<i>pentamidine inj</i>	4	[EDS]	<i>haloperidol oral</i>	2	[EDS]
<i>PRIMAQUINE</i>	3	[EDS]	<i>haloperidol decanoate inj</i>	2	[EDS]
<i>pyrimethamine</i>	5	[PA]	<i>haloperidol lactate inj</i>	2	[EDS]
<i>quinine sulfate caps</i>	3	[PA] [EDS]	<i>loxapine</i>	2	[EDS]
ANTIPARKINSON AGENTS			<i>molindone</i>	2	[EDS]
Anticholinergics			<i>perphenazine</i>	2	[EDS]
<i>benztropine tabs</i>	2	[EDS]	<i>pimozide</i>	2	[EDS]
<i>trihexyphenidyl elixir & tabs</i>	2	[EDS]	<i>thioridazine</i>	2	[EDS]
Antiparkinson Agents, Other			<i>thiothixene</i>	2	[EDS]
<i>amantadine</i>	2	[EDS]	<i>trifluoperazine</i>	2	[EDS]
<i>carbidopa & levodopa & entacapone</i>	4	[EDS]	2nd Generation/Atypical		
<i>entacapone</i>	4	[EDS]	<i>ABILIFY ASIMTUFII INJ</i>	5	
Dopamine Agonists			<i>ABILIFY MAINTENA INJ</i>	5	
<i>apomorphine hydrochloride inj</i>	5	[PA]	<i>aripiprazole odt</i>	5	
<i>bromocriptine</i>	2	[EDS]	<i>aripiprazole soln</i>	3	[EDS]
<i>NEUPRO PATCH</i>	4	[EDS]	<i>aripiprazole tabs</i>	3	[EDS]
<i>pramipexole ir</i>	2	[EDS]	<i>ARISTADA INJ</i>	5	
<i>ropinirole ir</i>	2	[EDS]	<i>ARISTADA INITIO INJ</i>	4	[EDS]

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits	
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制	
FANAPT	4	[EDS]	ziprasidone inj	3	[EDS]	
FANAPT TITRATION PACK	4	[EDS]	ziprasidone oral	2	[EDS]	
INVEGA HAFYERA INJ	5		ZYPREXA RELPREVV INJ 210MG	4	[EDS]	
INVEGA SUSTENNA INJ 39MG	4	[EDS]	Treatment-Resistant			
INVEGA SUSTENNA INJ 78MG, 117MG, 156MG & 234MG	5		clozapine	2	[EDS]	
INVEGA TRINZA INJ	5		clozapine odt	4	[EDS]	
lurasidone hcl tabs	5		VERSACLOZ	5		
LYBALVI	5	[PA]	ANTISPASTICITY AGENTS			
NUPLAZID	5	[PA]	Antispasticity Agents			
olanzapine inj, tabs & odt tabs	2	[EDS]	baclofen tabs	2	[EDS]	
paliperidone er tabs	4	[EDS]	tizanidine caps	3	[EDS]	
PERSERIS INJ	5		tizanidine tabs	2	[EDS]	
quetiapine fumarate 25mg, 50mg, 100mg, 200mg, 300mg & 400mg tabs	2	[EDS]	ANTIVIRALS			
QUETIAPINE FUMARATE 150MG TABS	3	[EDS]	Anti-cytomegalovirus (CMV) Agents			
quetiapine er tabs	3	[EDS]	PREVYMIS	5	[PA]	
REXULTI	5		valganciclovir	3	[EDS]	
RISPERDAL CONSTA INJ 12.5MG & 25MG	4	[EDS]	Anti-hepatitis B (HBV) Agents			
RISPERDAL CONSTA INJ 37.5MG & 50MG	5		adefovir dipivoxil	4	[EDS]	
risperidone	2	[EDS]	BARACLUDÉ ORAL SOLN 0.05MG/ML	4	[EDS]	
risperidone odt	2	[EDS]	entecavir tabs	4	[EDS]	
SECUADO	5	[PA]	lamivudine tabs 100mg	3	[EDS]	
SEROQUEL XR	4	[EDS]	VEMLIDY	5		
UZEDY INJ	5		Anti-hepatitis C (HCV) Agents			
VRAYLAR CAPSULES	5		EPCLUSA	5	[PA]	
VRAYLAR DOSE PACK	4	[EDS]	HARVONI	5	[PA]	
			LEDIPASVIR/SOFOSBUVIR	5	[PA]	
			ribavirin	3	[EDS]	
			SOFOSBUVIR/VELPATASVIR	5	[PA]	
			VOSEVI	5	[PA]	
			Antitherapeutic Agents			
			acyclovir caps & tabs	2	[EDS]	
			acyclovir inj	2	[PA] [B vs D] [EDS]	
			acyclovir oral susp	4	[EDS]	
			famciclovir	2	[EDS]	

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
valacyclovir	2	[EDS]
Anti-HIV Agents, Integrase Inhibitors (INSTI)		
BIKTARVY	5	
DOVATO	5	
GENVOYA	5	
ISENTRESS CHEW TABS 25MG	3	[EDS]
ISENTRESS 100MG CHEW TABS	5	
ISENTRESS ORAL POWDER	5	
ISENTRESS TABS	5	
ISENTRESS HD TABS	5	
JULUCA	5	
STRIBILD	5	
TIVICAY TAB 10MG	4	[EDS]
TIVICAY TABS 25MG & 50MG	5	
TIVICAY PD	4	[EDS]
Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
COMPLERA	5	
DELSTRIGO	5	
EDURANT	5	
efavirenz caps & tabs	4	[EDS]
efavirenz & emtricitabine & tenofovir disoproxil fumarate tabs	5	
efavirenz & lamivudine & tenofovir disoproxil fumarate tabs	5	
etravirine tabs 100mg	4	[EDS]
etravirine tabs 200mg	5	
INTELENCE TAB 25MG	4	[EDS]
nevirapine er	2	[EDS]
nevirapine susp & tabs	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
ODEFSEY	5	
PIFELTRO	5	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir soln & tabs	4	[EDS]
abacavir & lamivudine	4	[EDS]
CIMDUO	5	
DESCOVY	5	
emtricitabine caps 200mg	4	[EDS]
emtricitabine & tenofovir disoproxil fumarate tabs 200mg-300mg	4	[EDS]
emtricitabine & tenofovir disoproxil fumarate tabs 100mg-150mg, 133mcg-200mg & 167mg-250mg	5	
EMTRIVA SOLN	4	[EDS]
lamivudine tabs 150mg & 300mg	3	[EDS]
lamivudine soln	2	[EDS]
lamivudine & zidovudine	3	[EDS]
tenofovir disoproxil fumarate	4	[EDS]
TRIUMEQ	5	
TRIUMEQ PD	5	
TRIZIVIR	5	
VIREAD TABS 150MG, 200MG & 250MG	5	
VIREAD POWDER	4	[EDS]
zidovudine	2	[EDS]
Anti-HIV Agents, Other		
FUZEON INJ	3	[EDS]
maraviroc	5	
RUKOBIA	5	
SELZENTRY SOLN	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
SELZENTRY 25MG & 75MG	3	[EDS]	<i>alprazolam soln</i>	2	[EDS]
SUNLENCA	5		<i>clorazepate</i>	2	[EDS]
TYBOST	3	[EDS]	<i>diazepam soln & tabs</i>	2	[EDS]
Anti-HIV Agents, Protease Inhibitors (PI)					
APTIVUS CAPS	5		<i>lorazepam soln & tabs</i>	2	[EDS]
<i>atazanavir sulfate caps</i>	4	[EDS]	<i>oxazepam</i>	3	[EDS]
<i>darunavir tab 600mg</i>	4	[EDS]	BIPOLAR AGENTS		
<i>darunavir tab 800mg</i>	5		Mood Stabilizers		
EVOTAZ	5		<i>lamotrigine odt</i>	4	[EDS]
<i>fosamprenavir tabs</i>	5		<i>lamotrigine odt kit</i>	4	[EDS]
LEXIVA ORAL SUSP	4	[EDS]	<i>lamotrigine chewable tabs</i>	2	[EDS]
<i>lopinavir & ritonavir</i>	4	[EDS]	<i>lamotrigine immediate-release tabs</i>	2	[EDS]
NORVIR POWDER	3	[EDS]	<i>lamotrigine starter kit</i>	4	[EDS]
PREZCOBIX	5		<i>lamotrigine titration kit</i>	4	[EDS]
PREZISTA SUSP 100MG/ML	4	[EDS]	<i>lithium carbonate</i>	2	[EDS]
PREZISTA TABS 75MG & 150MG	4	[EDS]	<i>lithium carbonate er</i>	2	[EDS]
PREZISTA TABS 600MG & 800MG	5		<i>lithium citrate oral soln</i>	2	[EDS]
REYATAZ ORAL POWDER	5		<i>subvenite starter kit</i>	4	[EDS]
<i>ritonavir tabs</i>	3	[EDS]	<i>subvenite tabs</i>	2	[EDS]
SYMTUZA	5		BLOOD GLUCOSE REGULATORS		
VIRACEPT	5		Antidiabetic Agents		
Anti-influenza Agents					
<i>oseltamivir caps</i>	2	[EDS]	<i>acarbose</i>	2	[EDS]
<i>oseltamivir susp</i>	3	[EDS]	BYDUREON BCISE INJ	3	[EDS]
RELENZA	3	[EDS]	BYETTA INJ	3	[EDS]
DISKHALER			CYCLOSET	3	[EDS]
<i>rimantadine</i>	2	[EDS]	FARXIGA	6	[EDS]
XOFLUZA	4	[EDS]	<i>glimepiride</i>	1	[EDS]
ANXIOLYTICS			<i>glimepiride & pioglitazone</i>	2	[EDS]
Anxiolytics, Other			<i>glipizide er</i>	1	[EDS]
<i>buspirone</i>	2	[EDS]	<i>glipizide tabs 5mg & 10mg</i>	1	[EDS]
<i>meprobamate</i>	4	[EDS]	<i>glipizide & metformin tabs</i>	1	[EDS]
Benzodiazepines			GLYXAMBI	6	[EDS]
<i>alprazolam ir tabs</i>	2	[EDS]	JANUMET	6	[EDS]
<i>alprazolam er tabs</i>	2	[EDS]			

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
JANUMET XR	6	[EDS]	HUMALOG MIX 50/50 KWIKPEN INJ	3	[EDS]
JANUVIA	6	[EDS]	HUMALOG MIX 75/25 KWIKPEN INJ	3	[EDS]
JARDIANCE	6	[EDS]	HUMALOG MIX 50/50 VIAL INJ	3	[EDS]
JENTADUETO	6	[EDS]	HUMALOG MIX 75/25 VIAL INJ	3	[EDS]
JENTADUETO XR	6	[EDS]	HUMALOG VIAL INJ	3	[EDS]
<i>metformin tabs</i>	1	[EDS]	HUMULIN 70/30 KWIKPEN INJ	3	[EDS]
<i>metformin er uncoated tabs 500mg & 750mg</i>	1	[EDS]	HUMULIN 70/30 VIAL INJ	3	[EDS]
MOUNJARO INJ	3	[EDS]	HUMULIN N KWIKPEN INJ	3	[EDS]
<i>nateglinide</i>	2	[EDS]	HUMULIN N VIAL INJ	3	[EDS]
OZEMPIC INJ	3	[EDS]	HUMULIN R U-500 (CONCENTRATED) KWIKPEN INJ	3	[EDS]
<i>pioglitazone</i>	1	[EDS]	HUMULIN R U-500 (CONCENTRATED) VIAL INJ	3	[EDS]
<i>pioglitazone & metformin</i>	2	[EDS]	HUMULIN R VIAL INJ	3	[EDS]
<i>repaglinide</i>	2	[EDS]	INSULIN GLARGINE VIAL INJ	3	[EDS]
RYBELSUS	3	[EDS]	INSULIN GLARGINE SOLOSTAR INJ	3	[EDS]
SYMLINPEN INJ	5		INSULIN LISPRO VIAL INJ	3	[EDS]
SYNJARDY	6	[EDS]	LANTUS SOLOSTAR PEN INJ	3	[EDS]
TRADJENTA	6	[EDS]	LANTUS VIAL INJ	3	[EDS]
TRIJARDY XR	6	[EDS]	LEVEMIR VIAL INJ	3	[EDS]
TRULICITY INJ	3	[EDS]	LEVEMIR FLEXPEN INJ	3	[EDS]
VICTOZA INJ	3	[EDS]	LYUMJEV VIAL INJ	3	[EDS]
XIGDUO XR	6	[EDS]	LYUMJEV KWIKPEN INJ	3	[EDS]
Glycemic Agents			SOLIQUA INJ	3	[EDS]
BAQSIMI	3	[EDS]	TOUJEO SOLOSTAR INJ	3	[EDS]
<i>diazoxide</i>	4	[EDS]			
GLUCAGEN HYPOKIT INJ	3	[EDS]			
GLUCAGON EMERGENCY KIT INJ	3	[EDS]			
GVOKE INJ	3	[EDS]			
ZEGALOGUE INJ	3	[EDS]			
Insulins					
HUMALOG CARTRIDGE INJ	3	[EDS]			
HUMALOG JUNIOR KWIKPEN INJ	3	[EDS]			
HUMALOG KWIKPEN INJ	3	[EDS]			

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
TOUJEO MAX SOLOSTAR INJ	3	[EDS]	RETACRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML,10000 UNIT/ML, 20000UNIT/2ML & 20000UNIT/ML	3	[PA] [EDS]
TRESIBA VIAL INJ	3	[EDS]	RETACRIT INJ 40000UNIT/ML	5	[PA]
TRESIBA FLEXTOUCH INJ	3	[EDS]	UDENYCA INJ	5	[PA]
BLOOD PRODUCTS AND MODIFIERS					
Anticoagulants					
dabigatran etexilate	4	[EDS]	tranexamic acid tabs	3	[EDS]
ELIQUIS STARTER PACK & TABS	6	[EDS]	Platelet Modifying Agents		
enoxaparin inj syringe	4	[EDS]	BRILINTA	3	[EDS]
fondaparinux inj 2.5mg/0.5ml & 5mg/0.4ml	4	[EDS]	cilostazol	2	[EDS]
fondaparinux inj 7.5mg/0.6ml & 10mg/0.8ml	5		clopidogrel tabs 75mg	1	[EDS]
heparin inj vials 1000u/ml, 5000u/ml, 10000u/ml & 20000u/ml	2	[PA] [B vs D] [EDS]	dipyridamole er & aspirin	4	[EDS]
jantoven	1	[EDS]	dipyridamole oral	2	[EDS]
warfarin	1	[EDS]	prasugrel	2	[EDS]
XARELTO ORAL SUSP TABS & STARTER PACK	6	[EDS]	CARDIOVASCULAR AGENTS		
XARELTO STARTER PACK	6	[EDS]	Alpha-adrenergic Agonists		
Blood Products and Modifiers, Other			clonidine patches	4	[EDS]
anagrelide	2	[EDS]	clonidine tabs immediate-release	1	[EDS]
LEUKINE INJ	5	[PA]	droxidopa	5	[PA]
NIVESTYM INJ	5	[PA]	guanfacine ir	2	[EDS]
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML & 10000UNIT/ML	3	[PA] [EDS]	midodrine tabs	3	[EDS]
PROCRIT INJ 20000UNIT/ML & 40000UNIT/ML	5	[PA]	Alpha-adrenergic Blocking Agents		
PROMACTA	5	[PA] [LD]	doxazosin	2	[EDS]
			prazosin	2	[EDS]
			terazosin	1	[EDS]
Angiotensin-converting Enzyme (ACE) Inhibitors					
			benazepril	1	[EDS]
			captopril	1	[EDS]
			enalapril tabs	1	[EDS]
			fosinopril	1	[EDS]
			lisinopril	1	[EDS]
			moexipril	1	[EDS]

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[LD] = Limited Distribution [EDS] = Extended Day Supply

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
<i>perindopril</i>	1	[EDS]
<i>quinapril</i>	1	[EDS]
<i>ramipril</i>	1	[EDS]
<i>trandolapril</i>	1	[EDS]
Angiotensin II Receptor Antagonists		
<i>candesartan</i>	2	[EDS]
<i>irbesartan</i>	1	[EDS]
<i>losartan</i>	1	[EDS]
<i>olmesartan</i>	2	[EDS]
<i>telmisartan</i>	2	[EDS]
<i>valsartan tabs</i>	1	[EDS]
Antiarrhythmics		
<i>amiodarone tabs</i>	2	[EDS]
<i>disopyramide phosphate</i>	4	[EDS]
<i>dofetilide</i>	4	[EDS]
<i>flecainide acetate</i>	2	[EDS]
<i>mexiletine</i>	2	[EDS]
<i>MULTAQ</i>	3	[EDS]
<i>pacerone tabs</i>	2	[EDS]
<i>propafenone tabs</i>	2	[EDS]
<i>quinidine gluconate cr</i>	4	[EDS]
<i>quinidine sulfate</i>	2	[EDS]
<i>sorine</i>	2	[EDS]
<i>sotalol tabs</i>	2	[EDS]
Beta-adrenergic Blocking Agents		
<i>acebutolol</i>	2	[EDS]
<i>atenolol</i>	1	[EDS]
<i>bisoprolol</i>	2	[EDS]
<i>carvedilol</i>	1	[EDS]
<i>carvedilol phosphate er</i>	4	[EDS]
<i>labetalol oral</i>	2	[EDS]
<i>metoprolol succinate er</i>	2	[EDS]
<i>metoprolol tartrate tabs 25mg, 50mg & 100mg</i>	1	[EDS]
<i>nadolol</i>	2	[EDS]
<i>nebivolol hcl</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
<i>pindolol</i>	2	[EDS]
<i>propranolol ir tabs</i>	1	[EDS]
<i>propranolol er caps</i>	2	[EDS]
<i>propranolol oral soln</i>	2	[EDS]
<i>timolol oral</i>	1	[EDS]
Calcium Channel Blocking Agents, Dihydropyridines		
<i>amlodipine</i>	1	[EDS]
<i>felodipine er</i>	2	[EDS]
<i>isradipine</i>	2	[EDS]
<i>nicardipine caps</i>	2	[EDS]
<i>nifedipine caps</i>	2	[EDS]
<i>nifedipine er</i>	2	[EDS]
<i>nimodipine</i>	4	[EDS]
<i>nisoldipine er</i>	4	[EDS]
Calcium Channel Blocking Agents, Nondihydropyridines		
<i>cartia xt</i>	2	[EDS]
<i>diltiazem tabs</i>	2	[EDS]
<i>diltiazem er caps</i>	2	[EDS]
<i>dilt-xr</i>	2	[EDS]
<i>taztia xt</i>	2	[EDS]
<i>tiadylt er</i>	2	[EDS]
<i>verapamil ir</i>	1	[EDS]
<i>verapamil er</i>	2	[EDS]
<i>verapamil sr</i>	2	[EDS]
Cardiovascular Agents, Other		
<i>aliskiren</i>	3	[EDS]
<i>amiloride & hydrochlorothiazide</i>	1	[EDS]
<i>amlodipine & atorvastatin</i>	2	[EDS]
<i>amlodipine & benazepril</i>	1	[EDS]
<i>amlodipine & valsartan & hydrochlorothiazide tabs</i>	2	[EDS]
<i>atenolol & chlorthalidone</i>	1	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
benazepril & hydrochlorothiazide	1	[EDS]
bisoprolol & hydrochlorothiazide	2	[EDS]
CORLANOR	4	[EDS]
digoxin oral soln	2	[EDS]
digoxin tabs 125mcg & 250mcg	2	[EDS]
digoxin tab 62.5mcg	3	[EDS]
enalapril & hydrochlorothiazide	1	[EDS]
ENTRESTO	6	[EDS]
fosinopril & hydrochlorothiazide	1	[EDS]
irbesartan hct	1	[EDS]
KERENDIA	3	[EDS]
LANOXIN ORAL	3	[EDS]
lisinopril & hydrochlorothiazide	1	[EDS]
losartan hct	1	[EDS]
metoprolol & hydrochlorothiazide	2	[EDS]
metyrosine caps	5	[PA]
olmesartan & amlodipine	2	[EDS]
olmesartan hct	2	[EDS]
olmesartan medoxomil & amlodipine & hydrochlorothiazide tabs	2	[EDS]
pentoxifylline er	2	[EDS]
ranolazine er	3	[EDS]
spironolactone & hydrochlorothiazide	1	[EDS]
triamterene & hydrochlorothiazide	1	[EDS]
valsartan & amlodipine	1	[EDS]
valsartan hct	1	[EDS]
VERQUVO	4	[PA] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
Diuretics, Loop		
bumetanide inj	2	[EDS]
bumetanide tabs	2	[EDS]
furosemide oral	1	[EDS]
furosemide inj	2	[EDS]
torsemide	2	[EDS]
Diuretics, Potassium-sparing		
amiloride	2	[EDS]
eplerenone	3	[EDS]
spironolactone tabs	1	[EDS]
Diuretics, Thiazide		
chlorthalidone	1	[EDS]
hydrochlorothiazide	1	[EDS]
indapamide	1	[EDS]
metolazone	2	[EDS]
Dyslipidemics, Fibric Acid Derivatives		
fenofibrate caps 43mg & 130mg	2	[EDS]
fenofibrate micronized caps 67mg, 134mg & 200mg	2	[EDS]
fenofibrate tabs 48mg, 54mg, 145mg & 160mg	2	[EDS]
fenofibric acid dr caps	3	[EDS]
gemfibrozil	2	[EDS]
Dyslipidemics, HMG CoA Reductase Inhibitors		
atorvastatin	1	[EDS]
lovastatin	1	[EDS]
pravastatin	1	[EDS]
rosuvastatin	1	[EDS]
simvastatin	1	[EDS]
Dyslipidemics, Other		
cholestyramine	2	[EDS]
cholestyramine light	2	[EDS]
colesevelam	4	[EDS]
colestipol pack	2	[EDS]
colestipol tabs	2	[EDS]
ezetimibe	2	[EDS]
ezetimibe & simvastatin	3	[EDS]

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
<i>icosapent ethyl</i>	4	[EDS]	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
JUXTAPID	5	[PA] [LD]	<i>atomoxetine</i>	3	[EDS]
<i>niacin er tabs</i>	3	[EDS]	<i>clonidine er</i>	2	[EDS]
<i>omega-3-acid ethyl esters</i>	2	[EDS]	<i>dexamphetamine ir tabs</i>	2	[EDS]
<i>prevalite</i>	2	[EDS]	<i>methylphenidate er tabs 10mg & 20mg</i>	3	[EDS]
REPATHA INJ	3	[EDS]	<i>methylphenidate ir tabs 5mg, 10mg & 20mg</i>	2	[EDS]
VASCEPA CAPS	4	[EDS]			
Vasodilators, Direct-acting Arterial					
<i>hydralazine oral</i>	2	[EDS]	Central Nervous System, Other		
<i>minoxidil</i>	2	[EDS]	AUSTEDO	5	[PA] [LD]
Vasodilators, Direct-acting Arterial/Venous			AUSTEDO XR	5	[PA] [LD]
<i>isosorbide dinitrate tabs 5mg, 10mg, 20mg & 30mg</i>	2	[EDS]	AUSTEDO XR PATIENT TITRATION KIT	5	[PA]
<i>isosorbide mononitrate</i>	2	[EDS]	NUEDEXTA	5	[PA]
<i>isosorbide mononitrate er</i>	2	[EDS]	<i>riluzole</i>	3	[EDS]
<i>nitro-bid oint</i>	2	[EDS]	<i>tetrabenazine</i>	5	[PA]
NITRO-DUR PATCHES 0.3MG/HR & 0.8MG/HR	3	[EDS]	Fibromyalgia Agents		
<i>nitroglycerin lingual</i>	2	[EDS]	<i>duloxetine hcl</i>	2	[EDS]
<i>nitroglycerin patches</i>	2	[EDS]	SAVELLA	3	[EDS]
<i>nitroglycerin sublingual</i>	2	[EDS]	SAVELLA TITRATION PACK	3	[EDS]
CENTRAL NERVOUS SYSTEM AGENTS					
Attention Deficit Hyperactivity Disorder Agents, Amphetamines			Multiple Sclerosis Agents		
<i>amphetamine & dextroamphetamine tabs</i>	2	[QL] [EDS]	AVONEX INJ	5	[PA]
<i>dextroamphetamine sulfate tabs 5mg & 10mg</i>	3	[QL] [EDS]	AVONEX PEN INJ	5	[PA]
<i>dextroamphetamine sulfate er</i>	4	[QL] [EDS]	BETASERON INJ	5	[PA]
<i>zenzedi tabs 5mg & 10mg</i>	3	[QL] [EDS]	COPAXONE INJ 40MG/ML	5	[PA]
			<i>dalfampridine er</i>	3	[PA] [EDS]
			<i>dimethyl fumarate caps</i>	5	[PA]
			<i>dimethyl fumarate starter pack</i>	5	[PA]
			<i>fingolimod</i>	5	[PA]
			<i>glatiramer acetate inj</i>	5	[PA]
			<i>glatopa inj</i>	5	[PA]
			PLEGRIDY INJ	5	[PA]
			REBIF INJ	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits	
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制	
REBIF REBIDOSE INJ	5	[PA]	<i>tretinoi</i> n gel 0.01%, 0.025% & 0.05%	3	[PA] [EDS]	
REBIF REBIDOSE TITRATION PACK INJ	5	[PA]	<i>zenatane</i>	4	[EDS]	
REBIF TITRATION PACK INJ	5	[PA]	Dermatitis and Pruritus Agents			
<i>teriflunomide tabs</i>	5	[PA]	<i>alclometasone dipropionate</i>	2	[EDS]	
VUMERITY	5	[PA]	<i>ammonium lactate</i>	2	[EDS]	
DENTAL AND ORAL AGENTS						
Dental and Oral Agents						
<i>cevimeline</i>	3	[EDS]	<i>betamethasone dipropionate augmented</i>	2	[EDS]	
<i>chlorhexidine gluconate</i>	2	[EDS]	<i>betamethasone valerate cream, oint & lotion</i>	2	[EDS]	
<i>kourzeq</i>	2	[EDS]	CAPEX SHAMPOO	4	[EDS]	
<i>lidocaine viscous soln</i>	2	[EDS]	<i>clobetasol propionate cream, foam, gel, oint & soln</i>	4	[EDS]	
<i>periogard</i>	2	[EDS]	<i>clobetasol propionate emollient</i>	4	[EDS]	
<i>pilocarpine tabs</i>	3	[EDS]	<i>desonide lotion, oint & cream</i>	3	[QL] [EDS]	
<i>triamcinolone dental paste</i>	2	[EDS]	<i>desoximetasone topical cream, gel & oint 0.05%</i>	4	[QL] [EDS]	
DERMATOLOGICAL AGENTS						
Acne and Rosacea Agents						
<i>acitretin</i>	4	[PA] [EDS]	<i>desoximetasone topical cream & oint 0.25%</i>	3	[QL] [EDS]	
<i>accutane</i>	4	[EDS]	<i>diflorasone diacetate</i>	4	[QL] [EDS]	
<i>adapalene cream 0.1%</i>	4	[EDS]	<i>fluocinolone acetonide cream, oint, soln</i>	3	[EDS]	
<i>adapalene gel 0.3%</i>	4	[EDS]	<i>fluocinolone acetonide scalp oil</i>	3	[EDS]	
ALTRENO	3	[PA] [EDS]	<i>fluocinonide cream 0.05%, gel & oint</i>	2	[QL] [EDS]	
<i>amnesteem caps</i>	4	[EDS]	<i>fluocinonide emulsified base cream</i>	2	[QL] [EDS]	
<i>claravis</i>	4	[EDS]	<i>fluocinonide soln</i>	2	[EDS]	
<i>clindamycin & benzoyl peroxide gel 5%-1% & 5%-1.2%</i>	3	[EDS]				
<i>isotretinoin caps 10mg, 20mg, 30mg & 40mg</i>	4	[EDS]				
<i>tazarotene cream</i>	4	[EDS]				
<i>tazarotene gel</i>	4	[QL] [EDS]				
TAZORAC CREAM 0.05%	4	[EDS]				
<i>tretinoi</i> n cream	3	[PA] [EDS]				

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
<i>fluticasone propionate cream & oint</i>	2	[EDS]	<i>imiquimod cream 5%</i>	3	[EDS]
<i>halobetasol propionate cream & ointment</i>	2	[EDS]	<i>methoxsalen</i>	5	
<i>hydrocortisone cream, lotion & oint 2.5%</i>	2	[EDS]	<i>nystatin & triamcinolone</i>	3	[EDS]
<i>hydrocortisone butyrate cream, oint & soln</i>	2	[EDS]	<i>podofilox soln</i>	2	[EDS]
<i>hydrocortisone valerate</i>	2	[EDS]	<i>silver sulfadiazine</i>	2	[EDS]
<i>mometasone cream, oint & soln</i>	2	[EDS]	REGRANEX	5	[QL]
<i>pimecrolimus</i>	4	[QL] [EDS]	SANTYL	3	[QL] [EDS]
<i>selenium sulfide lotion</i>	2	[EDS]	<i>ssd</i>	2	[EDS]
<i>tacrolimus oint</i>	4	[QL] [EDS]	Pediculicides/Scabicides		
<i>triamcinolone acetonide topical cream & lotion</i>	2	[EDS]	<i>malathion</i>	4	[EDS]
<i>triamcinolone acetonide topical oint 0.025%, 0.1% & 0.5%</i>	2	[EDS]	<i>permethrin cream</i>	2	[EDS]
<i>triderm cream 0.1%</i>	2	[EDS]	Topical Anti-infectives		
Dermatological Agents, Other			<i>acyclovir cream & oint 5%</i>	4	[QL] [EDS]
<i>calcipotriene cream & oint</i>	4	[QL] [EDS]	<i>ciclopirox cream, gel, nail soln shampoo & susp</i>	2	[EDS]
<i>calcipotriene soln</i>	3	[EDS]	<i>clindamycin topical gel, lotion, soln & swab</i>	2	[EDS]
<i>clotrimazole & betamethasone</i>	2	[EDS]	<i>erythromycin topical gel & soln</i>	2	[EDS]
<i>diclofenac sodium gel 1%</i>	3	[EDS]	<i>mupirocin ointment</i>	2	[EDS]
<i>diclofenac sodium gel 3%</i>	4	[PA] [EDS]	<i>mupirocin cream</i>	4	[QL] [EDS]
<i>FLUOROURACIL CREAM 0.5%</i>	5		<i>penciclovir cream</i>	4	[EDS]
<i>fluorouracil topical 2% and 5%</i>	3	[EDS]	ELECTROLYTES/MINERALS/METALS/VITAMINS		
<i>imiquimod cream 3.75%</i>	4	[EDS]	Electrolyte/Mineral/Metal Modifiers		
			<i>deferasirox granule pack</i>	5	[PA]
			<i>deferasirox tabs 90mg</i>	4	[PA] [EDS]
			<i>deferasirox tabs 180mg & 360mg</i>	5	[PA]
			<i>deferasirox tabs for soln 125mg</i>	4	[PA] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
deferasirox tabs for soln 250mg & 500mg	5	[PA]	potassium chloride & dextrose & sodium chloride inj	2	[EDS]
deferiprone	5	[PA]	2mEq/5%/0.2%, 10mEq/5%/0.45%, 20mEq/5%/0.45%, 20mEq/5%/0.9%, 30mEq/5%/0.45% 40mEq/5%/0.9% & 40mEq/5%/0.45%		
FERRIPROX SOLN	5	[PA]	potassium citrate er	2	[EDS]
FERRIPROX TAB 1000MG	5	[PA]	PROSOL INJ	4	[PA] [B vs D] [EDS]
INTRALIPID INJ	4	[PA] [B vs D] [EDS]	sodium chloride inj	2	[EDS]
penicillamine tabs	5		TPN	3	[EDS]
trientine	5		ELECTROLYTES INJ		
Electrolyte/Mineral Replacement					
carglumic acid	5	[PA]	TRAVASOL INJ	4	[PA] [B vs D] [EDS]
CLINISOL SF INJ	4	[PA] [B vs D] [EDS]	Phosphate Binders		
dextrose inj	2	[EDS]	AURYXIA	5	[PA]
dextrose (10%, 5% or 2.5%) & sodium chloride inj	2	[EDS]	calcium acetate	2	[EDS]
klor-con pack	4	[EDS]	lanthanum carbonate	5	
klor-con tabs	2	[EDS]	sevelamer carbonate powder	4	[EDS]
magnesium sulfate inj	2	[EDS]	sevelamer carbonate tabs	4	[EDS]
plenamine inj	2	[PA] [B vs D] [EDS]	VELPHORO	5	[PA]
potassium chloride oral soln	4	[EDS]	Potassium Binders		
potassium chloride inj	2	[EDS]	LOKELMA	3	[EDS]
potassium chloride pack 20meq	4	[EDS]	sodium polystyrene sulfonate powder	2	[EDS]
potassium chloride er & cr	2	[EDS]	sps suspension	2	[EDS]
potassium chloride & dextrose 20mEq/5% inj	2	[EDS]	VELTASSA	3	[EDS]
potassium chloride & dextrose & lactated ringers inj	2	[EDS]	Vitamins		
			prenatal multi-vitamin	2	[EDS]
GASTROINTESTINAL AGENTS					
Anti-Constipation Agents					
constulose soln	2	[EDS]	enulose	2	[EDS]
enulose	2	[EDS]	generlac	2	[EDS]

[PA] = Prior Authorization [B vs D] = B versus D [QL] = Quantity Limit

[LD] = Limited Distribution [EDS] = Extended Day Supply

You can find information on what the symbols and abbreviations on this table mean by going to page 28

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
<i>lactulose soln 10g/15ml</i>	2	[EDS]
LINZESS	3	[EDS]
<i>lubiprostone</i>	3	[EDS]
MOVANTIK	3	[EDS]
RELISTOR INJ	5	[PA]
RELISTOR TABS	5	[PA]
<i>sodium sulfate, potassium sulfate and magnesium sulfate</i>	3	[EDS]
Anti-Diarrheal Agents		
<i>alosetron hcl tab 0.5mg</i>	4	[PA] [EDS]
<i>alosetron hcl tab 1mg</i>	5	[PA]
<i>diphenoxylate & atropine oral soln</i>	3	[EDS]
<i>diphenoxylate & atropine tabs</i>	2	[EDS]
<i>loperamide caps 2mg</i>	2	[EDS]
XERMELO	5	[PA]
Antispasmodics, Gastrointestinal		
<i>dicyclomine</i>	2	[EDS]
<i>glycopyrrolate tabs 1mg & 2mg</i>	2	[EDS]
Gastrointestinal Agents, Other		
<i>cromolyn sodium oral</i>	4	[EDS]
GATTEX INJ	5	[PA]
<i>gavilyte-c</i>	2	[EDS]
<i>gavilyte-g</i>	2	[EDS]
<i>metoclopramide oral tablets & soln</i>	2	[EDS]
<i>peg 3350 & electrolytes</i>	2	[EDS]
<i>peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride</i>	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
<i>peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride</i>	3	[EDS]
PLENU	3	[EDS]
RECTIV	4	[EDS]
<i>ursodiol cap 300mg & tabs 250mg & 500mg</i>	3	[EDS]
Histamine2 (H2) Receptor Antagonists		
<i>cimetidine tabs</i>	2	[EDS]
<i>famotidine tabs</i>	1	[EDS]
Protectants		
<i>misoprostol</i>	2	[EDS]
<i>sucralfate tabs</i>	2	[EDS]
Proton Pump Inhibitors		
<i>esomeprazole</i>	3	[EDS]
<i>magnesium dr caps</i>		
<i>lansoprazole dr caps</i>	2	[EDS]
<i>omeprazole caps</i>	1	[EDS]
<i>pantoprazole tabs</i>	1	[EDS]
<i>rabeprazole sodium</i>	3	[EDS]
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
<i>betaine anhydrous</i>	5	
CERDELGA	5	[PA]
CREON DR	3	[EDS]
CYSTAGON	3	[EDS]
<i>miglustat</i>	5	[PA] [LD]
<i>nitisinone</i>	5	[PA]
ORFADIN CAPS 20MG	5	[PA] [LD]
ORFADIN SUSP	5	[PA] [LD]
RAVICTI	5	
<i>sapropterin</i>	5	

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits			
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制			
sodium phenylbutyrate powder & tabs	5		hydrocortisone oral	2	[EDS]			
SUCRAID	5		MEDROL TABS	4	[PA] [B vs D] [EDS]			
GENITOURINARY AGENTS								
<i>Antispasmodics, Urinary</i>								
fesoterodine fumarate er	3	[EDS]	methylprednisolone dose pack	2	[EDS]			
flavoxate	2	[EDS]	methylprednisolone oral	2	[PA] [B vs D] [EDS]			
GEMTESA	4	[EDS]	MILLIPRED	4	[PA] [B vs D] [EDS]			
MYRBETRIQ	3	[EDS]	ORAPRED ODT	4	[PA] [B vs D] [EDS]			
oxybutynin ir	2	[EDS]	prednisolone oral soln	2	[PA] [B vs D] [EDS]			
oxybutynin er	2	[EDS]	prednisolone odt	4	[PA] [B vs D] [EDS]			
OXYTROL	4	[EDS]	prednisolone tablet 5mg	4	[PA] [B vs D] [EDS]			
solifenacin succinate	3	[EDS]	prednisone tab pack	1	[EDS]			
tolterodine tartrate er	2	[EDS]	HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)					
trospium ir	2	[EDS]	<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)</i>					
trospium er	2	[EDS]	desmopressin acetate nasal	4	[EDS]			
Benign Prostatic Hypertrophy Agents								
alfuzosin hcl er	2	[EDS]	desmopressin acetate oral	2	[EDS]			
dutasteride	3	[EDS]	GENOTROPIN INJ	5	[PA]			
dutasteride & tamsulosin	3	[EDS]	GENOTROPIN MINIQUICK INJ 0.2MG, 0.4MG, 0.6MG & 0.8MG	4	[PA] [EDS]			
finasteride tabs 5mg	1	[EDS]	GENOTROPIN MINIQUICK INJ 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG & 2MG	5	[PA]			
tamsulosin	1	[EDS]	HUMATROPE INJ CARTRIDGE 6MG	4	[PA] [EDS]			
Genitourinary Agents, Other			HUMATROPE INJ CARTRIDGE 12MG & 24MG	5	[PA]			
bethanechol	2	[EDS]	INCRELEX INJ	5	[PA]			
ELMIRON	4	[EDS]						
THIOLA EC	5							
tiopronin	5							
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)								
<i>Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)</i>								
dexamethasone dose pack	2	[EDS]						
dexamethasone elixir	2	[EDS]						
dexamethasone tabs	2	[EDS]						
fludrocortisone acetate	2	[EDS]						
HEMADY	4	[EDS]						

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)					
Androgens					
<i>danazol</i>	3	[EDS]	<i>estradiol vaginal cream</i>	2	[EDS]
<i>testosterone cypionate inj</i>	2	[EDS]	<i>estradiol vaginal tabs</i>	2	[EDS]
<i>testosterone enanthate inj</i>	2	[EDS]	<i>estradiol & norethindrone acetate 0.5mg/0.1mg & 1mg/0.5mg</i>	2	[EDS]
<i>testosterone gel 1% & 1.62%</i>	3	[EDS]	<i>ESTRING</i>	3	[EDS]
<i>testosterone gel 25mg/2.5g, 20.25mg/1.25g, 40.5mg/2.5g & 50mg/5g</i>	3	[EDS]	<i>ethinyl estradiol & ethynodiol</i>	2	[EDS]
Estrogens					
<i>altavera</i>	2	[EDS]	<i>ethinyl estradiol & norethindrone acetate 5mcg/1mg & 2.5mcg-0.5mg</i>	2	[EDS]
<i>alyacen 1/35</i>	2	[EDS]	<i>etongestrel & ethinyl estradiol ring</i>	4	[EDS]
<i>amabelz</i>	2	[EDS]	<i>falmina</i>	2	[EDS]
<i>apri</i>	2	[EDS]	<i>fyavolv</i>	2	[EDS]
<i>aranelle</i>	2	[EDS]	<i>haloette</i>	4	[EDS]
<i>aubra eq</i>	2	[EDS]	<i>IMVEXXY PACK</i>	3	[EDS]
<i>aviane</i>	2	[EDS]	<i>introvale</i>	2	[EDS]
<i>blisovi fe 1.5/30</i>	2	[EDS]	<i>isibloom</i>	2	[EDS]
<i>briellyn</i>	2	[EDS]	<i>jasmiel</i>	2	[EDS]
<i>cyred eq</i>	2	[EDS]	<i>jintelii</i>	2	[EDS]
<i>desogestrel & ethinyl estradiol</i>	2	[EDS]	<i>juleber</i>	2	[EDS]
<i>dotti</i>	2	[EDS]	<i>junel 21 day</i>	2	[EDS]
<i>drospirenone & ethinyl estradiol 3mg/0.02mg</i>	2	[EDS]	<i>junel fe 1/20</i>	2	[EDS]
<i>eluryng</i>	4	[EDS]	<i>kariva</i>	2	[EDS]
<i>enilloring</i>	4	[EDS]	<i>kelnor 1/35 & 1/50</i>	2	[EDS]
<i>enpresse-28</i>	2	[EDS]	<i>kurvelo</i>	2	[EDS]
<i>enskyce</i>	2	[EDS]	<i>larin</i>	2	[EDS]
<i>estarylla</i>	2	[EDS]	<i>larin fe</i>	2	[EDS]
<i>estradiol oral</i>	2	[EDS]	<i>leena</i>	2	[EDS]
<i>estradiol patches</i>	2	[EDS]	<i>levonest</i>	2	[EDS]
			<i>levonorgestrel & ethinyl estradiol 0.1-0.02mg & 0.15-0.03mg & triphasic packs</i>	2	[EDS]

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您可以前往第 56 頁，找到本表中的符號和縮寫詞所代表含義的相關資訊。

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
<i>levonorgestrel & ethinyl estradiol and ethinyl estradiol 0.1/0.02mg-0.01mg packs</i>	2	[EDS]	<i>setlakin</i>	2	[EDS]
<i>levora</i>	2	[EDS]	<i>tarina fe 1/20 eq</i>	2	[EDS]
<i>loryna</i>	2	[EDS]	<i>tri-estarrylla</i>	2	[EDS]
<i>low-ogestrel</i>	2	[EDS]	<i>tri-lo-estarrylla</i>	2	[EDS]
<i>lyllana</i>	2	[EDS]	<i>tri-lo-sprintec</i>	2	[EDS]
<i>marlissa 28 day</i>	2	[EDS]	<i>tri-mili</i>	2	[EDS]
MENEST	3	[EDS]	<i>tri-nymyo</i>	2	[EDS]
<i>microgestin 1/20 & 1.5/30</i>	2	[EDS]	<i>tri-sprintec</i>	2	[EDS]
<i>microgestin 24 fe</i>	2	[EDS]	<i>tri-vylibra</i>	2	[EDS]
<i>microgestin fe 1/20 & 1.5/30</i>	2	[EDS]	<i>tri-vylibra lo</i>	2	[EDS]
<i>mili</i>	2	[EDS]	<i>trivora-28</i>	2	[EDS]
<i>mimvey</i>	2	[EDS]	<i>turqoz</i>	2	[EDS]
<i>necon</i>	2	[EDS]	<i>velivet</i>	2	[EDS]
<i>nikki</i>	2	[EDS]	<i>vestura</i>	2	[EDS]
<i>norgestimate-ethinyl estradiol</i>	2	[EDS]	<i>vienna</i>	2	[EDS]
<i>norethindrone, ethinyl estradiol, ferrous fumarate 0.4mg/0.035mg</i>	2	[EDS]	<i>vyfemla</i>	2	[EDS]
<i>norethindrone, ethinyl estradiol, ferrous fumarate 20mcg/75mg/1mg</i>	2	[EDS]	<i>vylibra</i>	2	[EDS]
<i>nylia 7/7/7 & 1/35</i>	2	[EDS]	<i>wymzya fe</i>	2	[EDS]
<i>nymyo</i>	2	[EDS]	<i>yuvafem</i>	2	[EDS]
<i>pimtrea</i>	2	[EDS]	<i>zovia</i>	2	[EDS]
PREMARIN ORAL	3	[EDS]	Progestins		
PREMARIN VAGINAL CREAM	3	[EDS]	<i>deblitane</i>	2	[EDS]
PREMPHASE	3	[EDS]	<i>DEPO-SUBQ PROVERA 104 INJ</i>	3	[EDS]
PREMPRO	3	[EDS]	<i>incassia</i>	2	[EDS]
<i>reclipsen</i>	2	[EDS]	<i>lyleq</i>	2	[EDS]
			<i>lyza</i>	2	[EDS]
			<i>medroxyprogesterone acetate inj</i>	2	[EDS]
			<i>medroxyprogesterone acetate tabs</i>	2	[EDS]
			<i>megestrol acetate oral susp 40mg/ml</i>	2	[EDS]
			<i>megestrol tabs</i>	2	[EDS]
			<i>norethindrone</i>	2	[EDS]
			<i>progesterone caps</i>	2	[EDS]
			<i>sharobel</i>	2	[EDS]
			Selective Estrogen Receptor Modifying Agents		
			<i>DUAVEE</i>	3	[EDS]
			<i>raloxifene hcl</i>	3	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
<i>Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)</i>		
CYTOMEL	3	[EDS]
levothyroxine tabs	1	[EDS]
levoxyl	1	[EDS]
liothyronine tabs	2	[EDS]
SYNTHROID	3	[EDS]
unithroid	1	[EDS]
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
<i>Hormonal Agents, Suppressant (Adrenal)</i>		
LYSODREN	5	
ISTURISA	5	[PA]
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
<i>Hormonal Agents, Suppressant (Pituitary)</i>		
cabergoline	2	[EDS]
ELIGARD INJ	4	[PA] [EDS]
leuprolide acetate inj kit 1mg/0.2ml	2	[EDS]
LUPRON DEPOT INJ	5	[PA]
octreotide inj 50mcg/ml, 100mcg/ml, 200mcg/ml & 500mcg/ml	4	[EDS]
octreotide inj 1000mcg/ml	5	
ORGOVYX	5	[PA] [LD]
SIGNIFOR INJ	5	[PA]
SOMAVERT INJ	5	[PA]
SYNAREL	4	[EDS]
TRELSTAR MIXJECT INJ	4	[PA] [EDS]
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
<i>Antithyroid Agents</i>		
methimazole	2	[EDS]
propylthiouracil	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
IMMUNOLOGICAL AGENTS		
<i>Angioedema Agents</i>		
CINRYZE INJ	5	[PA]
icatibant inj	5	[PA]
sazair inj	5	[PA]
<i>Immunoglobulins</i>		
GAMMAGARD INJ	5	[PA] [B vs D]
GAMUNEX-C INJ	5	[PA] [B vs D]
<i>Immunological Agents, Other</i>		
ARCALYST INJ	5	[PA]
BENLYSTA INJ	5	[PA]
COSENTYX INJ	5	[PA]
COSENTYX SENSOREADY PEN INJ	5	[PA]
COSENTYX UNOREADY PEN INJ	5	[PA]
DUPIXENT INJ	5	[PA]
KINERET INJ	5	[PA]
ORENCIA INJ PF SYRINGE	5	[PA]
ORENCIA CLICKJET	5	[PA]
OTEZLA	5	[PA]
OTEZLA STARTER	5	[PA]
RIDAURA	5	
RINVOQ	5	[PA]
SKYRIZI INJ	5	[PA]
STELARA INJ	5	[PA]
XELJANZ	5	[PA]
XELJANZ XR	5	[PA]
XOLAIR INJ	5	[PA] [LD]
<i>Immunostimulants</i>		
ACTIMMUNE INJ	5	[PA]
PEGASYS INJ	5	
<i>Immunosuppressants</i>		
ASTAGRAF XL	4	[PA] [B vs D] [EDS]
AZASAN	4	[PA] [B vs D] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
<i>azathioprine tabs 50mg</i>	2	[PA] [B vs D] [EDS]	<i>methotrexate inj 50mg/2ml</i>	2	[EDS]
<i>azathioprine tabs 75mg & 100mg</i>	4	[PA] [B vs D] [EDS]	<i>methotrexate oral</i>	2	[EDS]
CELLCEPT CAPS	4	[PA] [B vs D] [EDS]	<i>mycophenolate mofetil caps & tabs</i>	2	[PA] [B vs D] [EDS]
CELLCEPT ORAL SUSPENSION & TABS	5	[PA] [B vs D]	<i>mycophenolate mofetil oral susp</i>	5	[PA] [B vs D]
<i>cyclosporine caps</i>	3	[PA] [B vs D] [EDS]	<i>mycophenolic acid dr</i>	4	[PA] [B vs D] [EDS]
<i>cyclosporine modified</i>	2	[PA] [B vs D] [EDS]	MYFORTIC	4	[PA] [B vs D] [EDS]
ENBREL INJ	5	[PA]	NEORAL	4	[PA] [B vs D] [EDS]
ENBREL MINI INJ	5	[PA]	PROGRAF CAPS	4	[PA] [B vs D] [EDS]
ENBREL SURECLICK INJ	5	[PA]	PROGRAF PACK	4	[PA] [B vs D] [EDS]
ENVARSUS XR	4	[PA] [B vs D] [EDS]	RAPAMUNE SOLN	5	[PA] [B vs D]
<i>everolimus 0.25mg</i>	4	[PA] [B vs D] [EDS]	RAPAMUNE TABS	4	[PA] [B vs D] [EDS]
<i>everolimus 0.5mg, 0.75mg & 1mg</i>	5	[PA] [B vs D]	SANDIMMUNE ORAL SOLN 100MG/ML	4	[PA] [B vs D] [EDS]
<i>gengraf</i>	2	[PA] [B vs D] [EDS]	SANDIMMUNE CAPS 25MG & 100MG	4	[PA] [B vs D] [EDS]
HUMIRA INJ	5	[PA]	<i>sirolimus soln</i>	5	[PA] [B vs D]
HUMIRA PEDIATRIC CROHNS STARTER PACK INJ	5	[PA]	<i>sirolimus tabs</i>	4	[PA] [B vs D] [EDS]
HUMIRA PEN-CD/UC/HS STARTER INJ	5	[PA]	<i>tacrolimus caps 0.5mg & 1mg</i>	3	[PA] [B vs D] [EDS]
HUMIRA PEN-PEDIATRIC UC STARTER PACK INJ	5	[PA]	<i>tacrolimus caps 5mg</i>	4	[PA] [B vs D] [EDS]
HUMIRA PEN-PS/UV STARTER INJ	5	[PA]	XATMEP	4	[EDS]
HUMIRA PEN INJ	5	[PA]	ZORTRESS TABS 0.25MG	4	[PA] [B vs D] [EDS]
IMURAN TABS	4	[PA] [B vs D] [EDS]	ZORTRESS TABS 0.5MG, 0.75MG & 1MG	5	[PA] [B vs D]
<i>leflunomide</i>	2	[EDS]	Vaccines		
			ABRYSVO INJ	3	[EDS]
			ACTHIB INJ	3	[EDS]
			ADACEL INJ	3	[EDS]
			AREXVY INJ	3	[EDS]

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Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制
BCG INJ	3	[EDS]
BEXSERO INJ	3	[EDS]
BOOSTRIX INJ	3	[EDS]
DAPTACEL INJ	3	[EDS]
DIPHTHERIA & TETANUS TOXOIDS PEDIATRIC INJ	3	[EDS]
ENGERIX-B INJ	3	[PA] [B vs D] [EDS]
GARDASIL 9 INJ	4	[EDS]
HAVRIX INJ	3	[EDS]
HEPLISAV-B INJ	3	[PA] [B vs D] [EDS]
HIBERIX INJ	3	[EDS]
IMOVAX RABIES INJ	3	[EDS]
INFANRIX INJ	3	[EDS]
IPOP INACTIVATED IPV INJ	3	[EDS]
IXIARO INJ	4	[EDS]
JYNNEOS INJ	3	[PA] [B vs D] [EDS]
KINRIX INJ	3	[EDS]
MENACTRA INJ	3	[EDS]
MENQUADFI INJ	3	[EDS]
MENVEO-A/C/Y/W-135 INJ	3	[EDS]
M-M-R II INJ	3	[EDS]
PEDIARIX INJ	3	[EDS]
PEDVAX HIB INJ	3	[EDS]
PENTACEL INJ	3	[EDS]
PREHEVBrio INJ	3	[PA] [B vs D] [EDS]
PRIORIX INJ	3	[EDS]
PROQUAD INJ	3	[EDS]
QUADRACEL INJ	3	[EDS]
RABAVERT INJ	3	[EDS]
RECOMBIVAX HB INJ	3	[PA] [B vs D] [EDS]
ROTARIX	3	[EDS]
ROTATEQ	3	[EDS]
SHINGRIX INJ	3	[EDS]

Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制
TDVAX INJ	3	[EDS]
TENIVAC INJ	3	[EDS]
TICOVAC INJ	4	[EDS]
TRUMENBA INJ	3	[EDS]
TWINRIX INJ	3	[EDS]
TYPHIM VI INJ	3	[EDS]
VAQTA INJ	3	[EDS]
VARIVAX INJ	3	[EDS]
YF-VAX INJ	3	[EDS]
INFLAMMATORY BOWEL DISEASE AGENTS		
Aminosalicylates		
balsalazide	3	[EDS]
DIPENTUM	5	
mesalamine dr	4	[EDS]
mesalamine enema	4	[EDS]
mesalamine er caps	4	[EDS]
mesalamine rectal suppository	4	[EDS]
PENTASA CAP 250MG	4	[EDS]
sulfasalazine	2	[EDS]
Glucocorticoids		
budesonide ec caps	4	[EDS]
budesonide er tabs 9mg	5	
hydrocortisone enema	2	[EDS]
prednisone tabs	1	[PA] [B vs D] [EDS]
prednisone oral soln	2	[PA] [B vs D] [EDS]
PREDNISONE INTENSOL	4	[PA] [B vs D] [EDS]
procto-med hc	2	[EDS]
procto-pak	2	[EDS]
proctosol hc	2	[EDS]
proctozone-hc	2	[EDS]
METABOLIC BONE DISEASE AGENTS		
Metabolic Bone Disease Agents		
alendronate tabs	1	[EDS]

[PA] = 事先授權 [B vs D] = B 與 D [QL] = 數量限制 [LD] = 限量分配 [EDS] = 延長天數供藥

您可以前往第 56 頁，找到本表中的符號和縮寫詞所代表含義的相關資訊。

Drug Name	Drug Tier	Requirements/ Limits	Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
<i>alendronate oral soln</i>	3	[EDS]	<i>paroxetine mesylate</i>	3	[EDS]
<i>calcitonin-salmon nasal</i>	2	[EDS]	PAXLOVID	3	[EDS]
<i>calcitriol caps</i>	2	[PA] [B vs D] [EDS]	<i>pmdd fluoxetine hcl tabs 10mg & 20mg</i>	2	[EDS]
<i>cinacalcet tab 30mg</i>	3	[PA] [B vs D] [EDS]	OPHTHALMIC AGENTS		
<i>cinacalcet tab 60mg</i>	4	[PA] [B vs D] [EDS]	Ophthalmic Agents, Other		
<i>cinacalcet tab 90mg</i>	5	[PA] [B vs D]	<i>atropine sulfate soln</i>	2	[EDS]
<i>doxercalciferol oral</i>	3	[PA] [B vs D] [EDS]	<i>brimonidine & timolol maleate</i>	3	[EDS]
FORTEO INJ	5	[PA]	<i>cyclosporine emulsion 0.05%</i>	3	[EDS]
<i>ibandronate oral</i>	2	[EDS]	CYSTARAN	5	
<i>paricalcitol caps</i>	3	[PA] [B vs D] [EDS]	<i>dorzolamide & timolol maleate</i>	2	[EDS]
PROLIA INJ	4	[PA] [EDS]	LACRISERT	4	[EDS]
RAYALDEE	5		<i>neomycin & polymyxin & bacitracin</i>	2	[EDS]
<i>risedronate sodium</i>	3	[EDS]	<i>neomycin & polymyxin & bacitracin & hydrocortisone</i>	2	[EDS]
<i>risedronate sodium dr</i>	3	[EDS]	<i>neomycin & polymyxin & dexamethasone</i>	2	[EDS]
TERIPARATIDE INJ	5	[PA]	<i>neomycin & polymyxin & gramicidin ophthalmic</i>	2	[EDS]
TYMLOS INJ	5	[PA]	<i>neomycin & polymyxin & hydrocortisone</i>	2	[EDS]
XGEVA INJ	5	[PA]	ROCKLATAN	3	[EDS]
MISCELLANEOUS THERAPEUTIC AGENTS			SIMBRINZA	4	[EDS]
Miscellaneous Therapeutic Agents			<i>sulfacetamide sodium & prednisolone sodium phosphate ophthalmic</i>	2	[EDS]
<i>alcohol pads</i>	2	[EDS]	TOBRADEX OINT	3	[EDS]
<i>bd insulin syringe ultrafine</i>	2	[EDS]			
<i>bd insulin syringe safetyglide</i>	2	[EDS]			
<i>bd pen needle ultrafine</i>	2	[EDS]			
ENDARI	5	[PA]			
<i>gauze pads 2"x2"</i>	2	[EDS]			
KORLYM	5	[PA]			
KOSELUGO	5	[PA]			
LAGEVRIO	4	[EDS]			
<i>levocarnitine oral</i>	2	[PA] [B vs D] [EDS]			
NATPARA INJ	5	[PA] [LD]			

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制
<i>tobramycin & dexamethasone ophthalmic suspension</i>	2	[EDS]	Ophthalmic Anti-inflammatory Agents		
XIIDRA	3	[EDS]	<i>bromfenac ophthalmic soln 0.09%</i>	3	[EDS]
Ophthalmic Anti-allergy Agents			<i>BROMSITE</i>	4	[EDS]
<i>azelastine 0.05%</i>	2	[EDS]	<i>dexamethasone ophthalmic soln</i>	2	[EDS]
<i>cromolyn sodium ophthalmic soln</i>	2	[EDS]	<i>diclofenac sodium ophthalmic soln 0.1%</i>	2	[EDS]
Ophthalmic Anti-infectives			<i>difluprednate</i>	3	[EDS]
AZASITE	3	[EDS]	<i>fluorometholone</i>	2	[EDS]
<i>bacitracin ophthalmic ointment</i>	2	[EDS]	<i>ketorolac soln</i>	2	[EDS]
<i>bacitracin & polymyxin b ointment</i>	2	[EDS]	<i>LOTEMAX OINT</i>	4	[EDS]
<i>ciprofloxacin ophthalmic soln 0.3%</i>	2	[EDS]	<i>LOTEMAX SM GEL 0.38%</i>	4	[EDS]
<i>erythromycin ophthalmic oint</i>	2	[EDS]	<i>PRED MILD</i>	3	[EDS]
<i>gentamicin ophthalmic soln 0.3%</i>	2	[EDS]	<i>prednisolone acetate</i>	2	[EDS]
<i>moxifloxacin hcl ophthalmic</i>	2	[EDS]	<i>prednisolone sodium phosphate</i>	2	[EDS]
NATACYN	4	[EDS]	<i>PROLENSA</i>	3	[EDS]
<i>neo-polycin ophthalmic ointment</i>	2	[EDS]	Ophthalmic Beta-Adrenergic Blocking Agents		
<i>neo-polycin hc ophthalmic ointment</i>	2	[EDS]	<i>betaxolol soln</i>	2	[EDS]
<i>ofloxacin ophthalmic</i>	2	[EDS]	<i>carteolol</i>	1	[EDS]
<i>polycin ophthalmic ointment</i>	2	[EDS]	<i>levobunolol</i>	2	[EDS]
<i>polymyxin b sulfate & trimethoprim sulfate ophthalmic soln</i>	2	[EDS]	<i>timolol ophthalmic gel forming</i>	2	[EDS]
<i>sulfacetamide sodium ophthalmic oint & soln 10%</i>	2	[EDS]	<i>timolol ophth soln 12 hours 0.25% & 0.5% multi-use bottles</i>	1	[EDS]
<i>tobramycin ophthalmic solution</i>	2	[EDS]	Ophthalmic Intraocular Pressure Lowering Agents, Other		
<i>trifluridine</i>	2	[EDS]	<i>acetazolamide tabs</i>	2	[EDS]
ZIRGAN	4	[EDS]	<i>acetazolamide er caps</i>	2	[EDS]
			<i>ALPHAGAN P 0.1%</i>	3	[EDS]
			<i>brimonidine tartrate soln 0.15%</i>	3	[EDS]
			<i>brimonidine tartrate soln 0.2%</i>	2	[EDS]
			<i>dorzolamide</i>	2	[EDS]
			<i>methazolamide</i>	4	[EDS]

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您可以前往第 56 頁，找到本表中的符號和縮寫詞所代表含義的相關資訊。

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
PHOSPHOLINE IODIDE	3	[EDS]
pilocarpine soln	2	[EDS]
RHOPRESSA	3	[EDS]
Ophthalmic Prostaglandin and Prostamide Analogs		
latanoprost	1	[EDS]
LUMIGAN	3	[EDS]
travoprost	3	[EDS]
VYZULTA	4	[EDS]
OTIC AGENTS		
Otic Agents		
acetic acid & hydrocortisone	2	[EDS]
CIPRO HC	3	[EDS]
ciprofloxacin & dexamethasone otic susp	3	[EDS]
fluocinolone acetonide otic soln	3	[EDS]
neomycin & polymyxin & hydrocortisone	2	[EDS]
ofloxacin otic	2	[EDS]
RESPIRATORY TRACT/PULMONARY AGENTS		
Antihistamines		
azelastine nasal 0.1%	2	[EDS]
ciproheptadine	2	[EDS]
desloratadine tabs	2	[EDS]
hydroxyzine hcl tabs	2	[EDS]
hydroxyzine pamoate caps	2	[EDS]
levocetirizine	2	[EDS]
Anti-inflammatories, Inhaled Corticosteroids		
ARNUITY ELLIPTA	3	[EDS]
ASMANEX HFA	3	[EDS]
ASMANEX TWISTHALER	3	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
BREZTRI AEROSPHERE	3	[EDS]
budesonide nebulizer	3	[PA] [B vs D] [EDS]
flunisolide nasal	2	[QL] [EDS]
fluticasone propionate nasal	2	[QL] [EDS]
mometasone furoate nasal	3	[QL] [EDS]
PULMICORT NEBULIZER	4	[PA] [B vs D] [EDS]
QVAR REDIHALER	3	[EDS]
Antileukotrienes		
montelukast	2	[EDS]
zafirlukast	2	[EDS]
Bronchodilators, Anticholinergic		
ATROVENT HFA	3	[QL] [EDS]
ipratropium bromide nasal	2	[QL] [EDS]
ipratropium bromide nebulizer	2	[PA] [B vs D] [EDS]
SPIRIVA HANDIHALER	3	[EDS]
SPIRIVA RESPIMAT	3	[EDS]
YUPELRI	5	[PA] [B vs D]
Bronchodilators, Sympathomimetic		
albuterol sulfate hfa 6.7gm inhaler	2	[QL] [EDS]
albuterol sulfate hfa 8.5gm inhaler	2	[QL] [EDS]
albuterol sulfate nebulizer	2	[PA] [B vs D] [EDS]
albuterol sulfate syrup	2	[EDS]
albuterol sulfate tabs	4	[EDS]
arformoterol tartrate nebulizer	4	[PA] [B vs D] [EDS]
BROVANA NEBULIZER	4	[PA] [B vs D] [EDS]

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Drug Name	Drug Tier	Requirements/Limits	Drug Name	Drug Tier	Requirements/Limits	
藥物名稱	藥物等級	要求/限制	藥物名稱	藥物等級	要求/限制	
EPINEPHRINE AUTO-INJECTOR 0.15MG/0.3ML & 0.3MG/0.3ML	3	[EDS]	OPSUMIT	5	[PA] [LD]	
<i>formoterol fumarate nebulizer</i>	4	[PA] [B vs D] [EDS]	<i>sildenafil tab 20mg</i>	3	[PA] [EDS]	
<i>levalbuterol nebulizer</i>	2	[PA] [B vs D] [EDS]	<i>tadalafil tab 20mg</i>	5	[PA]	
LEVALBUTEROL TARTRATE HFA	4	[EDS]	TRACLEER 32MG	5	[PA] [LD]	
PERFOROMIST NEBULIZER	5	[PA] [B vs D]	UPTRAVI	5	[PA]	
PROAIR RESPICLICK	3	[EDS]	VENTAVIS	5	[PA] [B vs D]	
SEREVENT DISKUS	3	[EDS]	Pulmonary Fibrosis Agents			
STRIVERDI RESPIMAT	3	[EDS]	OFEV	5	[PA]	
<i>terbutaline sulfate oral</i>	3	[EDS]	<i>pirfenidone tabs</i>	5	[PA]	
Cystic Fibrosis Agents						
BETHKIS	5	[PA] [B vs D]	<i>acetylcysteine nebulizer soln</i>	2	[PA] [B vs D] [EDS]	
CAYSTON	5	[PA] [LD]	ADVAIR HFA	3	[EDS]	
KALYDECO	5	[PA]	ANORO ELLIPTA	3	[EDS]	
KITABIS NEBULIZER	5	[PA] [B vs D]	BEVESPI AEROSPHERE	3	[EDS]	
ORKAMBI	5	[PA]	BREO ELLIPTA	3	[EDS]	
PULMOZYME	5	[PA] [B vs D]	COMBIVENT RESPIMAT	3	[EDS]	
TOBI SOLN	5	[PA] [B vs D]	DULERA	3	[EDS]	
TOBI PODHALER	5		FASENRA INJ	5	[PA]	
<i>tobramycin nebulizer</i>	5	[PA] [B vs D]	<i>fluticasone propionate/salmeterol diskus 100mcg-50mcg, 250mcg-50mcg & 500mcg-50mcg</i>	2	[EDS]	
TRIKAFTA	5	[PA]	<i>ipratropium bromide & albuterol sulfate nebulizer</i>	2	[PA] [B vs D] [EDS]	
Mast Cell Stabilizers						
<i>cromolyn sodium nebulizer soln</i>	4	[PA] [B vs D] [EDS]	PROLASTIN C INJ	5	[PA] [LD]	
Phosphodiesterase Inhibitors, Airways Disease			STIOLTO RESPIMAT	3	[EDS]	
roflumilast tabs	3	[EDS]	TRELEGY ELLIPTA	3	[EDS]	
<i>theophylline er tabs</i>	2	[EDS]	<i>wixela inh</i>	2	[EDS]	
Pulmonary Antihypertensives						
ADEMPAS	5	[PA] [LD]	SKELETAL MUSCLE RELAXANTS			
<i>alyq</i>	5	[PA]	Skeletal Muscle Relaxants			
<i>ambrisentan</i>	5	[PA] [LD]	<i>carisoprodol tabs 350mg</i>	2	[EDS]	
<i>bosentan tabs 62.5mg & 125mg</i>	5	[PA] [LD]	<i>chlorzoxazone tabs 500mg</i>	2	[EDS]	
			<i>cyclobenzaprine hcl ir</i>	2	[EDS]	

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
<i>methocarbamol tabs</i>	2	[EDS]
SLEEP DISORDER AGENTS		
<i>Sleep Promoting Agents</i>		
BELSOMRA	3	[QL] [EDS]
<i>doxepin tabs</i>	3	[EDS]
<i>estazolam</i>	2	[EDS]
<i>ramelteon</i>	3	[EDS]
<i>tasimelteon caps</i>	5	[PA]
<i>temazepam caps 7.5mg, 15mg & 30mg</i>	2	[EDS]
<i>temazepam caps 22.5mg</i>	3	[EDS]
<i>triazolam</i>	2	[EDS]
<i>zolpidem ir tabs 5mg & 10mg</i>	2	[EDS]
<i>Wakefulness Promoting Agents</i>		
<i>armodafinil</i>	3	[PA] [EDS]
<i>modafinil</i>	3	[PA] [EDS]
SODIUM OXYBATE ORAL SOLN	5	[PA][LD]
XYWAV	5	[PA] [LD]

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Additional Covered Drugs

Your plan has additional coverage for the prescription drugs listed below if you are enrolled in one of these plans:

- SCAN Classic (HMO): Los Angeles, Orange, Riverside, San Bernardino, Ventura, Alameda, San Mateo, Fresno, Madera Counties
- Scripps Classic offered by SCAN Health Plan (HMO): San Diego County
- Scripps Signature offered by SCAN Health Plan (HMO): San Diego County
- SCAN Alta (HMO): San Diego County
- SCAN Venture (HMO): Los Angeles, Orange, Riverside, San Bernardino Counties
- SCAN Prime (HMO): Los Angeles, Orange, Riverside, San Bernardino Counties
- SCAN Affirm partnered with Included LGBTQ+ Health (HMO): Los Angeles, Orange, Riverside, San Diego, San Francisco Counties
- SCAN Inspired by women for women (HMO): Los Angeles, Orange Counties
- SCAN Compass (HMO): Los Angeles, Orange, Riverside, San Bernardino Counties
- SCAN Navigate (HMO): Los Angeles, Orange, Riverside, San Bernardino Counties
- SCAN MyChoice (HMO): Orange, San Diego, Alameda, San Mateo Counties
- SCAN Options (HMO): Ventura County

These prescription drugs are not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs.

Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制
ERECTILE DYSFUNCTION		
<i>sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)</i>	1	[QL] (4 tablets per 30-day supply with a maximum of 49 tablets per year)
PRESCRIPTION VITAMINS		
<i>cyanocobalamin inj 1000 mcg/ml (vitamin B12)</i>	1	
<i>ergocalciferol caps 1.25mg (50,000 units) (vitamin D2)</i>	1	
<i>folic acid tabs 1 mg (vitamin B9)</i>	1	

額外承保藥物

如果您參保了以下某項計劃，您的計劃對下列處方藥有額外承保：

- SCAN Classic (HMO)：洛杉磯郡、橘郡、河濱郡、聖貝納迪諾郡、文圖拉郡、阿拉米達郡、聖馬刁郡、弗雷斯特諾郡、馬德拉郡
- Scripps Classic offered by SCAN Health Plan (HMO)：聖地牙哥郡
- Scripps Signature offered by SCAN Health Plan (HMO)：聖地牙哥郡
- SCAN Alta (HMO)：聖地牙哥郡
- SCAN Venture (HMO)：洛杉磯郡、橘郡、河濱郡、聖貝納迪諾郡
- SCAN Prime (HMO)：洛杉磯郡、橘郡、河濱郡、聖貝納迪諾郡
- SCAN Affirm 與 Included LGBTQ+ Health 聯盟 (HMO)：洛杉磯郡、橘郡、河濱郡、聖地牙哥郡、三藩市郡
- SCAN Inspired 女性專屬計劃 (HMO)：洛杉磯，橘郡
- SCAN Compass (HMO)：洛杉磯郡、橘郡、河濱郡、聖貝納迪諾郡
- SCAN Navigate (HMO)：洛杉磯郡、橘郡、河濱郡、聖貝納迪諾郡
- SCAN MyChoice (HMO)：橘郡、聖地牙哥郡、阿拉米達郡、聖馬刁郡
- SCAN Options (HMO)：文圖拉郡

這些處方藥通常不在 Medicare 處方藥計劃的承保範圍內。您為這些藥物配藥時支付的金額不計入您的藥物總費用（也就是說，您所支付的金額無法幫助您獲得重大傷病承保）。此外，如果您正在接受額外補助來支付您的處方藥費用，您將不會獲得任何額外補助來支付這些藥物的費用。

Drug Name	Drug Tier	Requirements/Limits
藥物名稱	藥物等級	要求/限制
勃起功能障礙		
<i>sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)</i>	1	[QL] (每 30 天份量 4 片，每年最多 49 片)
處方維生素		
<i>cyanocobalamin inj 1000 mcg/ml (vitamin B12)</i>	1	
<i>ergocalciferol caps 1.25mg (50,000 units) (vitamin D2)</i>	1	
<i>folic acid tabs 1 mg (vitamin B9)</i>	1	

FORMULARY DRUGS WITH QUANTITY LIMITS

有數量限制的藥物

Drugs with Quantity Limits

有數量限制的藥物

Drug Name 藥物名稱	Quantity Limits 數量限制
<i>acetaminophen & codeine #2 & #3 tabs</i>	360 tabs per 30 days
<i>acetaminophen & codeine #4 tabs</i>	180 tabs per 30 days
<i>acetaminophen & codeine elixir</i>	5000ml per 30 days
<i>acyclovir cream</i>	5gm per 30 days
<i>acyclovir ointment</i>	30gm per 30 days
<i>albuterol sulfate hfa 6.7gm inhaler</i>	13.4gm per 30 days
<i>albuterol sulfate hfa 8.5gm inhaler</i>	17gm per 30 days
<i>amphetamine & dextroamphetamine</i>	60 tabs per 30 days
<i>ATROVENT HFA</i>	2 inhalers per 30 days
<i>BELSOMRA</i>	30 tabs per 30 days
<i>butorphanol tartrate nasal</i>	4 bottles per 30 days
<i>calcipotriene cream</i>	60gm: 2 tubes per 30 days; 120gm: 1 tube per 30 days
<i>calcipotriene oint</i>	60gm: 2 tubes per 30 days
<i>desonide lotion, oint & cream</i>	cream & oint: 120gm per 30 days lotion: 118ml per 30 days
<i>desoximetasone topical cream, gel & oint 0.05%</i>	120gm per 30 days
<i>desoximetasone topical cream & oint 0.25%</i>	120gm per 30 days
<i>dextroamphetamine sulfate</i>	5mg: 120 tabs per 30 days; 10mg: 180 tabs per 30 days
<i>dextroamphetamine sulfate er</i>	5mg: 30 caps per 30 days; 10mg & 15mg: 120 caps per 30 days
<i>diflorasone diacetate</i>	60gm per 30 days
<i>endocet tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg</i>	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg: 240 tabs per 30 days; 10-325mg: 180 tabs per 30 days
<i>fentanyl patches</i>	15 patches per 30 days
<i>flunisolide nasal</i>	2 bottles per 30 days
<i>fluocinonide cream, gel & ointment</i>	15gm: 4 tubes per 30 days; 30gm: 2 tubes per 30 days; 60g: 1 tube per 30 days
<i>fluticasone propionate nasal</i>	2 bottles per 30 days
<i>hydrocodone & acetaminophen soln 7.5-325mg/15ml</i>	2700ml per 30 days
<i>hydrocodone & acetaminophen tabs 5-325mg, 7.5-325mg & 10-325mg</i>	5-325mg: 360 tabs per 30 days; 7.5-325mg & 10-325mg: 180 tabs per 30 days

Drugs with Quantity Limits

有數量限制的藥物

Drug Name 藥物名稱	Quantity Limits 數量限制
<i>hydrocodone & ibuprofen tabs 5-200mg, 7.5-200mg & 10-200mg</i>	150 tabs per 30 days
<i>ipratropium bromide nasal</i>	1 bottle per 30 days
<i>lidocaine ointment</i>	1 tube per 30 days
<i>lidocaine topical soln</i>	1 bottle per 30 days
<i>lidocaine & prilocaine</i>	30gm: 1 tube per 30 days
<i>mometasone furoate nasal</i>	3 bottles per 30 days
<i>morphine sulfate er tabs</i>	120 tabs per 30 days
<i>mupirocin cream</i>	30gm per 30 days
<i>oxycodone & acetaminophen tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg</i>	2.5-325mg & 5-325mg: 360 tabs per 30 days; 7.5-325mg: 240 tabs per 30 days; 10-325mg: 180 tabs per 30 days
OXYCODONE ER TABS 10MG & 20MG	60 tabs per 30 days
<i>pimecrolimus</i>	30gm: 3 tubes per 30 days
REGRANEX	2 tubes per 30 days
SANTYL	90gm per 30 days
<i>tacrolimus oint</i>	100g per 30days
<i>tazarotene gel</i>	30gm: 3 tubes per 30 days; 100gm: 1 tube per 30
<i>tramadol er tabs</i>	30 tabs per 30 days
<i>tramadol ir tab 100mg</i>	120 tabs per 30 days
<i>tramadol & acetaminophen tabs 37.5-325mg</i>	240 tabs per 30 days
<i>zenzedi</i>	5mg: 120 tabs per 30 days 10mg: 180 tabs per 30 days

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SCAN Health Plan complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of, or because of, race, color, national origin, age, disability, or sex. SCAN Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats). SCAN Health Plan provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact SCAN Member Services.

If you believe that SCAN Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by phone, mail, or fax, at:

SCAN Health Plan
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
PHONE: 1-800-559-3500
FAX: 1-562-989-0958
TTY: 711

Or by filling out the "File a Grievance" form on our website at:
<https://www.scanhealthplan.com/contact-us/file-a-grievance>

If you need help filing a grievance, SCAN Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (TTY: 1-800-537-7697)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Services).

- In writing: Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413

Complaint forms are available at http://www.dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov

SCAN Health Plan、SCAN Desert Health Plan 與 SCAN Health Plan New Mexico 均遵守適用聯邦民權法，不會基於或因為種族、膚色、原國籍、年齡、殘障或性別而歧視、拒絕接納或區別對待任何人。SCAN Health Plan、SCAN Desert Health Plan 與 SCAN Health Plan New Mexico 均向殘障人士提供免費協助和服務，幫助他們與我們進行有效溝通，比如：合格的手語翻譯員，以及其他格式的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）。SCAN Health Plan、SCAN Desert Health Plan 與 SCAN Health Plan New Mexico 均向母語非英語的人員免費提供語言服務，如合格的翻譯員和以其他語言書寫的資訊。如果您需要這些服務，請聯絡 SCAN 會員服務部。

如果您認為 SCAN Health Plan、SCAN Desert Health Plan 或 SCAN Health Plan New Mexico 因種族、膚色、原國籍、年齡、殘障或性別而未能提供這些服務或在其他方面存在歧視行為，您可透過打電話、致函或發傳真的方式向以下機構提出申訴：

SCAN Health Plan
Attention: Grievance and Appeals Department
P.O. Box 22616
Long Beach, CA 90801-5616

SCAN Member Services
1-800-559-3500
傳真: 1-562-989-0958
聽障專線：711

或者透過在我們的網站上填寫「提出申訴」表提出申訴：

<https://www.scanhealthplan.com/contact-us/file-a-grievance>

如果您在提出申訴時需要幫助，SCAN 會員服務部可向您提供幫助。

您還可透過民權辦公室投訴入口網站 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>，以電子形式向美國衛生與公眾服務部民權辦公室提出民權投訴，或者透過郵件或電話進行此投訴：

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 (聽障專線：1-800-537-7697)

投訴表格可在以下網址獲取：<https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>。

您還可以透過電話、書面或電子方式向加州衛生保健服務部民權辦公室提出民權投訴：

- 透過電話：請致電 1-916-440-7370。如果您為聽障或語障人士，請致電 711（電信中繼服務）。
- 書面方式：填寫投訴表或寄信至：
Deputy Director, Office of Civil Rights
Department of Health Care Services
Office of Civil Rights
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
投訴表格可在以下網址獲取 http://www.dhcs.ca.gov/Pages/Language_Access.aspx。
- 電子方式：傳送電郵至 CivilRights@dhcs.ca.gov

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-559-3500. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, llame al 1-800-559-3500. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Cantonese (Traditional): 我們提供免費的口譯服務，以解答您對我們的健康或藥物計劃可能有的任何問題。如需獲得口譯服務，請致電 1-800-559-3500 聯絡我們。我們有會說中文的工作人員可以為您提供幫助。這是一項免費服務。

Chinese Mandarin (Simplified): 我们提供免费的口译服务，以解答您对我们的健康或药物计划可能有的任何问题。如需获得口译服务，请致电 1-800-559-3500 联系我们。我们有会说中文的工作人员可以为您提供帮助。这是一项免费服务。

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số 1-800-559-3500. Người nói Tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Tagalog: Mayroon kaming mga libreng serbisyo ng interpreter upang masagot ang anumang katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng interpreter, tawagan lamang kami sa 1-800-559-3500. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-559-3500 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Armenian: Առողջության կամ դեղերի ծրագրի վերաբերյալ որևէ հարց առաջանալու դեպքում կարող եք օգտվել անվճար թարզմանչական ծառայությունից: Թարզմանչի ծառայությունից օգտվելու համար զանգահարեք 1-800-559-3500 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سوالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره 1-800-559-3500 تماس بگیرید. شخصی که به زبان فارسی صحبت می کند، می تواند به شما کمک کند. این یک سرویس رایگان است.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру 1-800-559-3500. Вам окажет помощь сотрудник, который говорит на русском языке. Данная услуга бесплатная.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするため に、無料の通訳サービスをご用意しています。通訳をご利用になるには、1-800-559-3500 にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة لديك تتعلق بخطتنا الصحية أو جدول الدواء. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم 1-800-559-3500. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه الخدمة المجانية.

Punjabi: ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਦਵਾਈ ਯੋਜਨਾ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲਾਂ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੇਲ ਮੁਫ਼ਤ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਹਨ। ਕੋਈ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਬੱਸ ਸਾਨੂੰ 1-800-559-3500 'ਤੇ ਕਾਲ ਕਰੋ। ਕੋਈ ਵਿਅਕਤੀ ਜੋ ਪੰਜਾਬੀ ਬੋਲਦਾ ਹੈ, ਉਹ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫ਼ਤ ਸੇਵਾ ਹੈ।

Mon-Khmer, Cambodian:

យើងខ្លំបានសេវាអ្នកបកព្រៃច្បាស់មាត់ដោយមិនគិតថ្លែងទៅដោយរាយការណ៍ដែលអ្នកអាជមានអំពីសុខភាព
ប្រឹជនការឱសចរបសយើងខ្លំ។ ដើម្បីទទួលបានអ្នកបកព្រៃ ត្រាន់តែហេរទូរសព្ទមកយើងខ្លំតាមរយៈលេខ
1-800-559-3500។ មានគេដែលនិយាយភាសាខ្មែរអាមេរិកខ្លំ។ សេវាអ្នកនេះមិនគិតថ្លែងទេ។

Hmong: Peb muaj cov kev pab cuam txhais lus los teb koj cov lus nug uas koj muaj txog ntawm
peb lub phiaj xwm kho mob thiab tshuaj kho mob. Kom tau txais tus kws txhais lus, tsuas yog hu
peb ntawm 1-800-559-3500. Muaj qee tus neeg hais lus Hmoob tuaj yeem pab tau koj. Qhov no
yog kev pab cuam pab dawb.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त
दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-559-3500 पर फोन करें। कोई व्यक्ति
जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Thai: ເວມືບຣິກາຣລໍາມພຣີເພື່ອຕອບຂໍ້ອສລໍາດຳຕ່າງໆ ທີ່ຄຸນອາຈານມີເກີຍວັກປແຜນສຸຂາກພແລະດໍ້ານເກສ້າກວມຂອງເວາ
ຂອງຄວາມຫຼວຍເໝີ້ຈາກລໍາມໂດຍໂທຣິດຕ່ອງເຈົ້າທີ່ໜ້າຍເລີ້າ 1-800-559-3500
ເຈົ້າໜ້າທີ່ໃນພາສາໄທຍະເປັນຜູ້ໃຫ້ບຣິກາຣໂດຍໄໝ່ມີຄໍາໃຫ້ຈ່າຍໄດ້ ພົບ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຝຣີ ເພື່ອຕອບຄໍາຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສູຂະພາບ ຫຼື ເພັນການຢາຂອງ
ພວກເຮົາ. ເພື່ອຮັບອຳນານາຍພາສາ, ພົບໄຕ້ທ່ານພວກເຮົາທີ່ເປີ 1-800-559-3500. ບາງຄົນທີ່ວ້າພາສາວາວ
ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຝຣີ.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos
questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service
d'interprétation, il vous suffit de nous appeler au 1-800-559-3500. Quelqu'un parlant français
pourra vous aider. Ce service est gratuit.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem
Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-559-3500. Man
wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul
nostro piano sanitario e farmaceutico. Per usufruire di un interprete, contattare il numero
1-800-559-3500. Un nostro incaricato che parla Italiano Le fornirà l'assistenza necessaria.
È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão
que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete,
contacte-nos através do número 1-800-559-3500. Irá encontrar alguém que fale português para
o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprt gratis pou reponn tout kesyon ou ta genyen konsènan
plan sante oswa medikaman nou yo. Pou w jwenn yon entèprt, jis rele nou nan 1-800-559-3500.
Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu
odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy
tłumacza znajdującego się język polski, należy zadzwonić pod numer 1-800-559-3500. Ta usługa jest
bezpłatna.

Hmong-Mien: Peb muaj kev pab cuam txhais lus pub dawb los teb cov lus nug uas koj muaj txog
ntawm peb lub phiaj xwm kev noj qab haus huv los sis phiaj xwm tshuaj kho mob. Kom tau txais
tus kws txhais lus, tsuas yog hu peb ntawm 1-800-559-3500. Muaj tus neeg hais lus Hmoob tuaj
yeem pab tau koj. Qhov kev pab cuam no yog pab dawb xwb.

Ukrainian: Ми надаємо безкоштовні послуги усного перекладача, який відповість на будь-які
ваші запитання щодо нашого плану медичного обслуговування або лікарського
забезпечення. Щоб отримати послуги перекладача, просто зателефонуйте нам за номером
1-800-559-3500. Вам може допомогти людина, яка володіє українською мовою. Ця послуга
безкоштовна.



The formulary and pharmacy network may change at any time. You will receive notice when necessary.

This formulary was updated on 03/01/2024. For more recent information or other questions, please contact SCAN Health Plan Member Services at 1-800-559-3500 (TTY users should call 711), 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31. From April 1 to September 30, hours are 8 a.m. to 8 p.m., Monday through Friday (messages received on holidays and outside of our business hours will be returned within one business day), or visit www.scanhealthplan.com.

處方藥一覽表和藥房網絡可能會隨時變更。必要時您會收到通知。

本處方藥一覽表更新於 03/01/2024。如需瞭解最新資訊或有其他疑問，請聯絡 SCAN Health Plan 會員服務部，電話：1-800-559-3500（聽障人士應致電 711），10 月 1 日至 3 月 31 日期間，服務時間為每週 7 天，上午 8 點至晚上 8 點。4 月 1 日至 9 月 30 日期間的服務時間為週一至週五，上午 8 點至晚上 8 點（節假日及營業時間之外收到的訊息將在一個工作日內回覆），或瀏覽 www.scanhealthplan.com。

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