Drug List – Preventive Items and Services Offering - 2025

The Patient Protection and Affordable Care Act (PPACA) imposes a number of insurance reforms and mandates including a requirement to cover certain *preventive items and services* at 100 percent and ensure these items and services are not subject to deductibles or other cost-sharing limitations.

The following list of preventive medications should be used as a guide. It cannot be considered a comprehensive listing of medications available or covered without cost-sharing. Coverage of any of the listed medications (including over-the-counter (OTC) medications) requires a prescription from a licensed health care provider.

The availability or coverage of these medications without cost-sharing may be subject to criteria established by the terms of the health plan.

This list is subject to change as PPACA guidelines are updated or modified.

Please note: coverage of medications at $0 cost share is dependent on the list of medications covered by your drug formulary.

Medicine Category and Who is Covered	Examples of Medicines Covered
Aspirin *Persons of any age*	Generic, single-entity aspirin 81 mg Includes copay exception review process
Breast Cancer – Primary Prevention Persons ≥ 35 years who meet criteria. *(Only one of the available options described is chosen for coverage by a prescription drug plan)*	**Preferred Option: Copay Exception Review only:** Brand and generic tamoxifen (tablet, liquid solution); and for post-menopausal persons: raloxifene, anastrozole, and exemestane **Non-Preferred Option**: Generic tamoxifen, raloxifene, anastrozole, exemestane, and brand Soltamox are all covered at POS for $0 member-share without review. For other products not covered at $0 cost-share at the point of service, a member- or prescriber-initiated copay exception review is available.
Contraceptive Methods Persons of any age capable of pregnancy *(Only one of the available options described is chosen for coverage by a prescription drug plan)*	*Brand name contraceptives with a generic equivalent are $0 cost share only when the prescriber indicates the brand product must be dispensed or generic is not available.* **Expanded Product Option*:** Covered products include all generic and single source brands within required categories, including: OTC contraceptive methods (condoms, spermicides, etc.), diaphragms, cervical cap, hormonal contraceptives (including emergency contraception), and contraceptive devices. *Quantity limit is applied to OTC Opill®.* **Preferred Product with Step Therapy Option*:** Covered products include select products within required categories. including: spermicide VCF® gel and legend diaphragms; Today® contraceptive sponge; condoms; Femcap®; generic oral, transdermal and intramuscular hormonal methods; contraceptive ring; generic, OTC emergency contraceptives; the intrauterine system Mirena®; and the intradermal agent, Nexplanon®. *Step Therapy criteria are applied to select brand contraceptives. Quantity limit is applied to OTC Opill®.* **Preferred Product Option*:** Covered products include select products within required categories including: spermicide VCF® gel and legend diaphragms; Today® contraceptive sponge; condoms; Femcap®; generic oral, transdermal and intramuscular hormonal methods; contraceptive ring; generic, OTC emergency contraceptives; the intrauterine system Mirena®; and the intradermal agent, Nexplanon®. *Quantity limit is applied to OTC Opill®.* All options include copay exception review process. *coverage of medications at $0 cost share is dependent on the list of medications covered by the member's drug formulary.
Fluoride Persons 6 months through <17 years	Fluoride Chewable or Drops ≤ 1.0 MG generic Multivitamin/Fluoride (≤ 1.0 MG)Chewable/Drops/Suspension generic Includes copay exception review process
Folic Acid Persons of any age	Folic Acid Tablet 0.4 MG and 0.8 MG generic Multivitamin and Prenatal Vitamins with Folic Acid (0.4 MG and 0.8 MG) generic Includes copay exception review process
HIV Prep Persons of any age Only for members lacking a history of treatment for HIV (using claims data).	Emtricitabine / tenofovir disoproxil fumarate (TDF) generic - 200 mg / 300 mg dose only Includes copay exception review process

Medicine Category and Who is Covered	Examples of Medicines Covered
Immunizations The age for coverage varies based on the vaccine product prescribed and recommendations by the U.S. Centers for Disease Control and Prevention *(Only one of the available options described is chosen for coverage by a prescription drug plan)*	**Option 1:** Covered immunizations include those that are routine vaccines and non-routine immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention and that meet the US Food and Drug Administration approved indications for age limitations. **Option 2:** This option only includes routine vaccines as defined by the ACIP. Both options include copay exception review process.
Medications used to prepare for Colonoscopy Persons ≥ 45 and ≤ 75 years of age Limit of 2 prescriptions per year; Package size limitations may apply *(Only one of the available options described is chosen for coverage by a prescription drug plan)*	**Generic Only Option:** Covered products include legend and over-the-counter medicines such as: Bisacodyl; Magnesium Citrate; Milk of Magnesia; and PEG 3350 generic. **Generic Plus Brand Option:** Covered products include the above listed generics plus select brands. Both options include copay exception review process.
Statins Persons ≥ 40 years and ≤ 75 years *(Only one of the available options described is chosen for coverage by a prescription drug plan)*	Covered products may include generic low to moderate intensity statins such as: • Atorvastatin ≤ 20mg • Fluvastatin ≤ 80mg • Lovastatin ≤ 40 mg • Pitavastatin ≤ 4mg • Pravastatin ≤ 80mg • Rosuvastatin ≤ 10mg • Simvastatin ≤ 40mg **Standard Program Option 1:** generic low/moderate intensity statins **Trend Management Program Option 2:** generic low/moderate intensity statins only for members meeting CVD medical history and Rx risk factor requirements (using claims data). Both options include copay exception review process.
Tobacco Cessation Persons 18 and older *(Only one of the available options described is chosen for coverage by a prescription drug plan)*	Bupropion sustained release 150mg generic; Varenicline; and Nicotine **Smoking Cessation Option 1** All FDA approved products listed above are covered with no limitations. **Smoking Cessation Option 2** All FDA approved products listed above are covered for a maximum of 180 days therapy per 365 days after which, the member is responsible for a usual co-payment amount. **Smoking Cessation Option 3** All FDA approved products listed above are covered for a maximum of 180 days therapy per 365 days after which, the member is responsible for 100% of the prescription cost. **Smoking Cessation Option 4** All Generic FDA approved products listed above are covered for a maximum of 180 days therapy per 365 days after which, the member is responsible for a usual co-payment amount. All options include copay exception review process.