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 12/01/2024. 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 12/01/2024。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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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 12/01/2024. 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 December 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 Pharmacy[SM] 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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Table of Contents

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 December, 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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$42	$106	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$40	$100	$47	$121
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	$85
		Other Drugs	$37	$91	$47	$121
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	$85
		Other Drugs	$40	$100	$47	$121
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	$85
		Other Drugs	$37	$91	$47	$121
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	$85
		Other Drugs	$40	$100	$45	$115
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$42	$106	$47	$121	$106	$121
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	$85
		Other Drugs	$37	$91	$47	$121	$91	$121
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	$85
		Other Drugs	$42	$106	$47	$121	$106	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$0
		Other Drugs	$30	$70	$35	$85
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	$0
		Other Drugs	$35	$85	$45	$115
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	$0
		Other Drugs	$40	$100	$47	$121
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	$0
		Other Drugs	$30	$70	$35	$85
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	$0
		Other Drugs	$35	$85	$47	$121
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	$0
		Other Drugs	$30	$70	$35	$85
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	$0
		Other Drugs	$35	$85	$45	$115
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$40	$100	$47	$121
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	$85
		Other Drugs	$40	$100	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$40	$100	$47	$121
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	$0
		Other Drugs	$37	$91	$37	$91
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	$85
		Other Drugs	$42	$126	$47	$141
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$85
		Other Drugs	$35	$85	$47	$121
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	$55
		Other Drugs	$35	$85
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	$55
		Other Drugs	$35	$85
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	$55
		Other Drugs	$35	$85
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" Retail & Mail Order Pharmacies (one-, two- or three-month supply)	Members with "Extra Help" 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, 22

本處方藥一覽表更新於 12/01/2024。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 12 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 Pharmacy℠ 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。

Y0057_SCAN_20519_2024_C

目錄

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 12 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	$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 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	$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
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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	$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 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	$85
		其他藥物	$42	$106	$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 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	$85
		其他藥物	$35	$85	$47	$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		$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	$85
		其他藥物	$40	$100	$47	$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		$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	$85
		其他藥物	$37	$91	$47	$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		$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	$85
		其他藥物	$40	$100	$47	$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		$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	$85
		其他藥物	$37	$91	$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）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	$85
		其他藥物	$40	$100	$45	$115
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	$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）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	$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		$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	$85
		其他藥物	$37	$91	$47	$121	$91	$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		$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	$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 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	$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		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	$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		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	$0
		其他藥物	$30	$70	$35	$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)：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	$0
		其他藥物	$35	$85	$45	$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 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	$0
		其他藥物	$40	$100	$47	$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)：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	$0
		其他藥物	$30	$70	$35	$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	$0
		其他藥物	$35	$85	$47	$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	$0
		其他藥物	$30	$70	$35	$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	$0
		其他藥物	$35	$85	$45	$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	$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		$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	$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		$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	$85
		其他藥物	$40	$100	$47	$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 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	$85
		其他藥物	$40	$100	$47	$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 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	$85
		其他藥物	$35	$85	$47	$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 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	$85
		其他藥物	$40	$100	$47	$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 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	$0
		其他藥物	$37	$91	$37	$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	$85
		其他藥物	$42	$126	$47	$141
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	$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 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	$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 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	$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 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	$55
		其他藥物	$35	$85
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	$55
		其他藥物	$35	$85
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	$55
		其他藥物	$35	$85
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 零售和郵購藥房 （一個月、兩個月或三個月的份量）	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）
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。	對於我們計劃承保的每種胰島素產品的一個月到三個月的供應量，您支付的費用不會超過 $0。 大多數 D 部分疫苗由我們的計劃承保，您無需支付任何費用。
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）。

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 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]
hydrocodone & acetaminophen soln 7.5-325mg/15ml	2	[QL] [EDS]
hydrocodone & acetaminophen soln 10-325mg/15ml	3	[QL] [EDS]
hydrocodone & acetaminophen tabs 5-325mg, 7.5-325mg & 10-325mg	2	[QL] [EDS]
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]
tridacaine ii patch	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
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
Opioid Dependence		
buprenorphine sublingual tabs	1	[EDS]
buprenorphine & naloxone sublingual film	2	[EDS]
buprenorphine & naloxone sublingual tabs	2	[EDS]
naltrexone	1	[EDS]
Opioid Reversal Agents		
KLOXXADO	3	[EDS]
naloxone inj	2	[EDS]
Smoking Cessation Agents		
bupropion sr 150mg	2	[EDS]
NICOTROL INHALER	3	[EDS]
NICOTROL NASAL	3	[EDS]
varenicline starting month box	4	[EDS]
varenicline tartrate	4	[EDS]
ANTI-INFLAMMATORY AGENTS		
Nonsteroidal Anti-inflammatory Drugs		
celecoxib	2	[EDS]
diclofenac potassium tab 50mg	1	[EDS]
diclofenac sodium dr	1	[EDS]
diclofenac sodium er	1	[EDS]
diflunisal	2	[EDS]
etodolac	2	[EDS]
etodolac er	2	[EDS]
ibu	1	[EDS]
ibuprofen	1	[EDS]
indomethacin er	2	[EDS]
indomethacin ir caps	2	[EDS]
ketorolac oral tabs	2	[EDS]
LODINE TABS	2	[EDS]
meloxicam tabs	1	[EDS]
nabumetone	2	[EDS]
naproxen tabs 250mg, 375mg & 500mg	1	[EDS]
naproxen dr tabs	1	[EDS]
naproxen sodium ir tabs	1	[EDS]
piroxicam	2	[EDS]
sulindac	2	[EDS]
ANTIBACTERIALS		
Aminoglycosides		
amikacin inj	2	[EDS]
gentamicin cream 0.1% & oint 0.1%	2	[EDS]
gentamicin inj 40mg/ml	2	[EDS]
neomycin sulfate oral	2	[EDS]
streptomycin inj	2	[EDS]
tobramycin sulfate inj	2	[EDS]
Antibacterials, Other		
aztreonam inj	4	[EDS]
CLEOCIN VAGINAL SUPP	3	[EDS]
clindamycin oral	2	[EDS]
clindamycin phosphate inj	2	[EDS]
clindamycin phosphate/dextrose inj	2	[EDS]
clindamycin vaginal cream	2	[EDS]
colistimethate inj	2	[EDS]
daptomycin inj	5	
fosfomycin pack	4	[EDS]
linezolid inj	4	[EDS]
linezolid oral susp and tabs	4	[EDS]
methenamine hippurate	2	[EDS]
metronidazole inj	2	[EDS]
metronidazole oral	2	[EDS]
metronidazole topical	3	[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 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
metronidazole vaginal gel	2	[EDS]
nitrofurantoin caps	2	[EDS]
SIVEXTRO TABS & INJ	5	
tigecycline inj	5	
trimethoprim	2	[EDS]
vancomycin caps	4	[EDS]
vancomycin inj 500mg, 750mg, 1gm & 10gm	3	[EDS]
vancomycin oral soln 250mg/5ml	4	[EDS]
vandazole	2	[EDS]
XIFAXAN TABS 200MG	3	[PA] [EDS]
XIFAXAN TABS 550MG	5	[PA]
Beta-lactam, Cephalosporins		
cefaclor	2	[EDS]
cefaclor er	2	[EDS]
cefadroxil caps & tabs	2	[EDS]
cefazolin inj	2	[EDS]
cefdinir	2	[EDS]
cefepime inj	2	[EDS]
cefixime caps	3	[EDS]
cefixime susp	4	[EDS]
cefoxitin sodium	2	[EDS]
cefpodoxime tabs	2	[EDS]
cefprozil	2	[EDS]
ceftazidime inj	2	[EDS]
ceftriaxone inj	2	[EDS]
cefuroxime oral	2	[EDS]
cefuroxime inj	2	[EDS]
cephalexin caps & tabs 250mg & 500mg	1	[EDS]
cephalexin oral susp	1	[EDS]
tazicef inj	2	[EDS]
TEFLARO INJ	5	
ZERBAXA INJ	5	

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
Beta-lactam, Penicillins		
amoxicillin	1	[EDS]
amoxicillin-clavulanate potassium chew tabs 400-57mg	2	[EDS]
amoxicillin & clavulanate potassium er	2	[EDS]
amoxicillin & clavulanate potassium oral susp & tabs	2	[EDS]
ampicillin inj	2	[EDS]
ampicillin oral	2	[EDS]
ampicillin & sulbactam inj 10-5gm, 2-1gm & 1-0.5gm	2	[EDS]
BICILLIN L-A INJ	4	[EDS]
dicloxacillin sodium	2	[EDS]
nafcillin sodium inj	4	[EDS]
penicillin g inj 5 million units & 20 million units	2	[EDS]
penicillin v potassium	2	[EDS]
piperacillin/tazobactam inj	3	[EDS]
ZOSYN INJ	4	[EDS]
Carbapenems		
cilastatin/imipenem inj	2	[EDS]
ertapenem inj	4	[EDS]
meropenem inj	4	[EDS]
Macrolides		
azithromycin tabs & oral susp bottle	2	[EDS]
azithromycin inj	2	[EDS]
clarithromycin	2	[EDS]
clarithromycin er	2	[EDS]
DIFICID	5	

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

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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 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
DIAZEPAM RECTAL GEL	3	[EDS]
divalproex sodium dr	2	[EDS]
divalproex sodium er	2	[EDS]
gabapentin caps, ir tabs & oral soln	2	[EDS]
LIBERVANT	4	[EDS]
phenobarbital elixir & tabs	2	[EDS]
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]
vigadrone	5	[LD]
VIGAFYDE	5	
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]
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]

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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
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]
SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/Serotonin & Norepinephrine Reuptake Inhibitors)		
citalopram tabs	1	[EDS]
citalopram oral soln	2	[EDS]
DESVENLAFAXINE ER	4	[EDS]
desvenlafaxine succinate er	3	[EDS]
DRIZALMA SPRINKLE	4	[EDS]
escitalopram	2	[EDS]
FETZIMA	4	[EDS]
FETZIMA TITRATION PACK	4	[EDS]
fluoxetine hcl caps 10mg, 20mg & 40mg	2	[EDS]
fluoxetine hcl tabs 10mg & 20mg	2	[EDS]
fluoxetine hcl oral soln	2	[EDS]
fluvoxamine	2	[EDS]
fluvoxamine er	4	[EDS]
paroxetine hcl ir tabs	1	[EDS]
paroxetine hcl er	2	[EDS]
paroxetine hcl susp	4	[EDS]
sertraline tabs	1	[EDS]
sertraline oral soln	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
VENLAFAXINE BESYLATE ER TAB 112.5MG	4	[EDS]
venlafaxine ir tabs	2	[EDS]
venlafaxine hcl er tabs	3	[EDS]
venlafaxine hcl er caps	2	[EDS]
vilazodone	3	[EDS]
Tricyclics		
amitriptyline	2	[EDS]
amoxapine	2	[EDS]
clomipramine	4	[EDS]
desipramine	2	[EDS]
doxepin caps	2	[EDS]
doxepin oral soln	2	[EDS]
imipramine hcl tabs	2	[EDS]
nortriptyline	2	[EDS]
protriptyline	3	[EDS]
trimipramine maleate	2	[EDS]
ANTIEMETICS		
Antiemetics, Other		
compro	2	[EDS]
meclizine	2	[EDS]
prochlorperazine oral	2	[EDS]
prochlorperazine suppositories	2	[EDS]
promethazine suppositories	3	[EDS]
promethazine syrup	2	[EDS]
promethazine tabs	2	[EDS]
promethegan	3	[EDS]
scopolamine patch	3	[EDS]
Emetogenic Therapy Adjuncts		
aprepitant caps 80mg & 125mg	4	[PA] [EDS]
aprepitant pack	4	[PA] [EDS]
dronabinol	4	[PA] [EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
granisetron oral	2	[PA] [B vs D] [EDS]
ondansetron odt	2	[PA] [B vs D] [EDS]
ondansetron oral soln	2	[PA] [B vs D] [EDS]
ondansetron tabs 4mg & 8mg	2	[PA] [B vs D] [EDS]
ANTIFUNGALS		
Antifungals		
ABELCET INJ	4	[PA] [B vs D] [EDS]
AMBISOME 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	
caspofungin inj 70mg	4	[EDS]
clotrimazole cream 1%	2	[EDS]
clotrimazole topical soln 1%	2	[EDS]
clotrimazole troche	2	[EDS]
CRESEMBA ORAL	5	[PA]
econazole nitrate	4	[EDS]
fluconazole in sodium chloride inj	2	[EDS]
fluconazole oral	2	[EDS]
flucytosine	5	
griseofulvin microsize	2	[EDS]
itraconazole	4	[EDS]
ketoconazole cream, shampoo & tabs	2	[EDS]
nyamyc	2	[EDS]
nystatin	2	[EDS]
nystop	2	[EDS]
posaconazole dr tabs	5	[PA]
posaconazole suspension	4	[PA] [EDS]
terbinafine	2	[EDS]
terconazole	2	[EDS]
voriconazole inj	5	[PA]
voriconazole oral suspension	5	
voriconazole tabs	4	[EDS]
ANTIGOUT AGENTS		
Antigout Agents		
allopurinol tabs 100mg & 300mg	1	[EDS]
COLCHICINE CAPS	4	[EDS]
colchicine tabs	3	[EDS]
febuxostat	3	[EDS]
probenecid	2	[EDS]
probenecid & colchicine	2	[EDS]
ANTIMIGRAINE AGENTS		
Antimigraine Agents, Other		
UBRELVY	3	[PA] [EDS]
Ergot Alkaloids		
caffeine-ergotamine	3	[EDS]
dihydroergotamine mesylate nasal	5	
migergot suppository	4	[EDS]
Prophylactic		
AIMOVIG INJ	3	[PA] [EDS]
EMGALITY INJ	3	[PA] [EDS]
NURTEC ODT	3	[PA] [EDS]
QULIPTA TABS	3	[PA] [EDS]
topiramate immediate-release	2	[EDS]
Serotonin (5-HT) Receptor Agonist		
naratriptan	2	[EDS]
rizatriptan	2	[EDS]
rizatriptan odt	2	[EDS]
sumatriptan nasal	4	[EDS]
sumatriptan succinate inj	4	[EDS]
sumatriptan succinate tabs	2	[EDS]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
zolmitriptan nasal soln 5mg	4	[EDS]
zolmitriptan tabs	3	[EDS]
zolmitriptan odt	3	[EDS]
ANTIMYASTHENIC AGENTS		
Parasympathomimetics		
pyridostigmine soln	4	[EDS]
pyridostigmine tabs 60mg	3	[EDS]
pyridostigmine er tabs 180mg	4	[EDS]
ANTIMYCOBACTERIALS		
Antimycobacterials, Other		
dapsone tabs	3	[EDS]
rifabutin	4	[EDS]
Antituberculars		
ethambutol	2	[EDS]
isoniazid	2	[EDS]
PRIFTIN	4	[EDS]
pyrazinamide	2	[EDS]
rifampin oral and inj	2	[EDS]
rifampin inj	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		
abiraterone acetate	5	[PA]
bicalutamide	2	[EDS]
ERLEADA	5	[PA]
nilutamide	5	
NUBEQA	5	[PA] [LD]
XTANDI	5	[PA]
YONSA	5	[PA]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
Antiangiogenic Agents		
FOTIVDA	5	[PA] [LD]
lenalidomide	5	[PA] [LD]
POMALYST	5	[PA] [LD]
QINLOCK	5	[PA] [LD]
REVLIMID	5	[PA] [LD]
TABRECTA	5	[PA]
THALOMID	5	[PA]
Antiestrogens/Modifiers		
SOLTAMOX	3	[EDS]
tamoxifen	2	[EDS]
toremifene citrate	5	
Antimetabolites		
hydroxyurea	2	[EDS]
mercaptopurine	2	[EDS]
PURIXAN	5	
TABLOID	4	[EDS]
Antineoplastics, Other		
AKEEGA	5	[PA] [LD]
BESREMI INJ	5	[PA] [LD]
GAVRETO	5	[PA] [LD]
IDHIFA	5	[PA] [LD]
INREBIC	5	[PA] [LD]
IWILFIN	5	[PA] [LD]
KRAZATI	5	[PA]
LAZCLUZE	5	[PA] [LD]
LONSURF	5	[PA]
LUMAKRAS	5	[PA]
LYTGOBI TABS	5	[PA] [LD]
NINLARO	5	[PA]
OGSIVEO	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]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
Aromatase Inhibitors, 3rd Generation		
anastrozole	2	[EDS]
exemestane	3	[EDS]
letrozole	2	[EDS]
Enzyme Inhibitors		
BALVERSA	5	[PA]
ZOLINZA	5	[PA]
Molecular Target Inhibitors		
AUGTYRO	5	[PA]
ALECENSA	5	[PA]
ALUNBRIG	5	[PA]
ALUNBRIG INITIATION PACK	5	[PA]
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]
COMETRIQ	5	[PA]
COPIKTRA	5	[PA] [LD]
COTELLIC	5	[PA]
dasatinib	5	[PA]
DAURISMO	5	[PA]
ERIVEDGE	5	[PA]
erlotinib	5	[PA]
everolimus tabs 2.5mg, 5mg, 7.5mg & 10mg	5	[PA]
everolimus tabs for suspension 2mg, 3mg & 5mg	5	[PA]
FRUZAQLA	5	[PA]
gefitinib	5	[PA]
GILOTRIF	5	[PA]
IBRANCE	5	[PA]
ICLUSIG	5	[PA]
imatinib	5	[PA]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
IMBRUVICA	5	[PA]
INLYTA	5	[PA]
INQOVI	5	[PA]
IRESSA	5	[PA]
JAKAFI	5	[PA]
JAYPIRCA TABS	5	[PA]
KISQALI	5	[PA]
KISQALI FEMARA CO-PACK	5	[PA]
lapatinib	5	[PA]
LENVIMA	5	[PA]
LORBRENA	5	[PA]
LYNPARZA	5	[PA]
MEKINIST	5	[PA]
MEKTOVI	5	[PA] [LD]
NERLYNX	5	[PA] [LD]
ODOMZO	5	[PA]
OJEMDA	5	[PA]
OJJAARA	5	[PA]
pazopanib	5	[PA]
PIQRAY	5	[PA]
REZLIDHIA CAPS	5	[PA]
RUBRACA	5	[PA] [LD]
RYDAPT	5	[PA]
SCEMBLIX	5	[PA]
sorafenib	5	[PA]
SPRYCEL	5	[PA]
STIVARGA	5	[PA]
sunitinib malate	5	[PA]
TAFINLAR	5	[PA]
TAGRISSO	5	[PA]
TALZENNA	5	[PA]
TASIGNA	5	[PA]
TEPMETKO	5	[PA] [LD]
TIBSOVO	5	[PA]
torpenz	5	[PA]
TRUQAP	5	[PA]
TURALIO	5	[PA] [LD]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
VENCLEXTA TABS 10MG & 50MG	3	[PA] [EDS]
VENCLEXTA TABS 100MG	5	[PA]
VENCLEXTA STARTING PACK	5	[PA]
VERZENIO	5	[PA] [LD]
VITRAKVI	5	[PA] [LD]
VIZIMPRO	5	[PA]
VORANIGO	5	[PA]
VOTRIENT	5	[PA]
WELIREG	5	[PA] [LD]
XALKORI	5	[PA]
XOSPATA	5	[PA] [LD]
VANFLYTA	5	[PA]
ZEJULA TABS	5	[PA] [LD]
ZELBORAF	5	[PA]
ZYDELIG	5	[PA]
ZYKADIA TABS	5	[PA]
Retinoids		
bexarotene	5	[PA]
PANRETIN	5	
tretinoin caps	5	
Treatment Adjuncts		
leucovorin oral	2	[EDS]
MESNEX TABS	4	[EDS]
ANTIPARASITICS		
Anthelmintics		
albendazole	4	[EDS]
ivermectin tabs	2	[EDS]
Antiprotozoals		
atovaquone susp	4	[EDS]
atovaquone/proguanil	2	[EDS]
chloroquine	2	[EDS]
COARTEM	3	[EDS]
hydroxychloroquine tab 200mg	2	[EDS]
mefloquine	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
NEBUPENT NEBULIZER	4	[PA] [B vs D] [EDS]
nitazoxanide	5	
pentamidine inhalation soln	3	[PA] [B vs D] [EDS]
pentamidine inj	4	[EDS]
PRIMAQUINE	3	[EDS]
pyrimethamine	5	[PA]
quinine sulfate caps	3	[PA] [EDS]
ANTIPARKINSON AGENTS		
Anticholinergics		
benztropine tabs	2	[EDS]
trihexyphenidyl elixir & tabs	2	[EDS]
Antiparkinson Agents, Other		
amantadine	2	[EDS]
carbidopa & levodopa & entacapone	4	[EDS]
entacapone	4	[EDS]
Dopamine Agonists		
apomorphine hydrochloride inj	5	[PA]
bromocriptine	2	[EDS]
NEUPRO PATCH	4	[EDS]
pramipexole ir	2	[EDS]
ropinirole ir	2	[EDS]
Dopamine Precursors and/or L-Amino Acid Decarboxylase Inhibitors		
carbidopa	4	[EDS]
carbidopa & levodopa ir, er, odt	2	[EDS]
Monoamine Oxidase B (MAO-B) Inhibitors		
rasagiline	4	[EDS]
selegiline	2	[EDS]
ANTIPSYCHOTICS		
1st Generation/Typical		
chlorpromazine oral	4	[EDS]
fluphenazine oral	2	[EDS]
fluphenazine decanoate inj	2	[EDS]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
fluphenazine inj	2	[EDS]
haloperidol oral	2	[EDS]
haloperidol decanoate inj	2	[EDS]
haloperidol lactate inj	2	[EDS]
loxapine	2	[EDS]
molindone	2	[EDS]
perphenazine	2	[EDS]
pimozide	2	[EDS]
thioridazine	2	[EDS]
thiothixene	2	[EDS]
trifluoperazine	2	[EDS]
2nd Generation/Atypical		
ABILIFY ASIMTUFII INJ	5	
ABILIFY MAINTENA INJ	5	
aripiprazole odt	5	
aripiprazole soln	3	[EDS]
aripiprazole tabs	3	[EDS]
ARISTADA INJ	5	
ARISTADA INITIO INJ	4	[EDS]
asenapine maleate sublinqual	4	[EDS]
CAPLYTA	5	
FANAPT	4	[EDS]
FANAPT TITRATION PACK	4	[EDS]
INVEGA HAFYERA INJ	5	
INVEGA SUSTENNA INJ 39MG	4	[EDS]
INVEGA SUSTENNA INJ 78MG, 117MG, 156MG & 234MG	5	
INVEGA TRINZA INJ	5	
lurasidone hcl tabs	5	
LYBALVI	5	[PA]
NUPLAZID	5	[PA]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
olanzapine inj, tabs & odt tabs	2	[EDS]
paliperidone er tabs	4	[EDS]
PERSERIS INJ	5	
quetiapine fumarate 25mg, 50mg, 100mg, 200mg, 300mg & 400mg tabs	2	[EDS]
QUETIAPINE FUMARATE 150MG TABS	3	[EDS]
quetiapine er tabs	3	[EDS]
REXULTI	5	
RISPERDAL CONSTA INJ 12.5MG & 25MG	4	[EDS]
RISPERDAL CONSTA INJ 37.5MG & 50MG	5	
risperidone	2	[EDS]
risperidone er inj 12.5mg & 25mg	4	[EDS]
risperidone er inj 37.5mg & 50mg	5	
risperidone odt	2	[EDS]
SECUADO	5	[PA]
SEROQUEL XR	4	[EDS]
UZEDY INJ	5	
VRAYLAR CAPSULES	5	
ziprasidone inj	3	[EDS]
ziprasidone oral	2	[EDS]
ZYPREXA RELPREVV INJ 210MG	4	[EDS]
Treatment-Resistant		
clozapine	2	[EDS]
clozapine odt	4	[EDS]
VERSACLOZ	5	

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
ANTISPASTICITY AGENTS		
Antispasticity Agents		
baclofen tabs	2	[EDS]
tizanidine caps	3	[EDS]
tizanidine tabs	2	[EDS]
ANTIVIRALS		
Anti-cytomegalovirus (CMV) Agents		
PREVYMIS	5	[PA]
valganciclovir	3	[EDS]
Anti-hepatitis B (HBV) Agents		
adefovir dipivoxil	4	[EDS]
BARACLUDE ORAL SOLN 0.05MG/ML	4	[EDS]
entecavir tabs	4	[EDS]
lamivudine tabs 100mg	3	[EDS]
VEMLIDY	5	
Anti-hepatitis C (HCV) Agents		
EPCLUSA	5	[PA]
HARVONI	5	[PA]
LEDIPASVIR/ SOFOSBUVIR	5	[PA]
ribavirin	3	[EDS]
SOFOSBUVIR/ VELPATASVIR	5	[PA]
VOSEVI	5	[PA]
Antiherpetic Agents		
acyclovir caps & tabs	2	[EDS]
acyclovir inj	2	[PA] [B vs D] [EDS]
acyclovir oral susp	4	[EDS]
famciclovir	2	[EDS]
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 & emtricitabine & tenofovir disoproxil fumarate tabs	5	
efavirenz & lamivudine & tenofovir disoproxil fumarate tabs	5	
efavirenz tabs	4	[EDS]
etravirine tabs 100mg	4	[EDS]
etravirine tabs 200mg	5	
INTELENCE TAB 25MG	4	[EDS]
nevirapine er	2	[EDS]
nevirapine susp & tabs	2	[EDS]
ODEFSEY	5	
PIFELTRO	5	
Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)		
abacavir soln & tabs	4	[EDS]
abacavir & lamivudine	4	[EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
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	
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]
SELZENTRY 25MG & 75MG	3	[EDS]
SUNLENCA	5	
TYBOST	3	[EDS]
Anti-HIV Agents, Protease Inhibitors (PI)		
APTIVUS CAPS	5	
atazanavir sulfate caps	4	[EDS]
darunavir tab 600mg	4	[EDS]
darunavir tab 800mg	5	
EVOTAZ	5	
fosamprenavir tabs	5	
lopinavir & ritonavir	4	[EDS]
NORVIR POWDER	3	[EDS]
PREZCOBIX	5	
PREZISTA SUSP 100MG/ML	4	[EDS]
PREZISTA TABS 75MG & 150MG	4	[EDS]
PREZISTA TABS 600MG & 800MG	5	
REYATAZ ORAL POWDER	5	
ritonavir tabs	3	[EDS]
SYMTUZA	5	
VIRACEPT	5	
Anti-influenza Agents		
oseltamivir caps	2	[EDS]
oseltamivir susp	3	[EDS]
RELENZA DISKHALER	3	[EDS]
rimantadine	2	[EDS]
XOFLUZA	4	[EDS]
ANXIOLYTICS		
Anxiolytics, Other		
buspirone	2	[EDS]
meprobamate	4	[EDS]
Benzodiazepines		
alprazolam ir tabs	2	[EDS]
alprazolam er tabs	2	[EDS]
alprazolam soln	2	[EDS]
clorazepate	2	[EDS]
diazepam soln & tabs	2	[EDS]
lorazepam soln & tabs	2	[EDS]
oxazepam	3	[EDS]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
BIPOLAR AGENTS		
Mood Stabilizers		
lamotrigine odt	4	[EDS]
lamotrigine odt kit	4	[EDS]
lamotrigine chewable tabs	2	[EDS]
lamotrigine immediate-release tabs	2	[EDS]
lamotrigine starter kit	4	[EDS]
lamotrigine titration kit	4	[EDS]
lithium carbonate	2	[EDS]
lithium carbonate er	2	[EDS]
lithium citrate oral soln	2	[EDS]
subvenite starter kit	4	[EDS]
subvenite tabs	2	[EDS]
BLOOD GLUCOSE REGULATORS		
Antidiabetic Agents		
acarbose	2	[EDS]
BYDUREON BCISE INJ	3	[EDS]
BYETTA INJ	3	[EDS]
CYCLOSET	3	[EDS]
FARXIGA	6	[EDS]
glimepiride	1	[EDS]
glimepiride & pioglitazone	2	[EDS]
glipizide er	1	[EDS]
glipizide tabs 5mg & 10mg	1	[EDS]
glipizide & metformin tabs	1	[EDS]
GLYXAMBI	6	[EDS]
JANUMET	6	[EDS]
JANUMET XR	6	[EDS]
JANUVIA	6	[EDS]
JARDIANCE	6	[EDS]
JENTADUETO	6	[EDS]
JENTADUETO XR	6	[EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
metformin tabs	1	[EDS]
metformin er uncoated tabs 500mg & 750mg	1	[EDS]
MOUNJARO INJ	3	[EDS]
nateglinide	2	[EDS]
OZEMPIC INJ	3	[EDS]
pioglitazone	1	[EDS]
pioglitazone & metformin	2	[EDS]
repaglinide	2	[EDS]
RYBELSUS	3	[EDS]
SYMLINPEN INJ	5	
SYNJARDY	6	[EDS]
SYNJARDY XR	6	[EDS]
TRADJENTA	6	[EDS]
TRIJARDY XR	6	[EDS]
TRULICITY INJ	3	[EDS]
VICTOZA INJ	3	[EDS]
XIGDUO XR	6	[EDS]
Glycemic Agents		
BAQSIMI	3	[EDS]
diazoxide	4	[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]
HUMALOG MIX 50/50 KWIKPEN INJ	3	[EDS]
HUMALOG MIX 75/25 KWIKPEN INJ	3	[EDS]
HUMALOG MIX 75/25 VIAL INJ	3	[EDS]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
HUMALOG VIAL INJ	3	[EDS]
HUMULIN 70/30 KWIKPEN INJ	3	[EDS]
HUMULIN 70/30 VIAL INJ	3	[EDS]
HUMULIN N KWIKPEN INJ	3	[EDS]
HUMULIN N VIAL INJ	3	[EDS]
HUMULIN R U-500 (CONCENTRATED) KWIKPEN INJ	3	[EDS]
HUMULIN R U-500 (CONCENTRATED) VIAL INJ	3	[EDS]
HUMULIN R VIAL INJ	3	[EDS]
INSULIN LISPRO VIAL INJ	3	[EDS]
LANTUS SOLOSTAR PEN INJ	3	[EDS]
LANTUS VIAL INJ	3	[EDS]
LEVEMIR VIAL INJ	3	[EDS]
LEVEMIR FLEXPEN INJ	3	[EDS]
LYUMJEV VIAL INJ	3	[EDS]
LYUMJEV KWIKPEN INJ	3	[EDS]
SOLIQUA INJ	3	[EDS]
TOUJEO SOLOSTAR INJ	3	[EDS]
TOUJEO MAX SOLOSTAR INJ	3	[EDS]
TRESIBA VIAL INJ	3	[EDS]
TRESIBA FLEXTOUCH INJ	3	[EDS]
BLOOD PRODUCTS AND MODIFIERS		
Anticoagulants		
dabigatran etexilate	4	[EDS]
ELIQUIS STARTER PACK & TABS	6	[EDS]
enoxaparin inj syringe	4	[EDS]
fondaparinux inj 2.5mg/0.5ml & 5mg/0.4ml	4	[EDS]
fondaparinux inj 7.5mg/0.6ml & 10mg/0.8ml	5	
heparin inj vials 1000u/ml, 5000u/ml, 10000u/ml & 20000u/ml	2	[PA] [B vs D] [EDS]
jantoven	1	[EDS]
warfarin	1	[EDS]
XARELTO ORAL SUSP TABS & STARTER PACK	6	[EDS]
XARELTO STARTER PACK	6	[EDS]
Blood Products and Modifiers, Other		
anagrelide	2	[EDS]
LEUKINE INJ	5	[PA]
NIVESTYM INJ	5	[PA]
PROCRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML & 10000UNIT/ML	3	[PA] [EDS]
PROCRIT INJ 20000UNIT/ML & 40000UNIT/ML	5	[PA]
PROMACTA	5	[PA] [LD]
RETACRIT INJ 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML,10000 UNIT/ML, 20000UNIT/2ML & 20000UNIT/ML	3	[PA] [EDS]
RETACRIT INJ 40000UNIT/ML	5	[PA]
UDENYCA INJ	5	[PA]
ZARXIO INJ	5	[PA]

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藥物名稱	藥物等級	要求/限制
Hemostasis Agents		
tranexamic acid tabs	3	[EDS]
Platelet Modifying Agents		
BRILINTA	3	[EDS]
cilostazol	2	[EDS]
clopidogrel tabs 75mg	1	[EDS]
dipyridamole er & aspirin	4	[EDS]
dipyridamole oral	2	[EDS]
prasugrel	2	[EDS]
CARDIOVASCULAR AGENTS		
Alpha-adrenergic Agonists		
clonidine patches	4	[EDS]
clonidine tabs immediate-release	1	[EDS]
droxidopa	5	[PA]
guanfacine ir	2	[EDS]
midodrine tabs	3	[EDS]
Alpha-adrenergic Blocking Agents		
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]
perindopril	1	[EDS]
quinapril	1	[EDS]
ramipril	1	[EDS]
trandolapril	1	[EDS]
Angiotensin II Receptor Antagonists		
candesartan	2	[EDS]
irbesartan	1	[EDS]
losartan	1	[EDS]
olmesartan	2	[EDS]
telmisartan	2	[EDS]
valsartan tabs	1	[EDS]
Antiarrhythmics		
amiodarone tabs	2	[EDS]
disopyramide phosphate	4	[EDS]
dofetilide	4	[EDS]
flecainide acetate	2	[EDS]
mexiletine	2	[EDS]
MULTAQ	3	[EDS]
pacerone tabs	2	[EDS]
propafenone tabs	2	[EDS]
quinidine gluconate cr	4	[EDS]
quinidine sulfate	2	[EDS]
sorine	2	[EDS]
sotalol tabs	2	[EDS]
Beta-adrenergic Blocking Agents		
acebutolol	2	[EDS]
atenolol	1	[EDS]
bisoprolol	2	[EDS]
carvedilol	1	[EDS]
carvedilol phosphate er	4	[EDS]
labetalol oral	2	[EDS]
metoprolol succinate er	2	[EDS]
metoprolol tartrate tabs 25mg, 50mg & 100mg	1	[EDS]
nadolol	2	[EDS]
nebivolol hcl	2	[EDS]
pindolol	2	[EDS]
propranolol ir tabs	1	[EDS]
propranolol er caps	2	[EDS]
propranolol oral soln	2	[EDS]
timolol oral	1	[EDS]
Calcium Channel Blocking Agents, Dihydropyridines		
amlodipine	1	[EDS]
felodipine er	2	[EDS]

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

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
enalapril & hydrochlorothiazide	1	[EDS]
ENTRESTO TABS	6	[EDS]
fosinopril & hydrochlorothiazide	1	[EDS]
irbesartan hct	1	[EDS]
ivabradine	4	[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]
Diuretics, Loop		
bumetanide inj	2	[EDS]
bumetanide tabs	2	[EDS]
furosemide oral	1	[EDS]
furosemide inj	2	[EDS]
torsemide	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
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]
icosapent ethyl	4	[EDS]
JUXTAPID	5	[PA] [LD]
niacin er tabs	3	[EDS]
omega-3-acid ethyl esters	2	[EDS]
prevalite	2	[EDS]
REPATHA INJ	3	[EDS]
VASCEPA CAPS	4	[EDS]
Vasodilators, Direct-acting Arterial		
hydralazine oral	2	[EDS]
minoxidil	2	[EDS]
Vasodilators, Direct-acting Arterial/Venous		
isosorbide dinitrate tabs 5mg, 10mg, 20mg & 30mg	2	[EDS]
isosorbide mononitrate	2	[EDS]
isosorbide mononitrate er	2	[EDS]
nitro-bid oint	2	[EDS]
NITRO-DUR PATCHES 0.3MG/HR & 0.8MG/HR	3	[EDS]
nitroglycerin lingual	2	[EDS]
nitroglycerin patches	2	[EDS]
nitroglycerin sublingual	2	[EDS]
CENTRAL NERVOUS SYSTEM AGENTS		
Attention Deficit Hyperactivity Disorder Agents, Amphetamines		
amphetamine & dextroamphetamine tabs	2	[QL] [EDS]
dextroamphetamine sulfate tabs 5mg & 10mg	3	[QL] [EDS]
dextroamphetamine sulfate er	4	[QL] [EDS]
zenzedi tabs 5mg & 10mg	3	[QL] [EDS]
Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines		
atomoxetine	3	[EDS]
clonidine er 0.1mg	2	[EDS]
dexmethylphenidate ir tabs	2	[EDS]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
methylphenidate er tabs 10mg & 20mg	3	[EDS]
methylphenidate ir tabs 5mg, 10mg & 20mg	2	[EDS]
Central Nervous System, Other		
AUSTEDO	5	[PA] [LD]
AUSTEDO XR 6MG, 12MG & 24MG	5	[PA] [LD]
AUSTEDO XR 18MG, 30MG, 36MG, 42MG & 48MG	5	[PA]
AUSTEDO XR PATIENT TITRATION KIT	5	[PA]
NUEDEXTA	5	[PA]
riluzole	3	[EDS]
tetrabenazine	5	[PA]
Fibromyalgia Agents		
duloxetine hcl	2	[EDS]
SAVELLA	3	[EDS]
SAVELLA TITRATION PACK	3	[EDS]
Multiple Sclerosis Agents		
AVONEX INJ	5	[PA]
AVONEX PEN INJ	5	[PA]
BETASERON INJ	5	[PA]
COPAXONE INJ 40MG/ML	5	[PA]
dalfampridine er	3	[PA] [EDS]
dimethyl fumarate caps	5	[PA]
dimethyl fumarate starter pack	5	[PA]
fingolimod	5	[PA]
glatiramer acetate inj	5	[PA]
glatopa inj	5	[PA]
PLEGRIDY INJ	5	[PA]
REBIF INJ	5	[PA]
REBIF REBIDOSE INJ	5	[PA]
REBIF REBIDOSE TITRATION PACK INJ	5	[PA]
REBIF TITRATION PACK INJ	5	[PA]
teriflunomide tabs	5	[PA]
VUMERITY	5	[PA]
DENTAL AND ORAL AGENTS		
Dental and Oral Agents		
cevimeline	3	[EDS]
chlorhexidine gluconate	2	[EDS]
kourzeq	2	[EDS]
lidocaine viscous soln	2	[EDS]
periogard	2	[EDS]
pilocarpine tabs	3	[EDS]
triamcinolone dental paste	2	[EDS]
DERMATOLOGICAL AGENTS		
Acne and Rosacea Agents		
acitretin	4	[PA] [EDS]
accutane	4	[EDS]
adapalene cream 0.1%	4	[EDS]
adapalene gel 0.3%	4	[EDS]
ALTRENO	3	[PA] [EDS]
amnesteem caps	4	[EDS]
claravis	4	[EDS]
clindamycin & benzoyl peroxide gel 5%-1% & 5%-1.2%	3	[EDS]
isotretinoin caps 10mg, 20mg, 30mg & 40mg	4	[EDS]
tazarotene cream	4	[EDS]
tazarotene gel	4	[QL] [EDS]
TAZORAC CREAM 0.05%	4	[EDS]
tretinoin cream	3	[PA] [EDS]
tretinoin gel 0.01%, 0.025% & 0.05%	3	[PA] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
zenatane	4	[EDS]
Dermatitis and Pruritus Agents		
alclometasone dipropionate	2	[EDS]
ammonium lactate	2	[EDS]
betamethasone dipropionate	2	[EDS]
betamethasone dipropionate augmented	2	[EDS]
betamethasone valerate cream, oint & lotion	2	[EDS]
clobetasol propionate cream, foam, gel, oint & soln	4	[EDS]
clobetasol propionate emollient	4	[EDS]
desonide lotion, oint & cream	3	[QL] [EDS]
desoximetasone topical cream, gel & oint 0.05%	4	[QL] [EDS]
desoximetasone topical cream & oint 0.25%	3	[QL] [EDS]
diflorasone diacetate	4	[QL] [EDS]
fluocinolone acetonide cream, oint, soln	3	[EDS]
fluocinolone acetonide scalp oil	3	[EDS]
fluocinonide cream 0.05%, gel & oint	2	[QL] [EDS]
fluocinonide emulsified base cream	2	[QL] [EDS]
fluocinonide soln	2	[EDS]
fluticasone propionate cream & oint	2	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
halobetasol propionate cream & ointment	2	[EDS]
hydrocortisone cream, lotion & oint 2.5%	2	[EDS]
hydrocortisone butyrate cream, oint & soln	2	[EDS]
hydrocortisone valerate	2	[EDS]
mometasone cream, oint & soln	2	[EDS]
pimecrolimus	4	[QL] [EDS]
selenium sulfide lotion	2	[EDS]
tacrolimus oint	4	[QL] [EDS]
triamcinolone acetonide topical cream & lotion	2	[EDS]
triamcinolone acetonide topical oint 0.025%, 0.1% & 0.5%	2	[EDS]
triderm cream 0.1%	2	[EDS]
Dermatological Agents, Other		
calcipotriene cream & oint	4	[QL] [EDS]
calcipotriene soln	3	[EDS]
clotrimazole & betamethasone	2	[EDS]
diclofenac sodium gel 3%	4	[PA] [EDS]
fluorouracil topical 2% and 5%	3	[EDS]
imiquimod cream 3.75%	4	[EDS]
imiquimod cream 5%	3	[EDS]
methoxsalen	5	
nystatin & triamcinolone	3	[EDS]
podofilox soln	2	[EDS]
silver sulfadiazine	2	[EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
REGRANEX	5	[QL]
SANTYL	3	[QL] [EDS]
ssd	2	[EDS]
Pediculicides/Scabicides		
malathion	4	[EDS]
permethrin cream	2	[EDS]
Topical Anti-infectives		
acyclovir cream & oint 5%	4	[QL] [EDS]
ciclopirox cream, gel, nail soln shampoo & susp	2	[EDS]
clindamycin topical gel, lotion, soln & swab	2	[EDS]
erythromycin topical gel & soln	2	[EDS]
mupirocin ointment	2	[EDS]
mupirocin cream	4	[QL] [EDS]
penciclovir cream	4	[EDS]
ELECTROLYTES/MINERALS/METALS/ VITAMINS		
Electrolyte/Mineral/Metal Modifiers		
deferasirox granule pack	5	[PA]
deferasirox tabs 90mg	4	[PA] [EDS]
deferasirox tabs 180mg & 360mg	5	[PA]
deferasirox tabs for soln 125mg	4	[PA] [EDS]
deferasirox tabs for soln 250mg & 500mg	5	[PA]
deferiprone	5	[PA]
FERRIPROX SOLN	5	[PA]
FERRIPROX TAB 1000MG	5	[PA]
INTRALIPID INJ	4	[PA] [B vs D] [EDS]
penicillamine tabs	5	
trientine cap 250mg	5	

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
Electrolyte/Mineral Replacement		
carglumic acid	5	[PA]
CLINISOL SF INJ	4	[PA] [B vs D] [EDS]
dextrose inj	2	[EDS]
dextrose (10%, 5% or 2.5%) & sodium chloride inj	2	[EDS]
klor-con pack	4	[EDS]
klor-con tabs	2	[EDS]
magnesium sulfate inj	2	[EDS]
plenamine inj	2	[PA] [B vs D] [EDS]
potassium chloride oral soln	4	[EDS]
potassium chloride inj	2	[EDS]
potassium chloride pack 20meq	4	[EDS]
potassium chloride er & cr	2	[EDS]
potassium chloride & dextrose 20mEq/5% inj	2	[EDS]
potassium chloride & dextrose & lactated ringers inj	2	[EDS]
potassium chloride & dextrose & sodium chloride inj 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%	2	[EDS]
potassium citrate er	2	[EDS]
PROSOL INJ	4	[PA] [B vs D] [EDS]
sodium chloride inj	2	[EDS]

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Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
TPN ELECTROLYTES INJ	3	[EDS]
TRAVASOL INJ	4	[PA] [B vs D] [EDS]
Phosphate Binders		
AURYXIA	5	[PA]
calcium acetate	2	[EDS]
lanthanum carbonate	5	
sevelamer carbonate powder	4	[EDS]
sevelamer carbonate tabs	4	[EDS]
VELPHORO	5	[PA]
Potassium Binders		
kionex susp	2	[EDS]
LOKELMA	3	[EDS]
sodium polystyrene sulfonate powder	2	[EDS]
sps suspension	2	[EDS]
VELTASSA	3	[EDS]
Vitamins		
prenatal multi-vitamin	2	[EDS]
GASTROINTESTINAL AGENTS		
Anti-Constipation Agents		
constulose soln	2	[EDS]
enulose	2	[EDS]
generlac	2	[EDS]
lactulose soln 10g/15ml	2	[EDS]
LINZESS	3	[EDS]
lubiprostone	3	[EDS]
MOVANTIK	3	[EDS]
RELISTOR INJ	5	[PA]
RELISTOR TABS	5	[PA]
sodium sulfate, potassium sulfate and magnesium sulfate	3	[EDS]
Anti-Diarrheal Agents		
alosetron hcl tab 0.5mg	4	[PA] [EDS]
alosetron hcl tab 1mg	5	[PA]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
diphenoxylate & atropine oral soln	3	[EDS]
diphenoxylate & atropine tabs	2	[EDS]
loperamide caps 2mg	2	[EDS]
XERMELO	5	[PA]
Antispasmodics, Gastrointestinal		
dicyclomine	2	[EDS]
glycopyrrolate tabs 1mg & 2mg	2	[EDS]
Gastrointestinal Agents, Other		
cromolyn sodium oral	4	[EDS]
GATTEX INJ	5	[PA]
gavilyte-c	2	[EDS]
gavilyte-g	2	[EDS]
gavilyte-n	2	[EDS]
metoclopramide oral tablets & soln	2	[EDS]
nitroglycerin rectal oint	4	[EDS]
peg 3350 & electrolytes	2	[EDS]
peg 3350 & sodium chloride & sodium bicarbonate & potassium chloride	2	[EDS]
peg 3350 & sodium sulfate & sodium chloride & potassium chloride & sodium ascorbate & ascorbic	3	[EDS]
PLENVU	3	[EDS]
RECTIV	4	[EDS]
ursodiol cap 300mg & tabs 250mg & 500mg	3	[EDS]
Histamine2 (H2) Receptor Antagonists		
cimetidine tabs	2	[EDS]
famotidine tabs	1	[EDS]
Protectants		
misoprostol	2	[EDS]
sucralfate tabs	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
Proton Pump Inhibitors		
esomeprazole magnesium dr caps	3	[EDS]
lansoprazole dr caps	2	[EDS]
omeprazole caps	1	[EDS]
pantoprazole tabs	1	[EDS]
rabeprazole sodium	3	[EDS]
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment		
betaine anhydrous	5	
CERDELGA	5	[PA]
CREON DR	3	[EDS]
CYSTAGON	3	[EDS]
miglustat	5	[PA] [LD]
nitisinone	5	[PA]
ORFADIN CAPS 20MG	5	[PA] [LD]
ORFADIN SUSP	5	[PA] [LD]
RAVICTI	5	
sapropterin	5	
sodium phenylbutyrate powder & tabs	5	
SUCRAID	5	
yargesa caps	5	[PA] [LD]
GENITOURINARY AGENTS		
Antispasmodics, Urinary		
fesoterodine fumarate er	3	[EDS]
flavoxate	2	[EDS]
GEMTESA	4	[EDS]
MYRBETRIQ	3	[EDS]
oxybutynin ir	2	[EDS]
oxybutynin er	2	[EDS]
OXYTROL	4	[EDS]
solifenacin succinate	3	[EDS]
tolterodine tartrate er	2	[EDS]
trospium ir	2	[EDS]
trospium er	2	[EDS]
Benign Prostatic Hypertrophy Agents		
alfuzosin hcl er	2	[EDS]
dutasteride	3	[EDS]
dutasteride & tamsulosin	3	[EDS]
finasteride tabs 5mg	1	[EDS]
tamsulosin	1	[EDS]
Genitourinary Agents, Other		
bethanechol	2	[EDS]
ELMIRON	4	[EDS]
THIOLA EC	5	
tiopronin	5	
tiopronin dr	5	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)		
dexamethasone dose pack	2	[EDS]
dexamethasone elixir	2	[EDS]
dexamethasone tabs	2	[EDS]
fludrocortisone acetate	2	[EDS]
HEMADY	4	[EDS]
hydrocortisone oral	2	[EDS]
MEDROL TABS	4	[PA] [B vs D] [EDS]
methylprednisolone dose pack	2	[EDS]
methylprednisolone oral	2	[PA] [B vs D] [EDS]
ORAPRED ODT	4	[PA] [B vs D] [EDS]
prednisolone oral soln	2	[PA] [B vs D] [EDS]
prednisolone odt	4	[PA] [B vs D] [EDS]
prednisolone tablet 5mg	4	[PA] [B vs D] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
prednisone tab pack	1	[EDS]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Pituitary)		
desmopressin acetate nasal	4	[EDS]
desmopressin acetate oral	2	[EDS]
GENOTROPIN INJ	5	[PA]
GENOTROPIN MINIQUICK INJ 0.2MG, 0.4MG, 0.6MG & 0.8MG	4	[PA] [EDS]
GENOTROPIN MINIQUICK INJ 1MG, 1.2MG, 1.4MG, 1.6MG, 1.8MG & 2MG	5	[PA]
HUMATROPE INJ CARTRIDGE 6MG	4	[PA] [EDS]
HUMATROPE INJ CARTRIDGE 12MG & 24MG	5	[PA]
INCRELEX INJ	5	[PA]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
Androgens		
danazol	3	[EDS]
testosterone cypionate inj	2	[EDS]
testosterone enanthate inj	2	[EDS]
testosterone gel 1% & 1.62%	3	[EDS]
testosterone gel 25mg/2.5g, 20.25mg/1.25g, 40.5mg/2.5g & 50mg/5g	3	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
Estrogens		
altavera	2	[EDS]
alyacen 1/35	2	[EDS]
amabelz	2	[EDS]
apri	2	[EDS]
aranelle	2	[EDS]
aubra eq	2	[EDS]
aviane	2	[EDS]
azurette	2	[EDS]
blisovi fe 1.5/30	2	[EDS]
briellyn	2	[EDS]
cyred eq	2	[EDS]
desogestrel & ethinyl estradiol	2	[EDS]
dotti	2	[EDS]
drospirenone & ethinyl estradiol 3mg/0.02mg	2	[EDS]
eluryng	4	[EDS]
enilloring	4	[EDS]
enpresse-28	2	[EDS]
enskyce	2	[EDS]
estarylla	2	[EDS]
estradiol oral	2	[EDS]
estradiol patches	2	[EDS]
estradiol vaginal cream	2	[EDS]
estradiol vaginal tabs	2	[EDS]
estradiol & norethindrone acetate 0.5mg/0.1mg & 1mg/0.5mg	2	[EDS]
ESTRING	3	[EDS]
ethinyl estradiol & ethynodiol	2	[EDS]
ethinyl estradiol & norethindrone acetate 5mcg/1mg & 2.5mcg-0.5mg	2	[EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
etonogestrel & ethinyl estradiol ring	4	[EDS]
falmina	2	[EDS]
fyavolv	2	[EDS]
haloette	4	[EDS]
IMVEXXY PACK	3	[EDS]
introvale	2	[EDS]
isibloom	2	[EDS]
jasmiel	2	[EDS]
jinteli	2	[EDS]
juleber	2	[EDS]
junel 21 day	2	[EDS]
junel fe 1/20	2	[EDS]
kariva	2	[EDS]
kelnor 1/35 & 1/50	2	[EDS]
kurvelo	2	[EDS]
larin	2	[EDS]
larin fe	2	[EDS]
leena	2	[EDS]
levonest	2	[EDS]
levonorgestrel & ethinyl estradiol 0.1-0.02mg & 0.15-0.03mg & triphasic packs	2	[EDS]
levonorgestrel & ethinyl estradiol and ethinyl estradiol 0.1/0.02mg-0.01mg packs	2	[EDS]
levora	2	[EDS]
loryna	2	[EDS]
low-ogestrel	2	[EDS]
lyllana	2	[EDS]
marlissa 28 day	2	[EDS]
MENEST	3	[EDS]
microgestin 1/20 & 1.5/30	2	[EDS]
microgestin 24 fe	2	[EDS]
microgestin fe 1/20 & 1.5/30	2	[EDS]
mili	2	[EDS]
mimvey	2	[EDS]
necon	2	[EDS]
nikki	2	[EDS]
norgestimate-ethinyl estradiol	2	[EDS]
norethindrone, ethinyl estradiol, ferrous fumarate 0.4mg/0.035mg	2	[EDS]
norethindrone, ethinyl estradiol, ferrous fumarate 20mcg/75mg/1mg	2	[EDS]
nylia 7/7/7 & 1/35	2	[EDS]
nymyo	2	[EDS]
pimtrea	2	[EDS]
PREMARIN ORAL	3	[EDS]
PREMARIN VAGINAL CREAM	3	[EDS]
PREMPHASE	3	[EDS]
PREMPRO	3	[EDS]
reclipsen	2	[EDS]
setlakin	2	[EDS]
tarina fe 1/20 eq	2	[EDS]
tri-estarylla	2	[EDS]
tri-lo-estarylla	2	[EDS]
tri-lo-sprintec	2	[EDS]
tri-mili	2	[EDS]
tri-nymyo	2	[EDS]
tri-sprintec	2	[EDS]
tri-vylibra	2	[EDS]
tri-vylibra lo	2	[EDS]
trivora-28	2	[EDS]
turqoz	2	[EDS]
velivet	2	[EDS]
vestura	2	[EDS]
vienva	2	[EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
vyfemla	2	[EDS]
vylibra	2	[EDS]
wymzya fe	2	[EDS]
yuvafem	2	[EDS]
zovia	2	[EDS]
Progestins		
deblitane	2	[EDS]
DEPO-SUBQ PROVERA 104 INJ	3	[EDS]
heather tabs	2	[EDS]
incassia	2	[EDS]
lyleq	2	[EDS]
lyza	2	[EDS]
medroxyprogesterone acetate inj	2	[EDS]
medroxyprogesterone acetate tabs	2	[EDS]
megestrol acetate oral susp 40mg/ml	2	[EDS]
megestrol tabs	2	[EDS]
norethindrone	2	[EDS]
progesterone caps	2	[EDS]
sharobel	2	[EDS]
Selective Estrogen Receptor Modifying Agents		
DUAVEE	3	[EDS]
raloxifene hcl	3	[EDS]
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)		
CYTOMEL	3	[EDS]
levothyroxine tabs	1	[EDS]
levoxyl	1	[EDS]
liothyronine tabs	2	[EDS]
SYNTHROID	3	[EDS]
unithroid	1	[EDS]
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
Hormonal Agents, Suppressant (Adrenal)		
LYSODREN	5	

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
ISTURISA	5	[PA]
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
Hormonal Agents, Suppressant (Pituitary)		
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)		
Antithyroid Agents		
methimazole	2	[EDS]
propylthiouracil	2	[EDS]
IMMUNOLOGICAL AGENTS		
Angioedema Agents		
CINRYZE INJ	5	[PA]
icatibant inj	5	[PA]
sajazir inj	5	[PA]
Immunoglobulins		
GAMMAGARD INJ	5	[PA] [B vs D]
GAMUNEX-C INJ	5	[PA] [B vs D]
Immunological Agents, Other		
ARCALYST INJ	5	[PA]
BENLYSTA INJ	5	[PA]
COSENTYX INJ	5	[PA]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
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]
RINVOQ LQ	5	[PA]
SKYRIZI INJ	5	[PA]
STELARA INJ	5	[PA]
XELJANZ	5	[PA]
XELJANZ XR	5	[PA]
XOLAIR INJ	5	[PA] [LD]
Immunostimulants		
ACTIMMUNE INJ	5	[PA]
PEGASYS INJ	5	
Immunosuppressants		
ASTAGRAF XL	4	[PA] [B vs D] [EDS]
AZASAN	4	[PA] [B vs D] [EDS]
azathioprine tabs 50mg	2	[PA] [B vs D] [EDS]
azathioprine tabs 75mg & 100mg	4	[PA] [B vs D] [EDS]
CELLCEPT CAPS	4	[PA] [B vs D] [EDS]
CELLCEPT ORAL SUSPENSION & TABS	5	[PA] [B vs D]
cyclosporine caps	3	[PA] [B vs D] [EDS]
cyclosporine modified	2	[PA] [B vs D] [EDS]
ENBREL INJ	5	[PA]
ENBREL MINI INJ	5	[PA]
ENBREL SURECLICK INJ	5	[PA]
ENVARSUS XR	4	[PA] [B vs D] [EDS]
everolimus 0.25mg	4	[PA] [B vs D] [EDS]
everolimus 0.5mg, 0.75mg & 1mg	5	[PA] [B vs D]
gengraf	2	[PA] [B vs D] [EDS]
HUMIRA INJ	5	[PA]
HUMIRA PEDIATRIC CROHNS STARTER PACK INJ	5	[PA]
HUMIRA PEN-CD/UC/HS STARTER INJ	5	[PA]
HUMIRA PEN-PEDIATRIC UC STARTER PACK INJ	5	[PA]
HUMIRA PEN-PS/UV STARTER INJ	5	[PA]
HUMIRA PEN INJ	5	[PA]
IMURAN TABS	4	[PA] [B vs D] [EDS]
JYLAMVO SOLN	4	[EDS]
leflunomide	2	[EDS]
methotrexate inj 50mg/2ml	2	[EDS]
methotrexate oral	2	[EDS]
mycophenolate mofetil caps & tabs	2	[PA] [B vs D] [EDS]
mycophenolate mofetil oral susp	5	[PA] [B vs D]
mycophenolic acid dr	4	[PA] [B vs D] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
MYFORTIC	4	[PA] [B vs D] [EDS]
MYHIBBIN	4	[PA] [B vs D] [EDS]
NEORAL	4	[PA] [B vs D] [EDS]
PROGRAF CAPS	4	[PA] [B vs D] [EDS]
PROGRAF PACK	4	[PA] [B vs D] [EDS]
RAPAMUNE SOLN	5	[PA] [B vs D]
RAPAMUNE TABS	4	[PA] [B vs D] [EDS]
SANDIMMUNE CAPS 25MG & 100MG	4	[PA] [B vs D] [EDS]
sirolimus soln	5	[PA] [B vs D]
sirolimus tabs	4	[PA] [B vs D] [EDS]
tacrolimus caps 0.5mg & 1mg	3	[PA] [B vs D] [EDS]
tacrolimus caps 5mg	4	[PA] [B vs D] [EDS]
XATMEP	4	[EDS]
ZORTRESS TABS 0.25MG	4	[PA] [B vs D] [EDS]
ZORTRESS TABS 0.5MG, 0.75MG & 1MG	5	[PA] [B vs D]
Vaccines		
ABRYSVO INJ	3	[EDS]
ACTHIB INJ	3	[EDS]
ADACEL INJ	3	[EDS]
AREXVY INJ	3	[EDS]
BCG INJ	3	[EDS]
BEXSERO INJ	3	[EDS]
BOOSTRIX INJ	3	[EDS]
DAPTACEL INJ	3	[EDS]
DIPHTHERIA & TETANUS TOXOIDS PEDIATRIC INJ	3	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
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]
IPOL INACTIVATED IPV INJ	3	[EDS]
IXCHIQ 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]
MRESVIA INJ	3	[EDS]
M-M-R II INJ	3	[EDS]
PEDIARIX INJ	3	[EDS]
PEDVAX HIB INJ	3	[EDS]
PENBRAYA 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]
TDVAX INJ	3	[EDS]
TENIVAC INJ	3	[EDS]
TICOVAC INJ	4	[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 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
TRUMENBA INJ	3	[EDS]
TWINRIX INJ	3	[EDS]
TYPHIM VI INJ	3	[EDS]
VAQTA INJ	3	[EDS]
VARIVAX INJ	3	[EDS]
VAXCHORA 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]
alendronate oral soln	3	[EDS]
calcitonin-salmon nasal	2	[EDS]
calcitriol caps	2	[PA] [B vs D] [EDS]
cinacalcet tab 30mg	3	[PA] [B vs D] [EDS]
cinacalcet tab 60mg	4	[PA] [B vs D] [EDS]
cinacalcet tab 90mg	5	[PA] [B vs D]
doxercalciferol oral	3	[PA] [B vs D] [EDS]
FORTEO INJ	5	[PA]
ibandronate oral	2	[EDS]
paricalcitol caps	3	[PA] [B vs D] [EDS]
PROLIA INJ	4	[PA] [EDS]
RAYALDEE	5	
risedronate sodium	3	[EDS]
risedronate sodium dr	3	[EDS]
TERIPARATIDE INJ	5	[PA]
TYMLOS INJ	5	[PA]
XGEVA INJ	5	[PA]
MISCELLANEOUS THERAPEUTIC AGENTS		
Miscellaneous Therapeutic Agents		
alcohol pads	2	[EDS]
bd insulin syringe ultrafine	2	[EDS]
bd insulin syringe safetyglide	2	[EDS]
bd pen needle ultrafine	2	[EDS]
ENDARI	5	[PA]
gauze pads 2"x2"	2	[EDS]
KORLYM	5	[PA]
KOSELUGO	5	[PA]
LAGEVRIO	4	[EDS]
levocarnitine oral	2	[PA] [B vs D] [EDS]
l-glutamine	5	[PA]
mifepristone tabs	5	[PA]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
paroxetine mesylate	3	[EDS]
PAXLOVID	3	[EDS]
pmdd fluoxetine hcl tabs 10mg & 20mg	2	[EDS]
OPHTHALMIC AGENTS		
Ophthalmic Agents, Other		
atropine sulfate soln	2	[EDS]
brimonidine & timolol maleate	3	[EDS]
cyclosporine emulsion 0.05%	3	[EDS]
CYSTARAN	5	
dorzolamide & timolol maleate	2	[EDS]
neomycin & polymyxin & bacitracin	2	[EDS]
neomycin & polymyxin & bacitracin & hydrocortisone	2	[EDS]
neomycin & polymyxin & dexamethasone	2	[EDS]
neomycin & polymyxin & gramicidin ophthalmic	2	[EDS]
neomycin & polymyxin & hydrocortisone	2	[EDS]
ROCKLATAN	3	[EDS]
SIMBRINZA	4	[EDS]
sulfacetamide sodium & prednisolone sodium phosphate ophthalmic	2	[EDS]
TOBRADEX OINT	3	[EDS]
tobramycin & dexamethasone ophthalmic suspension	2	[EDS]
XIIDRA	3	[EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
Ophthalmic Anti-allergy Agents		
azelastine 0.05%	2	[EDS]
cromolyn sodium ophthalmic soln	2	[EDS]
Ophthalmic Anti-infectives		
AZASITE	3	[EDS]
bacitracin ophthalmic ointment	2	[EDS]
bacitracin & polymyxin b ointment	2	[EDS]
ciprofloxacin ophthalmic soln 0.3%	2	[EDS]
erythromycin ophthalmic oint	2	[EDS]
gentamicin ophthalmic soln 0.3%	2	[EDS]
moxifloxacin hcl ophthalmic	2	[EDS]
NATACYN	4	[EDS]
neo-polycin ophthalmic ointment	2	[EDS]
neo-polycin hc ophthalmic ointment	2	[EDS]
ofloxacin ophthalmic	2	[EDS]
polycin ophthalmic ointment	2	[EDS]
polymyxin b sulfate & trimethoprim sulfate ophthalmic soln	2	[EDS]
sulfacetamide sodium ophthalmic oint & soln 10%	2	[EDS]
tobramycin ophthalmic solution	2	[EDS]
trifluridine	2	[EDS]
ZIRGAN	4	[EDS]
Ophthalmic Anti-inflammatories		
bromfenac ophthalmic soln 0.09%	3	[EDS]
BROMSITE	4	[EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
dexamethasone ophthalmic soln	2	[EDS]
diclofenac sodium ophthalmic soln 0.1%	2	[EDS]
difluprednate	3	[EDS]
fluorometholone	2	[EDS]
ketorolac soln	2	[EDS]
LOTEMAX OINT	4	[EDS]
LOTEMAX SM GEL 0.38%	4	[EDS]
PRED MILD	3	[EDS]
prednisolone acetate	2	[EDS]
prednisolone sodium phosphate	2	[EDS]
PROLENSA	3	[EDS]
Ophthalmic Beta-Adrenergic Blocking Agents		
betaxolol soln	2	[EDS]
carteolol	1	[EDS]
levobunolol	2	[EDS]
timolol ophthalmic gel forming	2	[EDS]
timolol ophth soln 12 hours 0.25% & 0.5% multi-use bottles	1	[EDS]
Ophthalmic Intraocular Pressure Lowering Agents, Other		
acetazolamide tabs	2	[EDS]
acetazolamide er caps	2	[EDS]
ALPHAGAN P 0.1%	3	[EDS]
brimonidine tartrate soln 0.15%	3	[EDS]
brimonidine tartrate soln 0.2%	2	[EDS]
dorzolamide	2	[EDS]
methazolamide	4	[EDS]
PHOSPHOLINE IODIDE	3	[EDS]
pilocarpine soln	2	[EDS]
RHOPRESSA	3	[EDS]

Drug Name 藥物名稱	Drug Tier 藥物等級	Requirements/ Limits 要求/限制
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]
cyproheptadine	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]
BREZTRI AEROSPHERE	3	[EDS]
budesonide nebulizer	3	[PA] [B vs D] [EDS]
flunisolide nasal	2	[QL] [EDS]

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Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
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]
EPINEPHRINE AUTO-INJECTOR 0.15MG/0.3ML & 0.3MG/0.3ML	3	[EDS]
formoterol fumarate nebulizer	4	[PA] [B vs D] [EDS]
levalbuterol nebulizer	2	[PA] [B vs D] [EDS]

Drug Name	Drug Tier	Requirements/ Limits
藥物名稱	藥物等級	要求/限制
LEVALBUTEROL TARTRATE HFA	4	[EDS]
PERFOROMIST NEBULIZER	5	[PA] [B vs D]
PROAIR RESPICLICK	3	[EDS]
SEREVENT DISKUS	3	[EDS]
STRIVERDI RESPIMAT	3	[EDS]
terbutaline sulfate oral	3	[EDS]
Cystic Fibrosis Agents		
BETHKIS	5	[PA] [B vs D]
CAYSTON	5	[PA] [LD]
KALYDECO	5	[PA]
KITABIS NEBULIZER	5	[PA] [B vs D]
ORKAMBI	5	[PA]
PULMOZYME	5	[PA] [B vs D]
TOBI SOLN	5	[PA] [B vs D]
TOBI PODHALER	5	
tobramycin nebulizer	5	[PA] [B vs D]
TRIKAFTA	5	[PA]
Mast Cell Stabilizers		
cromolyn sodium nebulizer soln	4	[PA] [B vs D] [EDS]
Phosphodiesterase Inhibitors, Airways Disease		
OHTUVAYRE NEBULIZER	5	[PA] [B vs D]
roflumilast tabs	3	[EDS]
theophylline er tabs	2	[EDS]
Pulmonary Antihypertensives		
ADEMPAS	5	[PA] [LD]
alyq	5	[PA]
ambrisentan	5	[PA] [LD]
bosentan tabs 62.5mg & 125mg	5	[PA] [LD]
OPSUMIT	5	[PA] [LD]
sildenafil tab 20mg	3	[PA] [EDS]
tadalafil tab 20mg	5	[PA]
TRACLEER 32MG	5	[PA] [LD]
UPTRAVI	5	[PA]

[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
藥物名稱	藥物等級	要求/限制
Pulmonary Fibrosis Agents		
OFEV	5	[PA]
pirfenidone tabs	5	[PA]
Respiratory Tract Agents, Other		
acetylcysteine nebulizer soln	2	[PA] [B vs D] [EDS]
ADVAIR HFA	3	[EDS]
ANORO ELLIPTA	3	[EDS]
BEVESPI AEROSPHERE	3	[EDS]
BREO ELLIPTA	3	[EDS]
COMBIVENT RESPIMAT	3	[EDS]
DULERA	3	[EDS]
FASENRA INJ	5	[PA]
fluticasone propionate/salmeterol diskus 100mcg-50mcg, 250mcg-50mcg & 500mcg-50mcg	2	[EDS]
ipratropium bromide & albuterol sulfate nebulizer	2	[PA] [B vs D] [EDS]
PROLASTIN C INJ	5	[PA] [LD]
STIOLTO RESPIMAT	3	[EDS]
TRELEGY ELLIPTA	3	[EDS]
wixela inhub	2	[EDS]
SKELETAL MUSCLE RELAXANTS		
Skeletal Muscle Relaxants		
carisoprodol tabs 350mg	2	[EDS]
chlorzoxazone tabs 500mg	2	[EDS]
cyclobenzaprine hcl ir	2	[EDS]
methocarbamol tabs 500mg & 750mg	2	[EDS]
SLEEP DISORDER AGENTS		
Sleep Promoting Agents		
BELSOMRA	3	[QL] [EDS]
doxepin tabs	3	[EDS]
estazolam	2	[EDS]
flurazepam caps	2	[EDS]
ramelteon	3	[EDS]
tasimelteon caps	5	[PA]
temazepam caps 7.5mg, 15mg & 30mg	2	[EDS]
temazepam caps 22.5mg	3	[EDS]
triazolam	2	[EDS]
zolpidem ir tabs 5mg & 10mg	2	[EDS]
Wakefulness Promoting Agents		
armodafinil	3	[PA] [EDS]
modafinil	3	[PA] [EDS]
SODIUM OXYBATE ORAL SOLN	5	[PA][LD]
XYWAV	5	[PA] [LD]

[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.

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 藥物名稱	Drug Tier 藥物等級	Requirements/Limits 要求/限制
ERECTILE DYSFUNCTION		
sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)	1	[QL] (4 tablets per 30-day supply with a maximum of 49 tablets per year)
PRESCRIPTION VITAMINS		
cyanocobalamin inj 1000 mcg/ml (vitamin B12)	1	
ergocalciferol caps 1.25mg (50,000 units) (vitamin D2)	1	
folic acid tabs 1 mg (vitamin B9)	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 藥物名稱	Drug Tier 藥物等級	Requirements/Limits 要求/限制
勃起功能障礙		
sildenafil tabs 25mg, 50mg, 100mg (generic for Viagra)	1	[QL]（每 30 天份量 4 片，每年最多 49 片）
處方維生素		
cyanocobalamin inj 1000 mcg/ml (vitamin B12)	1	
ergocalciferol caps 1.25mg (50,000 units) (vitamin D2)	1	
folic acid tabs 1 mg (vitamin B9)	1	

Drugs with Quantity Limits 有數量限制的藥物	
Drug Name **藥物名稱**	**Quantity Limits** **數量限制**
acetaminophen & codeine #2 & #3 tabs	360 tabs per 30 days
acetaminophen & codeine #4 tabs	180 tabs per 30 days
acetaminophen & codeine elixir	5000ml per 30 days
acyclovir cream	5gm per 30 days
acyclovir ointment	30gm per 30 days
albuterol sulfate hfa 6.7gm inhaler	13.4gm per 30 days
albuterol sulfate hfa 8.5gm inhaler	17gm per 30 days
amphetamine & dextroamphetamine	60 tabs per 30 days
ATROVENT HFA	2 inhalers per 30 days
BELSOMRA	30 tabs per 30 days
butorphanol tartrate nasal	4 bottles per 30 days
calcipotriene cream	60gm: 2 tubes per 30 days; 120gm: 1 tube per 30 days
calcipotriene oint	60gm: 2 tubes per 30 days
desonide lotion, oint & cream	cream & oint: 120gm per 30 days lotion: 118ml per 30 days
desoximetasone topical cream, gel & oint 0.05%	120gm per 30 days
desoximetasone topical cream & oint 0.25%	120gm per 30 days
dextroamphetamine sulfate	5mg: 120 tabs per 30 days; 10mg: 180 tabs per 30 days
dextroamphetamine sulfate er	5mg: 30 caps per 30 days; 10mg & 15mg: 120 caps per 30 days
diflorasone diacetate	60gm per 30 days
endocet tabs 2.5-325mg, *5-325mg, 7.5-325mg & 10-325mg*	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
fentanyl patches	15 patches per 30 days
flunisolide nasal	2 bottles per 30 days
fluocinonide cream, gel & ointment	15gm: 4 tubes per 30 days; 30gm: 2 tubes per 30 days; 60g: 1 tube per 30 days
fluticasone propionate nasal	2 bottles per 30 days
hydrocodone & acetaminophen soln 7.5-325mg/15ml	5500ml per 30 days
hydrocodone & acetaminophen soln 10-325mg/15ml	5500ml per 30 days
hydrocodone & acetaminophen tabs 5-325mg,7.5-325mg & 10-325mg	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
hydrocodone & ibuprofen tabs 5-200mg, 7.5-200mg & 10-200mg	150 tabs per 30 days
ipratropium bromide nasal	1 bottle per 30 days
lidocaine ointment	1 tube per 30 days
lidocaine topical soln	1 bottle per 30 days
lidocaine & prilocaine	30gm: 1 tube per 30 days
mometasone furoate nasal	3 bottles per 30 days
morphine sulfate er tabs	120 tabs per 30 days
mupirocin cream	30gm per 30 days
oxycodone & acetaminophen tabs 2.5-325mg, 5-325mg, 7.5-325mg & 10-325mg	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
pimecrolimus	30gm: 3 tubes per 30 days
REGRANEX	2 tubes per 30 days
SANTYL	90gm per 30 days
tacrolimus oint	100g per 30days
tazarotene gel	30gm: 3 tubes per 30 days; 100gm: 1 tube per 30
tramadol er tabs	30 tabs per 30 days
tramadol ir tab 100mg	120 tabs per 30 days
tramadol & acetaminophen tabs 37.5-325mg	240 tabs per 30 days
zenzedi	5mg: 120 tabs per 30 days 10mg: 180 tabs per 30 days

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附录

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 թարգմանչական ծառայությունից: Թարգմանչի ծառայությունից օգտվելու համար զանգահարե՛ք 1-800-559-3500 հեռախոսահամարով: Ձեզ կօգնի հայերենին տիրապետող մեր աշխատակիցը: Ծառայությունն անվճար է:

Persian: توجه: ما خدمات مترجم رایگان داریم تا به هر سؤالی که ممکن است در مورد برنامه بهداشتی یا داروهای ما داشته باشید پاسخ دهیم. برای آن که مترجم دریافت کنید فقط کافیست با شماره1-800-559-3500 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 الرقم1-800-559-3500. 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 ਕੋਲ 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:
យើងខ្ញុំមានសេវាអ្នកបកប្រែផ្តាល់មាត់ដោយមិនគិតថ្លៃចាំឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីសុខភាព ឬផែនការឱសថរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែ គ្រាន់តែហៅទូរស័ព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-800-559-3500។ មានគេដែលនិយាយភាសាខ្មែរអាចជួយលោកអ្នកបាន។ សេវាកម្មនេះមិនគិតថ្លៃទេ។

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: เรามีบริการล่ามฟรีเพื่อตอบข้อสงสัยต่าง ๆ ที่คุณอาจมีเกี่ยวกับแผนสุขภาพและด้านเภสัชกรรมของเรา ขอความช่วยเหลือจากล่ามโดยโทรติดต่อเราที่หมายเลข 1-800-559-3500 เจ้าหน้าที่ในภาษาไทยจะเป็นผู้ให้บริการโดยไม่มีค่าใช้จ่ายใด ๆ

Lao: ພວກເຮົາມີການບໍລິການນາຍພາສາຟຣີ ເພື່ອຕອບຄຳຖາມທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງ ພວກເຮົາ. ເພື່ອຮັບເອົານາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-559-3500. ບາງຄົນທີ່ເວົ້າພາສາລາວ ສາມາດຊ່ວຍທ່ານໄດ້. ນີ້ແມ່ນການບໍລິການຟຣີ.

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 entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante oswa medikaman nou yo. Pou w jwenn yon entèprèt, 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 znającego 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 12/01/2024. 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 12/01/2024。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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCAN Health Plan cumple con las leyes federales de derechos civiles vigentes y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad ni sexo. SCAN Health Plan 和 SCAN Desert 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。