

# Updates to your prescription benefits

Effective September 1, 2026

## Advantage 3-Tier PDL update summary

Within the Prescription Drug List (PDL), prescription drugs are grouped by tier. The tier indicates the cost and coverage level of a drug. Please reference the chart below as you review the following updates to the PDL.



\$

**Tier 1**

Lowest-cost medications

\$\$

**Tier 2**

Mid-range cost

\$\$\$

**Tier 3**

Highest-cost

### Prescription drugs excluded from benefit coverage<sup>1,2</sup>

We evaluate prescription drugs based on their total value, including how a drug works, its safety, and how much it costs. When several drugs work in the same way, we may choose to exclude the higher-cost option. Effective **September 1, 2026**, the drugs listed below may be excluded from coverage or you may need to get a prior authorization. Sign into your online account to check if there are any actions you need to take.

| Therapeutic use              | Medication name                    | Alternative treatment option(s)                                       |
|------------------------------|------------------------------------|-----------------------------------------------------------------------|
| <b>Cancer</b>                | Phyrago <sup>3,4</sup>             | dasatinib (generic Sprycel) <sup>5</sup>                              |
| <b>Cancer</b>                | Pomalyst (brand only) <sup>4</sup> | pomalidomide (generic Pomalyst) <sup>5</sup>                          |
| <b>Cancer</b>                | Revlimid (brand only) <sup>4</sup> | lenalidomide (generic Revlimid) <sup>5</sup>                          |
| <b>Endocrine disorders</b>   | Palsonify <sup>3,4</sup>           | octreotide (generic Sandostatin) <sup>5</sup> , Somavert <sup>5</sup> |
| <b>Heart failure</b>         | Furoscix <sup>4,6</sup>            | Enbumyst <sup>5</sup> , Lasix ONYU <sup>5</sup>                       |
| <b>Hereditary angioedema</b> | Dawnzera <sup>3,4</sup>            | Andembry <sup>5</sup> , Haegarda <sup>5</sup> , Takhzyro <sup>5</sup> |

| Therapeutic use         | Medication name                                         | Alternative treatment option(s)                                                                                                                                                                              |
|-------------------------|---------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hormone replacement     | EstroGel (brand only)                                   | estradiol gel (generic EstroGel)                                                                                                                                                                             |
| Inflammatory conditions | Tyenne autoinjector & prefilled syringe <sup>4</sup>    | Actemra <sup>5</sup> , Avtozma <sup>5</sup>                                                                                                                                                                  |
| Mental health           | Escitalopram 15 mg capsule <sup>3</sup>                 | citalopram (generic Celexa), escitalopram (generic Lexapro)                                                                                                                                                  |
| Migraines               | Brekiya <sup>3,4</sup>                                  | dihydroergotamine (generic D.H.E., generic Migranal <sup>5</sup> )                                                                                                                                           |
| Muscle spasms           | tizanidine (generic Zanaflex) 8 mg capsule <sup>3</sup> | cyclobenzaprine tablet (generic Flexeril), chlorzoxazone (generic Parafon Forte DSC), methocarbamol (generic Robaxin), orphenadrine extended-release (generic Norflex), tizanidine tablet (generic Zanaflex) |
| Muscle spasms           | Zanaflex 8 mg capsule <sup>3</sup>                      | cyclobenzaprine tablet (generic Flexeril), chlorzoxazone (generic Parafon Forte DSC), methocarbamol (generic Robaxin), orphenadrine extended-release (generic Norflex), tizanidine tablet (generic Zanaflex) |

1. Medication is typically excluded from coverage.

2. Exclusion includes brand, generic and authorized generic products unless otherwise noted.

3. Newly released medication which was excluded from coverage at the time of launch and will continue to be excluded from our pharmacy benefit.

4. For plans that do not exclude these medications, step therapy or prior authorization may be required prior to coverage.

5. Step therapy or prior authorization may be required prior to coverage.

6. A clinical review may be available for coverage.

# Advantage 3-Tier PDL clinical programs update summary

Some prescription drugs may have programs or limits that apply. Below are the changes that will be effective September 1, 2026.

## PA Prior authorization - new notification

Prior authorization – notification requires additional clinical information to verify members benefit coverage.

| Therapeutic use | Medication name       |
|-----------------|-----------------------|
| Amyloidosis     | Vyndamax <sup>7</sup> |

## QL New quantity limits

Quantity limits establish the maximum quantity of a drug that is covered per copay or in a specified time frame. The drugs below will now be part of the quantity limits program.

| Therapeutic use   | Medication name                      | New quantity limit          |
|-------------------|--------------------------------------|-----------------------------|
| Dry eye disease   | Cequa 0.09% <sup>8</sup>             | 60 vials per month          |
| Dry eye disease   | Restasis 0.05% <sup>8</sup>          | 60 vials per month          |
| Dry eye disease   | Xiidra 5% <sup>8</sup>               | 60 vials per month          |
| Diabetes supplies | Omnipod 5 Libre2 Plus G6 Intro Gen 5 | 1 kit per 2 years           |
| Diabetes supplies | Omnipod 5 Dexcom G7G6 Pods (Gen 5)   | 10 pods (2 boxes) per copay |

## QL Revised quantity limits

The following medications have revised quantity limits. Quantity limits establish the maximum quantity of a drug that is covered per copay or in a specified time frame.

| Therapeutic use | Medication name                       | Revised quantity limit |
|-----------------|---------------------------------------|------------------------|
| Dry eye disease | Miebo 1.3 gm/mL <sup>8</sup>          | 1 bottle per month     |
| Dry eye disease | Restasis Multidose 0.05% <sup>8</sup> | 1 bottle per month     |

7. If you already have a PA for this drug, there is no impact.

8. Supply limit already exists. Limit type is changing.

## Learn more



Call the toll-free phone number on your member ID card to speak with a Customer Service representative.



Visit the member website listed on your member ID card to look up the price of drugs covered by your plan, find lower-cost options and more.



This document applies to commercial group members of Surest plans with a pharmacy benefit subject to the Advantage 3-Tier PDL.

**Level Funded:** Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

**Fully Insured:** Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.

**All Fully Insured Plans in California:** If medically appropriate care from a qualified provider cannot be provided within the Network, we will arrange for the required care with an available and accessible out-of-Network provider. You will only be responsible for paying the cost sharing in an amount equal to the cost sharing you would have otherwise paid for that service or a similar service if you had received the Covered Health Care Service from a Network provider.

**Surest Fully Insured Plans in California:** A complete Network and timely access to care may only be available by obtaining treatment through providers available at the maximum Copayment shown for each service at the lowest cost-sharing tier. While some network providers are available at lower Copayments (reduced cost-sharing rates), there is no guarantee of a complete Network or timely access to care at any specific reduced cost-sharing rate.