List of Covered Drugs (Drug Formulary)

September 2026

CalOptima Health

This formulary was last updated on 9/24/2026. This formulary is subject to change and all previous versions of the formulary no longer apply. For the most current information about the List of Covered drugs, visit https://content.caloptima.org/api/public/content/2027-CalOptima-Health-Covered-Formulary-List-of-Covered-Drugs-English.

This Drug Formulary applies to the following CalOptima Health Covered products:

- CalOptima Health Covered Minimum Coverage HMO;
- CalOptima Health Covered Bronze 60 HMO;
- CalOptima Health Covered Silver 70 HMO;
- CalOptima Health Covered Silver 73 HMO;
- CalOptima Health Covered Silver 87 HMO;
- CalOptima Health Covered Silver 94 HMO;
- CalOptima Health Covered Gold 80 HMO;
- CalOptima Health Covered Platinum 90 HMO; and
- CalOptima Health Covered AI/AN plans.

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Informational Section

The *CalOptima Health List of Covered Drugs (Drug Formulary)* is a list of medications that are approved by the Food and Drug Administration (FDA) and are selected based on safety, effectiveness, and cost. This list of generic and brand drugs is covered by your health insurance policy under the prescription drug benefit of the policy.

Covered Formulary Drugs include:

- FDA-approved drugs that require a prescription either by California or Federal law.
- Insulin.
- Pen delivery systems for the administration of insulin, as medically necessary.
- Diabetic testing supplies, including these:
    - Lancets.
    - Lancet puncture devices.
    - Blood and urine testing strips.
- Over-the-counter drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B.
- Contraceptive drugs and devices, including these:
    - Diaphragms.
    - Cervical caps.
    - Contraceptive rings.
    - Contraceptive patches.
    - Oral contraceptives.
    - Emergency contraceptives.
    - Over-the-counter contraceptive products
- Disposable devices that are medically necessary for the administration of a covered outpatient prescription drug such as syringes and inhaler spacers.

If you have questions about your pharmacy coverage, call CalOptima Health Member Services at 1-888-312-2221 (TTY 711), Monday-Friday, 8am-6pm. We have customer service representatives available to provide you with accurate, specific information concerning prescription drug benefits, including but not limited to:

- Information concerning drugs covered under the medical benefit of your plan;
- The actual dollar amount of cost sharing under your plan for drugs subject to a copayment or coinsurance; and
- The process for submitting an exception request and requesting prior authorization and step therapy exceptions.

Definitions

"Age Limit (AL)" limits use of medication dependent on age.

"Brand name drug" is a drug that is marketed under a proprietary, trademark protected name. The brand name drug shall be listed in all CAPITAL letters.

"Coinsurance" is a percentage of the cost of a covered health care benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

"Copayment" is a fixed dollar amount that an enrollee pays for a covered health care benefit after the enrollee has paid the deductible, if a deductible applies to the health care benefit, such as the prescription drug benefit.

"Deductible" is the amount an enrollee pays for covered health care benefits before the enrollee's health plan begins payment for all or part of the cost of the health care benefit under the terms of the policy.

"Drug Tier" is a group of prescription drugs that corresponds to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

"Essential health benefits" or "EHB" are a set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services.

"Enrollee" is a person enrolled in a health plan who is entitled to receive services from the plan. All references to enrollees in this formulary template shall also include subscribers as defined in this section below.

"Evidence of Coverage" or "EOC" means any certificate, agreement, contract, brochure, or letter of entitlement issued to an enrollee setting forth the coverage to which the enrollee is entitled.

"Exception request" is a request for coverage of a prescription drug. If an enrollee, his or her designee, or prescribing healthcare provider submits an exception request for coverage of a prescription drug, the health plan must cover the prescription drug when the drug is determined to be medically necessary to treat the enrollee's condition.

"Exigent circumstances" are when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

"Food and Drug Administration (FDA)" is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices.

"Formulary" is the complete list of drugs preferred for use and eligible for coverage under a health plan product, and includes all drugs covered under the outpatient prescription drug benefit of the health plan product. Formulary is also known as a prescription drug list.

"Generic drug" is the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use. A generic drug is listed in ***bold and italicized lowercase*** letters.

"Nonformulary drug" is a prescription drug that is not listed on the health plan's formulary.

"Out-of-pocket cost" are copayments, coinsurance, and the applicable deductible, plus all costs

for health care services that are not covered by the health plan.

“Pharmacy & therapeutics (P&T) committee” is responsible for developing, managing, updating, and administering the drug formulary

“Prescribing provider” is a health care provider authorized to write a prescription to treat a medical condition for a health plan enrollee.

“Prescription” is an oral, written, or electronic order by a prescribing provider for a specific enrollee that contains the name of the prescription drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the enrollee, the medical condition or purpose for which the drug is being prescribed.

“Prescription drug” is a drug that is prescribed by the enrollee’s prescribing provider and requires a prescription under applicable law.

“Prior Authorization (PA)” is a health plan’s requirement that the enrollee or the enrollee’s prescribing provider obtain the health plan’s authorization for a prescription drug before the health plan will cover the drug. The health plan shall grant a prior authorization when it is medically necessary for the enrollee to obtain the drug.

“Step therapy (ST)” is a process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. The health plan may require the enrollee to try one or more drugs to treat the enrollee’s medical condition before the health plan will cover a particular drug for the condition pursuant to a step therapy request. If the enrollee’s prescribing provider submits a request for step therapy exception, the health plans shall make exceptions to step therapy when the criteria is met.

“Specialty Pharmacy” is a pharmacy that handles specialty drugs, pharmaceutical therapies that are either high cost, high complexity and/or high touch.

“Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

What is the process for finding a drug on this list?
The drugs are listed alphabetically under the column titled "Prescription Drug Name" by its brand or generic name under the therapeutic category and class to which it belongs. This formulary uses the First Data Bank Enhanced Therapeutic Classification System classification system.

You can search this list using the brand or generic name of the drug by:

- Searching for the category or class to which the drug belongs and search for the name of the drug in alphabetical order or
- Searching the Alphabetical Index of Drugs by the name of the drug.

Listing a drug on the formulary does not guarantee that it will be prescribed by your doctor or prescriber.

How can I tell if the drug listed is a brand or generic drug?
If a generic equivalent for a brand name drug is available, and both the brand name and generic equivalents are covered, the generic drug will be listed separately from the brand name drug in all ***bold and italicized lowercase*** letters.

In the event a generic drug is marketed under a proprietary, trademark protected brand name, the brand name will be listed in all CAPITAL letters after the generic name in parentheses and regular typeface with first letter of each word capitalized.

A brand name drug is listed in all CAPITAL letters followed by the generic name in parenthesis in all ***bold and italicized lowercase*** letters.

Example: CARDIOVASCULAR THERAPY AGENTS-DRUGS FOR THE HEART

Drug Name	Drug Tier	Requirements/Limits
eplerenone oral tablet 25 mg, 50 mg	1	
KERENDIA ORAL TABLET 10 MG, 20 MG, 40 MG (***finerenone***)	3	

From the above example:
Generic Drug:
- ***eplerenone oral tablet***

Brand Drug:
- KERENDIA ORAL TABLET ***(finerenone)***

What are drug tiers?
Drugs are placed into drug tiers based on defined categories. The amount you pay for drugs in different tiers will vary. You can find information about what you pay by drug tier in your *Summary of Benefits* or the CalOptima Health *Evidence of Coverage* (EOC). Please see the following link for the cost-sharing specific to your plan: https://content.caloptima.org/api/public/content/2027-CalOptima-Health-Covered-Evidence-of-Coverage-English .

The column titled "Drug Tier" is the cost level you pay for a drug.

Drug Tier	Description
1	Most generic drugs and low-cost, preferred brand drugs
2	Non-preferred generic drugs, preferred brand drugs, and any other drugs recommended by the P&T Committee based on drug safety, efficacy, and cost
3	Non-preferred brand drugs; drugs recommended by the P&T Committee based on safety, efficacy, and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier
4	Drugs that the FDA or drug manufacturer requires to be distributed by specialty pharmacies; drugs that require the enrollee have special training or clinical monitoring ; or drugs with a plan cost (net of rebates) greater than $600 for a one-month supply

Preventive health drugs, including contraceptive drugs and devices are covered at $0 when specific criteria are met.

How often is the formulary updated?
This formulary is updated monthly and the changes are effective on the first of the month. The formulary can change when a new drug, new generic, or new formulation is available during the year. Formulary changes may result in changes to your prescription such as change in dispensed brand, cost-sharing tier, or restrictions governing use.

The Plan will provide sixty (60) days written notice of a Formulary change to negatively affected Enrollees. The notice will include the date the Enrollee will be impacted by the change. Some examples of Formulary changes that will result in a notice to the Enrollee include, but are not limited to:

- A drug or dosage form is moved to a higher Drug Tier that results in an increase in cost sharing
- A drug or dosage form is removed from the Formulary
- Drug Coverage Requirements or Limits for a drug are added or changed

Changes to the Formulary that may occur without prior written notice to the Enrollee include:

- A drug is removed from the Formulary because it is removed from the market by either the drug manufacturer or the FDA
- A drug is added to the Formulary
- A drug is moved to a lower Drug Tier
- A Drug Coverage Requirement or Limit is removed from a drug
- A generic drug is added to the Formulary and the Brand Name drug is moved to a higher Drug Tier or removed from the Formulary

The drug formulary can be accessed by current and prospective Enrollees. To view the most current Formulary, please visit www.caloptima.org.

What is a drug covered under the medical benefit drug versus a drug covered under the Outpatient Prescription Drug Benefit?
A medical benefit drug is a medication that is generally administered by a health care professional and part of a doctor's office visit.

A drug covered under the Outpatient Prescription Drug Benefit is a medication that is self-administered drugs approved by the Federal Food and Drug Administration for sale to the public through retail or mail-order pharmacies that require prescriptions and are not provided for use on an inpatient basis.

For additional information, check the CalOptima Health *Evidence of Coverage* or call CalOptima Health Member Services at 1-888-312-2221 (TTY 711), Monday-Friday, 8am-6pm.

What are preventive health drugs?
Preventive health drugs are select drugs required by health reform legislation to be covered without charging the Enrollee a copayment, coinsurance, or deductible. Preventive health drugs are determined based on evidence-based recommendations that have in effect a rating of "A" or "B" in the recommendations of the United States Preventive Services Task Force (USPSTF), as periodically updated. Immunization recommendations by the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention are also preventive health drugs. Individuals who are determined to be at high risk of contracting HIV by their attending health care provider are covered without cost sharing by CalOptima Health. For more details about preventive health drugs, visit www.caloptima.org.

What is a contraceptive drug or device?
Contraceptives are drugs or devices, such as diaphragms or cervical caps, that help prevent pregnancy. The drug contraceptives and contraceptive devices are covered at no charge to the insured.

FDA-approved contraceptive drugs, devices, and other products, including FDA-approved over-the-counter contraceptive drugs, devices, and products, are covered at no charge to the insured. FDA-approved over-the-counter contraceptive drugs, devices, and products can be provided at a network pharmacy at no charge to the insured. Coverage also includes a 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time.

What diabetes care drugs and products are covered under the Outpatient Prescription Drug Benefit?
FDA-approved drugs for the treatment of diabetes are included in the Formulary Drug List. Diabetic testing supplies such as blood glucose test strips, urine test strips, lancets, insulin syringes/pens covered under the Outpatient Prescription Drug Benefit are also included in the Formulary Drug List.

What if my prescribed drug was previously approved and is no longer approved by the plan?
If a drug had previously been approved for coverage for treatment of an Enrollee's medical condition, and the Enrollee's provider continues to prescribe the drug for the medical

condition, provided the drug is appropriately prescribed, is safe, and effective therapy, the drug will continue to be covered by the plan and the plan will also not limit coverage. This does not preclude your prescriber from prescribing the alternative formulary drug.

What if my drug requires a prior authorization or step therapy?
The prior authorization process ("PA") is used to ensure that drug benefits are applied as intended and that Plan Enrollees receive the most appropriate, safe, and cost-effective medication therapy. Your Physician's request for prior authorization will be evaluated once the submitted information has been received and a determination made based on established clinical criteria for the specific medication. The criteria used for prior authorization are developed by the Pharmacy and Therapeutics Committee. Your physician may contact us to get the policy. Before payment can be approved for drugs requiring prior authorization, the conditions for approval must be met and the prior authorization must be entered into the system. CalOptima Health will reply to the doctor and/or pharmacist within 24 hours for exigent circumstance requests or 72 hours for standard requests after getting the requested medical information. Exigent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a course of treatment Once a medication is approved, its authorization becomes effective right away. You may get a list of drugs requiring Prior Authorization. Visit our website at www.caloptima.org.

Prior Authorization is required for most brand name drugs with generic equivalents to determine Medical Necessity. CalOptima Health will cover brand name drugs that have generic equivalents if the PA request is approved.

Some drugs have a special rule called step therapy. This means that you must first try another drug on the formulary before the prescribed drug is covered. If your doctor or other prescriber thinks the first drug does not work for you, then an exception to the step therapy rule can be requested and the plan will grant the exception when medically necessary and to confirm effectively and efficiently with continuity of care requirements.

Step therapy is the process of beginning therapy for a medical condition with drugs considered first-line treatment or that are more cost-effective, then progressing to drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, and the relative cost. If step therapy coverage requirements are not met for a prescription and your physician or health care provider believes the drug is medically necessary, the prior authorization process may be used and timeframes previously described will also apply.

Some drugs have a quantity limit (QL) that specifies quantity limitations or restrictions on prescriptions over time. Quantity limitations can take on various forms, the most typical being daily and monthly restrictions on the quantity issuance or re-issuance of a prescription. If a drug has a quantity limit, this Drug Formulary will specify QL in the "Coverage Requirements and Limits" column of the drug list.

Requests for prior authorization, non-formulary, quantity limit, or step therapy exceptions may be submitted electronically, by phone or fax. A prior authorization request is exigent circumstances when a Enrollee suffers from a health condition that may seriously jeopardize the Enrollee's life, health, or ability to regain maximum function. Exigent circumstance requests from Physicians for authorization are processed, and prescribing providers are

notified of CalOptima Health determination as soon as you can, not to exceed 24 hours, after receipt of the request and any additional information requested by CalOptima Health that is reasonably necessary to make the determination.

Routine requests from Physicians are processed, and prescribing providers are notified of CalOptima Health's determination in a timely fashion, not to exceed 72 hours. For both exigent circumstances and routine requests, CalOptima Health must also notify the Enrollee or their designee of its decision. If CalOptima Health fails to respond to a completed prior authorization or step therapy request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request is deemed granted.

If you are denied Prior Authorization, please refer to the "Grievances" portion of the Dispute Resolution Section in your CalOptima Health Evidence of Coverage or call CalOptima Health Member Services at 1-888-312-2221 (TTY 711), Monday-Friday, 8am-6pm. A "grievance" is any written or oral expression of dissatisfaction regarding the plan, a provider, and/or a pharmacy, including quality of care concerns, made by an enrollee or the enrollee's authorized representative. A grievance includes a complaint, dispute, request for reconsideration, or appeal made by the enrollee or their authorized representative.

What if my drug is non-formulary or not listed?
Sometimes, doctors may prescribe a drug that is not on the formulary. This will require that the doctor get authorization from CalOptima Health before you fill the prescription. To request a Formulary Exception, you, your Authorized Representative or your Prescribing Provider should follow the Prior Authorization Request process described above. To decide if the non-formulary drug will be covered, CalOptima Health may ask the doctor for a "supporting statement", which explains why the drug you are asking for is medically necessary. Once all of the required supporting information has been received, the Formulary Exception Request will be either approved or denied based on medical necessity within 72 hours for non-urgent requests, or within 24 hours in Exigent Circumstances. CalOptima Health will notify you or your Authorized Representative and your Prescribing Provider of its coverage determination within 24 hours of receipt of a request based on exigent circumstances and within 72 hours of receipt of all other requests. Exigent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a course of treatment using a non-formulary drug. CalOptima Health shall provide coverage pursuant to a non-urgent request for the duration of the prescription, including refills and shall provide coverage, including refills, pursuant to a request based on exigent circumstances for the duration of the exigency. If the Plan denies a Formulary Exception Request, the Enrollee, an Authorized Representative, or the Provider can file a grievance with the Plan.

Some drugs have coverage rules or limits on the amount you can get. In some cases, your doctor or other prescribers must do something before you can fill the prescription. For example, prior approval (or prior authorization): For some drugs, your doctor or other prescribers must get approval from CalOptima Health before you fill your prescription. If you do not get approval, CalOptima Health may not cover the drug. If you are denied Prior Authorization, please refer to the "Grievance" portion of the Dispute Resolution Section in your CalOptima Health Evidence of Coverage or call CalOptima Health Member Services at 1-888-312-2221 (TTY 711), Monday-Friday, 8am-6pm.

Participating retail pharmacies
You can fill prescriptions at any participating (network) pharmacy unless it is a prescription for specialty drug. CalOptima Health contracts with a wide network of retail pharmacies. To find a network pharmacy, visit www.caloptima.org.

What are specialty drugs?

Specialty drugs are drugs that may require coordination of care, close monitoring, or extensive patient training for self- administration. These requirements generally cannot be met by a retail pharmacy. Specialty drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain physicians or pharmacies or reporting of certain clinical events to the FDA. Specialty drugs are usually high cost.

Specialty drugs may require prior authorization for medical necessity by CalOptima Health. Most specialty drugs are available exclusively from a Network Specialty Pharmacy. If coverage is approved, a Network Specialty Pharmacy can provide the specialty drugs to you. Call CalOptima Health Member Services at 1-888-312-2221 (TTY 711), Monday-Friday, 8am-6pm, or visit www.caloptima.org if you have questions about specialty drugs.

Oral Anticancer Drugs

An Enrollee's cost share for orally administered anticancer medications covered under the plan will not exceed $250 for an individual prescription of up to a 30 day supply.

Mail order service pharmacy

CalOptima Health offers an easy-to-use mail service prescription drug program through our contracted mail service pharmacy. It can be a convenient way to fill maintenance medications for up to a 90-day supply. Maintenance medications are drugs that doctors prescribe on an ongoing, regular basis to maintain health. For more information on using the mail service prescription benefit, visit www.caloptima.org.