Vermont State Colleges System- Faculty

2024 Cigna True Choice Medicare (PPO) Formulary Addendum

2024 Standard Drug List Addendum

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Please read: This document contains information about the policies and criteria and any additional coverage offered with your plan.

Please visit **CignaMedicare.com/group/MAresources** to view the comprehensive 2024 Standard Drug List.

The drug list found on our website will be updated each month.

Are there any restrictions on my 2024 Cigna True Choice Medicare (PPO) coverage?

Some covered drugs may have additional requirements or limits on coverage. You can identify these by looking to the right of the name of the drug on the drug list located on our website. The requirements and limits for your plan are the following:

*	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a one-month supply.
^	This prescription drug has an administrative prior authorization requirement that is not waived. This drug may be covered under different benefits depending on circumstances.
+	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not apply to 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 this drug.
B/D PA	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on circumstances.
HRM	This high-risk medication requires prior authorization.
LA	Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.
V	This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).
PA	This drug requires prior authorization.
QL	This drug has quantity limits.
ST	This drug has step therapy requirements.

Where can I find the list of covered drugs for my plan?

You can visit **CignaMedicare.com/group/MAresource** to view the current list of covered drugs for the **2024 Standard Drug List**. While there, you can also view documents that explain our prior authorization and step therapy restrictions as well as other useful plan information. To locate the drug list you need, simply visit the location above and search for the **2024 Standard Drug List.**

What additional coverage is available with my plan?

The following pages include additional coverage offered by Vermont State Colleges System. This coverage includes drugs that are normally excluded from CMS coverage that Vermont State Colleges System has added to your plan. The cost share you pay for these drugs does not count towards your annual TrOOP.

Erectile Dysfunction Drugs^
Cough and Cold Drugs
Prescription Vitamins

^Some drugs are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories. Please review your 2024 Standard drug list for more information.

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. If your insulin is on a tier where cost-sharing is lower than $35, you will pay the lower cost for your insulin.

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. Call Customer Service for more information.

Covered Diabetic Test Strips and Meters
You will not pay more than $0 for Preferred Products.

Covered Diabetic Lancets and Control Solutions
You will not pay more than $0 for this benefit.

2024 Erectile Dysfunction and Lifestyle Supplemental Benefits

Drug Name	Drug Tier	Requirements / Limits
Sexual Dysfunction Supplemental Benefits		
ADDYI	2	QL 30/30,+
CAVERJECT VIALS	2	QL 6/30,+
CAVERJECT IMPULSE	2	QL 6/30,+
CIALIS 2.5 MG, 5 MG	2	PA, **^,** QL 8/30,+
CIALIS 10 MG, 20 MG	2	PA, **^,** QL 8/30,+
EDEX 10 MCG, 20 MCG, 40 MCG CARTRIDGES	2	QL 6/30,+
MUSE 250 MCG, 500 MCG, 1000 MCG URETHRAL SUPPOSITORY	2	QL 6/30,+
sildenafil 25 mg, 50 mg, 100 mg tablets (generic Viagra)	1	QL 8/30,+
STENDRA 50 MG, 100 MG, 200 MG TABLETS	2	QL 8/30,+
tadalafil 2.5 mg, 5 mg (generic Cialis)	1	PA, ^, QL 8/30,+
tadalafil 10 mg, 20 mg (generic Cialis)	1	PA, ^, QL 8/30,+
vardenafil tab 2.5 mg, 5 mg, 10 mg, 20 mg tablets	1	QL 8/30,+
vardenafil odt tab	1	QL 8/30,+
VIAGRA 25 MG, 50 MG, 100 MG	2	QL 8/30,+
VYLEESI	2	QL 30/30,+

2024 Cough and Cold Buy Up (Prescription Only)

Drug Name	Drug Tier	Requirements / Limits
Cough and Cold Supplemental Benefits		
benzonatate capsules 100mg, 150 mg, 200mg	1	+
benzonatate pearle 100 mg cap	1	
BROMFED DM 2-30-10 MG/5 ML SYR	2	+
bromphen-pse-dm 2-30-20 mg/5ml syr	1	+
CAPCOF LIQUID	2	+
codeine-guaifen 10-100 mg/5 ml	1	+
CODITUSSIN AC LIQUID	2	+
CODITUSSIN DAC LIQUID	2	+
g tussin ac liquid	1	+
guaiatussin ac liquid	1	+
guaifen-codeine 100-10mg/5ml	1	+
GUAIFEN-COD 100-10MG/ML, 200-20MG/10ML	2	+
guaifenesin ac cough syrup	1	+
guaifenesin dac oral solution	1	+
guaifenesin-codeine syrup (generics)	1	+
HISTEX-AC SYRUP	2	+
hydrocodone-chlorphen er susp	1	+
hydrocodone-homatropine 5-1.5	1	+
hydrocodone-homatropine soln	1	+
hydromet 5mg-1.5mg/5ml soln	1	+
MAR-COF BP LIQUID	2	+
MAR-COF CG LIQUID	2	+
MAXI-TUSS AC LIQUID	2	+
MAXI-TUSS CD LIQUID	2	+
m-clear wc liquid	1	+
Cough and Cold Supplemental Benefits		
M-END PE LIQUID	2	+

Drug Name	Drug Tier	Requirements / Limits
NINJACOF-XG LIQUID	2	+
OBREDON 2.5-200 MG/5 ML SOLN	2	+
pcm la tablet	1	+
pe-guai drops	1	+
POLY-TUSSIN AC LIQUID	2	+
promethazine-codeine syrup, solution	1	+
promethazine-dm solution	1	+
promethazine-dm syrup 6.25-15mg/5ml	1	+
promethazine-pe-codeine syrup	1	+
promethazine-vc codeine solution	1	+
RESPA A.R. TABLET SA	2	+
rydex liquid	1	+
TUXARIN ER 8-54.3 MG TABLET	2	+
TUZISTRA XR 14.7-2.8 MG/5 ML	2	+
virtussin dac liquid	1	+

2024 Prescription Vitamins Supplemental Benefits

Drug Name	Drug Tier	Requirements / Limits
Prescription Vitamins Supplemental Benefits		
AQUASOL A 100,000 UNITS/2ML VIAL	2	+
ascorbic acid 500 mg/ml vial	1	+
AZESCO TABLET	2	+
BAL-CARE DHA ESSENTIAL PACK	2	+
B-12 COMPLIANCE INJ KIT	2	+
b-complex 100 injection	1	+
calcitriol 0.25 mcg capsule	1	+
calcitriol 0.5 mcg capsule	1	+
calcitriol 1 mcg/ml ampul	1	+
cyanocobalamin 1,000 mcg/ml	1	+
DERMACINRX PRENATRIX CAPLET	2	+
DRISDOL 1.25 MG (50,000 UNIT)	2	+
DUET DHA 400 COMBO PACK, BALANCED	2	+
EMBRACE HR SOFTGEL	2	+
FERAHEME 510 MG/17 ML VIAL	2	+
FERRLECIT 62.5 MG/5 ML VIAL	2	+
FERUMOXYTOL 510 MG/17 ML VIAL	2	+
folic acid 1 mg tablet	1	+
folic acid 5 mg/ml vial	1	+
GALZIN 25 MG, 50MG CAPSULE	2	+
HECTOROL 2 MCG/ML, 4 MCG/2ML VIALS	2	+
INFED 100 MG/2ML VIAL	2	+
INFUVITE ADULT, PEDIATRIC	2	+
INJECTAFER 100 MG/2 ML VIAL	2	+
INJECTAFER 750 MG/15 ML VIAL	2	+
IODOPEN 100 MCG/ML VIAL	2	+
hydroxocobalamin 1,000 mcg/ml	1	+

Drug Name	Drug Tier	Requirements / Limits
MEPHYTON 5 MG TABLET	2	+
METHYLCOBALAMIN 10,000 MCG VIAL	2	+
m-natal plus tablet	1	+
MONOFERRIC 1,000 MG/10 ML VIAL	2	+
mynatal-z captab	1	+
NASCOBAL 500 MCG NASAL SPRAY	2	+
NEEVODHA CAPSULE	2	+
NESTABS ABC PRENATAL COMBO PK	2	+
NESTABS DHA COMBO PAK	2	+
NESTABS ONE SOFTGEL	2	+
NESTABS TABLET	2	+
newgen tablet	1	+
OBSTETRIX DHA COMBOPAK	2	+
OBSTETRIX EC CAPLET	2	+
OBSTETRIX ONE SOFTGEL	2	+
PHYTONADIONE 1 MG/0.5 ML SYRINGE	2	+
PHYTONADIONE 10 MG/ML AMPUL	2	+
phytonadione 5mg tablet	*1*	*+*
POTABA 500 MG CAPSULE	2	+
prenatabs rx tablet	1	+
PRENATE ELITE TABLET	2	+
PRENATE ESSENTIAL SOFTGEL	2	+
PRENATE STAR TABLET	2	+
PROVIDA DHA CAPSULE	2	+
PUREFE OB PLUS CAPSULE	2	+
pyridoxine 100 mg/ml vial	1	+
RAYALDEE ER 30 MCG CAPSULE	2	+
ROCALTROL 0.25 MCG CAPSULE	2	+
ROCALTROL 0.5 MCG CAPSULE	2	+
ROCALTROL 1 MCG/ML ORAL SOLN	2	+

Drug Name	Drug Tier	Requirements / Limits
se natal 19 chewable caplet, tablet	1	+
strong iodine solution	1	+
thiamine 200 mg/2 ml vial	1	+
TRIVITE RX TABLET	2	+
TRIFERIC 27.2 MG/5 ML AMPULE	2	+
TRIFERIC 272 MG POWDER PACKET	2	+
trinatal rx 1 tablet	1	+
TRINAZ TABLET	2	+
TRISTART DHA SOFTGEL	2	+
trust natal dha	1	+
VENOFER 100 MG/5 ML VIAL	2	+
VENOFER 200 MG/10 ML VIAL	2	+
VENOFER 50 MG/2.5 ML VIAL	2	+
VITAFOL GUMMIES, NANO TABLET, OB CAPLET	2	+
vitamin D2 1.25mg (50,000 unit) RX	1	+
vitamin K1 10 mg/ml, 1mg/0.5ml ampule	1	+
VITAPEARL SOFTGEL	2	+
VITATRUE COMBO PACK	2	+
wescap-c dha softgel	1	+
wesnate dha softgel	1	+
westab plus tablet	1	+
westgel dha softgel	1	+
ZALVIT TABLET	2	+
zatean pn dha capsule	1	+
zatean pn plus softgel	1	+
ZEMPLAR 1 MCG, 2 MCG CAPSULE	2	+
ZEMPLAR 10 MCG/2ML, 2 MCG/ML, 5 MCG/ML VIALS	2	+
zinc sulfate 10 mg/10ml, 30 mg/10 ml, 25mg/5ml vials	1	+
zingiber tablet	1	+
ZIPHEX TABLET	2	+

2024 Diabetic Glucose Testing Supplies

Drug Name	Medical Benefit	Requirements/Limits
BLOOD GLUCOSE MONITORING DEVICES & SUPPLIES		
PREFERRED DIABETIC METERS		
DEXCOM G6 RECEIVER	Part B $0 Copay	QL (1 EA/ 2 years)
DEXCOM G6 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
DEXCOM G6 TRANSMITTER	Part B $0 Copay	
DEXCOM G7 RECEIVER	Part B $0 Copay	QL (1 EA/ 2 years)
DEXCOM G7 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
DEXCOM RECEIVER KIT	Part B $0 Copay	QL (1 EA/ 2 years)
FREESTYLE GLUCOSE METER	Part B $0 Copay	QL (1 EA/ 2 years)
FREESTYLE FREEDOME LITE METER	Part B $0 Copay	QL (1 EA/ 2 years)
FREESTYLE LIBRE 14 DAY SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 14 DAY READER	Part B $0 Copay	QL (1 EACH /2 years)
FREESTYLE LIBRE 2 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 2 READER	Part B $0 Copay	QL (1 EACH/ 2 years)
FREESTYLE LIBRE 3 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 3 READER	Part B $0 Copay	QL (1 EACH/ 2 years)
FREESTYLE LITE GLUCOSE METER	Part B $0 Copay	QL (1 EACH/ 2 years)
FREESTYLE PRECISION NEO METER	Part B $0 Copay	QL (1 EACH/ 2 years)
ONETOUCH ULTRA2 GLUCOSE SYST	Part B $0 Copay	QL (1 EACH/ 2 years)
ONETOUCH VERIO FLEX METER	Part B $0 Copay	QL (1 EACH/ 2 years)
ONETOUCH VERIO REFLECT METER	Part B $0 Copay	QL (1 EACH/ 2 years)
PREFERRED DIABETIC GLUCOSE TEST STRIPS		
FREESTYLE LITE GLUCOSE TEST STRIPS	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)
FREESTYLE PREC NEO TEST STRIPS	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)
ONETOUCH ULTRA TEST STRIP	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)
ONETOUCH VERIO TEST STRIP	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)

2024 Covered Diabetic Lancets and Control Solutions

All lancing devices, lancets, and control solutions for diabetic blood sugar monitoring are covered. Below are examples of products available at the time the list was created.

Drug Name	Medical Benefit	Requirements/Limits
DIABETIC SUPPLIES MISCELLANEOUS		
CONTROL SOLUTIONS (EXAMPLES)		
FREESTYLE CONTROL SOLUTIONS	Part B $0 Copay	
ONETOUCH CONTROL SOLUTIONS	Part B $0 Copay	
LANCETS AND LANCING DEVICES (EXAMPLES)		
ACTI-LANCE LANCETS	Part B $0 Copay	
BD LANCETS DEVICES	Part B $0 Copay	
BD LANCETS	Part B $0 Copay	
E-Z JECT LANCETS	Part B $0 Copay	
FREESTYLE LANCETS	Part B $0 Copay	
LANCING DEVICES	Part B $0 Copay	
LANCETS	Part B $0 Copay	
MEDLANCE PLUS LANCETS	Part B $0 Copay	
ONETOUCH LANCET DEVICES	Part B $0 Copay	
ONETOUCH LANCETS	Part B $0 Copay	

1-888-281-7867 (TTY 711)

October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Customer service also has free language interpreter services available for non-English speakers.

CignaMedicare.com/group/MAresources