You can contact CarePlus for the most recent list of drugs by calling 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. You may also visit www.careplushealthplans.com.

This document applies to the following CarePlus Plans:

Plan	Market	Formulary ID	Version
H1019043	Treasure and Space Coast	19434	15
H1019065	South Florida: Broward, Palm Beach	19434	15
H1019069	North Florida	19435	15
H1019073	North Florida	19434	15
H1019085	North Florida	19434	15
H1019090	Treasure and Space Coast	19434	15
H1019091	Treasure and Space Coast	19434	15
H1019094	North Florida	19434	15

Drug Name	Step Therapy Criteria
ALMOTRIPTAN MALATE	An automatic approval will be given to members who have had previous treatment with two of the following: naratriptan, sumatriptan or rizatriptan.
AMOXICIL-CLARITHROMY-LANSOPRAZ	An automatic approval will be given to members who have had previous treatment, intolerance, or contraindication with Pylera.
ASPIRIN-DIPYRIDAMOLE	An automatic approval will be given to members who have had previous treatment with clopidogrel.
AZELAIC ACID	An automatic approval will be given to members who have had previous treatment with topical metronidazole.
BYETTA	An automatic approval will be given to members who have had previous treatment with at least two preferred GLP 1 Analogs (e.g. Victoza, Trulicity, Ozempic, Bydureon).
DARIFENACIN	An automatic approval will be given to members who have had previous treatment with two of the following: Oxybutynin (IR or ER), Toviaz, or Myrbetriq.
EZETIMIBE-SIMVASTATIN	An automatic approval will be given to members who have had previous treatment with two of the following statins: simvastatin, pravastatin, lovastatin, atorvastatin or rosuvastatin.
FENOFIBRATE MICRONIZED	An automatic approval will be given to members who have had previous treatment to one strength of generic fenofibrate tablet (145mg, 160mg, 48mg,54 mg) AND one strength of generic fenofibrate micronized capsule (200 mg, 134 mg, 67 mg).
FINACEA	An automatic approval will be given to members who have had previous treatment with topical metronidazole.
FROVATRIPTAN	An automatic approval will be given to members who have had previous treatment with two of the following: naratriptan, sumatriptan or rizatriptan.
LEVALBUTEROL TARTRATE	An automatic approval will be given to members who have had previous treatment with Ventolin HFA.

Drug Name	Step Therapy Criteria
MOMETASONE	An approval will be given to members who have had previous treatment with two of the following: Fluticasone nasal spray, Azelastine nasal spray, Flunisolide nasal spray. If the member has nasal polyps OR for prophylaxis to seasonal allergic rhinitis, the request will be approved.
NAFTIFINE	An automatic approval will be given to members who have had previous treatment, contraindication, or intolerance to two of the following: clotrimazole cream, ciclopirox 0.77% cream/gel/suspension, or ketoconazole cream.
NAPROXEN SODIUM	An automatic approval will be given to members who have had previous treatment with two of the following oral generics: Meloxicam, Diclofenac, Ibuprofen, Naproxen.
NASONEX	An approval will be given to members who have had previous treatment with two of the following: Fluticasone nasal spray, Azelastine nasal spray, Flunisolide nasal spray. If the member has nasal polyps OR for prophylaxis to seasonal allergic rhinitis, the request will be approved.
NUCYNTA	An automatic approval will be given to members who have had previous trial with at least two (2) of the following agents: oxycodone IR, hydromorphone, morphine sulfate IR.
OLOPATADINE	An automatic approval will be given to members who have had previous treatment with two of the following: Fluticasone nasal spray, Azelastine nasal spray or Flunisolide nasal spray.
OLOPATADINE	An automatic approval will be given to members who have had previous trial with at least two of the following agents: olopatadine 0.2%, azelastine, or cromolyn eye drops.
OMEPPI	An approval will be given to members who have had previous treatment or intolerance to omeprazole AND pantoprazole. For the diagnosis of reduction of risk of upper GI bleeding in critically ill patients, pantoprazole therapy is not required.

Drug Name	Step Therapy Criteria
OMEPRAZOLE-SODIUM BICARBONATE	An approval will be given to members who have had previous treatment or intolerance to omeprazole AND pantoprazole. For the diagnosis of reduction of risk of upper GI bleeding in critically ill patients, pantoprazole therapy is not required.
PATADAY	An automatic approval will be given to members who have had previous trial with at least two of the following agents: olopatadine 0.2%, azelastine, or cromolyn eye drops.
RANEXA	An automatic approval will be given to members who have had previous treatment with Calcium channel blockers (e.g. amlodipine) , beta blockers (e.g. metoprolol tartrate), or nitrates (e.g. isosorbide mononitrate ER, isosorbide mononitrate).
RANOLAZINE	An automatic approval will be given to members who have had previous treatment with Calcium channel blockers (e.g. amlodipine) , beta blockers (e.g. metoprolol tartrate), or nitrates (e.g. isosorbide mononitrate ER, isosorbide mononitrate).
RELPAX	An automatic approval will be given to members who have had previous treatment with two of the following: naratriptan, sumatriptan or rizatriptan.
RENAGEL	The member has had previous treatment, intolerance to, or contraindication to calcium acetate (tablet OR capsule) AND sevelamer carbonate (generic or brand Renvela powder packets OR tablets).
RYTARY	An automatic approval will be given to members who have had previous treatment or intolerance to an immediate-release or extended-release Carbidopa-Levodopa containing product.
SEVELAMER HCL	The member has had previous treatment, intolerance to, or contraindication to calcium acetate (tablet OR capsule) AND sevelamer carbonate (generic or brand Renvela powder packets OR tablets).

Drug Name	Step Therapy Criteria
SOLIQUA 100/33	An automatic approval will be given to members who have had previous treatment with or intolerance to at least one of the following products: a GLP-1 analog (e.g. Victoza, Trulicity, Bydureon, or Ozempic) OR a long acting insulin (insulin glargine [i.e. Lantus, Lantus Solostar, Toujeo], insulin degludec [i.e. Tresiba] OR insulin detemir [i.e. Levemir].)
SPRITAM	An automatic approval will be given to members who have had previous treatment with levetiracetam and one of the following: lamotrigine, carbamazepine, topiramate, divalproex, or phenytoin.
TELMISARTAN-HYDROCHLOROTHIAZID	An automatic approval will be given to members who have had previous treatment with two of the following: lisinopril, lisinopril-HCTZ, ramipril, benazepril, benazepril-HCTZ, quinapril, quinapril-HCTZ, enalapril, enalapril-HCTZ, Losartan, Losartan-HCTZ, Valsartan, Valsartan-HCTZ, Irbesartan, Irbesartan-HCTZ, Olmesartan, Olmesartan-HCTZ.
TRINTELLIX	An automatic approval will be given to members who have had previous treatment with a generic SSRI, SNRI, bupropion or mirtazapine.
ULORIC	An automatic approval will be given to members who have had previous treatment with Allopurinol.
VYTORIN 10-10	An automatic approval will be given to members who have had previous treatment with two of the following statins: simvastatin, pravastatin, lovastatin, atorvastatin or rosuvastatin.
VYTORIN 10-20	An automatic approval will be given to members who have had previous treatment with two of the following statins: simvastatin, pravastatin, lovastatin, atorvastatin or rosuvastatin.
VYTORIN 10-40	An automatic approval will be given to members who have had previous treatment with two of the following statins: simvastatin, pravastatin, lovastatin, atorvastatin or rosuvastatin.
VYTORIN 10-80	An automatic approval will be given to members who have had previous treatment with two of the following statins: simvastatin, pravastatin, lovastatin, atorvastatin or rosuvastatin.

Drug Name	Step Therapy Criteria
XULTOPHY 100/3.6	An automatic approval will be given to members who have had previous treatment with or intolerance to at least one of the following products: a GLP-1 analog (e.g. Victoza, Trulicity, Bydureon, or Ozempic) OR a long acting insulin (insulin glargine [i.e. Lantus, Lantus Solostar, Toujeo], insulin degludec [i.e. Tresiba] OR insulin detemir [i.e. Levemir].)

Discrimination is against the law

CarePlus Health Plans, Inc. ("CarePlus") complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. CarePlus does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. CarePlus provides:

- Free assistance and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Video remote interpretation
  - Written information in other formats
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call the number on the back of your Member ID Card or contact Member Services using the information below.

If you believe that CarePlus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion, you can file a grievance with: **CarePlus Health Plans, Inc. Attention: Member Services Department.** 11430 NW 20th Street, Suite 300. Miami, FL 33172.

Telephone: **1-800-794-5907;** (**TTY: 711**). From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within 1 business day. Fax: **1-800-956-4288**.

You can file a grievance in person or by mail, phone or fax. If you need help filing a grievance, our Member Services Representatives are available to help you at the contact information listed above.

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; 800-537-7697 (TDD)** Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-794-5907 (TTY: 711).

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-794-5907 (TTY: 711).

繁體中文 (Chinese): 注意： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-794-5907 (TTY: 711)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-794-5907 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-794-5907 (TTY: 711) 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-794-5907 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-794-5907 (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-794-5907 (TTY: 711).

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-794-5907 (ATS : 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-794-5907 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-794-5907 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-794-5907 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-794-5907 (TTY: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-794-5907 (TTY: 711).

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-800-794-5907 (TTY: 711).

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-794-5907 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-794-5907 (رقم هاتف الصم والبكم: 711).