

LEARN ABOUT YOUR PHARMACY PROGRAM

COVERED MEDICATIONS (FORMULARY)

**For members with the Blue Cross Blue Shield
of Massachusetts Formulary**

(Includes coverage for GLP-1 medications)

This guide includes important information about your pharmacy coverage, and lists some of the medications covered under your plan, as well as medications that aren't covered.



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PHARMACY PROGRAM OVERVIEW

Your pharmacy program is designed to provide you and your health care provider with access to a wide variety of safe, clinically effective medications. We've carefully developed a substantial covered medications list, also known as a formulary, that includes many medications available at affordable out-of-pocket costs.

ABOUT THIS GUIDE

This guide is up to date as of January 1, 2026, and is subject to change. Use it as a reference whenever you need coverage information about your pharmacy program. For the most current and complete information about covered medications, use our **Medication Lookup** tool at bluecrossma.org/medication.

MAIL SERVICE PHARMACY

You can have certain maintenance medications, also known as long-term medications, delivered right to your door when you order them through the mail service pharmacy. Most medications are available at a lower cost, and standard shipping is always included. You even have the option to have your medications automatically refilled and shipped every 90 days.

To get started with the mail service pharmacy, sign in to MyBlue or create an account at bluecrossma.org. Once signed in, click **90-Day Mail Service Pharmacy** under **My Medications**. You can also call CVS Customer Care at 1-877-817-0477 (TTY: 711).

GET A PERSONALIZED VIEW OF YOUR HEALTH PLAN WITH MYBLUE

MyBlue is your personalized online member account that makes understanding and using your health plan simple. Sign in to MyBlue or create an account at bluecrossma.org to review claims, track medications, look up plan information, and get easy access to these online resources:

Medication Lookup Tool

Visit bluecrossma.org/medication to search quickly and easily for covered medications, and learn about your pharmacy coverage. The information in the tool represents our standard pharmacy coverage. Your coverage may vary. In most cases, Teamsters Local 170 Health and Welfare Fund members will be responsible for paying Tier 3 out-of-pocket costs when purchasing non-covered medications, unless these medications are excluded from your pharmacy coverage.

If you have any questions, call Team Blue at 1-800-932-8323.

Pharmacy Benefit Manager

Go to **Pharmacy Benefit Manager** under **My Medications** to look up the cost of medications, search for a local pharmacy, or sign up for the mail service pharmacy and have your medications shipped directly to you.

HOW TIERS DETERMINE WHAT YOU PAY FOR MEDICATIONS

Our list of covered medications is based on a tiered cost structure. When you fill a prescription, the amount you pay the pharmacy is determined by your medication's tier and your benefits. The amount you pay may also include your copayment, co-insurance, and deductibles. The pharmacist will tell you what you owe at checkout. To find your out-of-pocket costs in advance, sign in to MyBlue or create an account at bluecrossma.org. Once signed in, click **Price a Medication** under **My Medications**.

HOW COVERED MEDICATIONS ARE PLACED INTO TIERS

Medications are placed into tiers according to a variety of factors, including what they're used for, their cost, and whether equivalent or alternative medications are available. Lower-tier medications typically cost less than higher-tier medications. For example, in a 3-tier structure, you'll likely pay the least for Tier 1 medications and the most for Tier 3 medications.

3-tier plan structure	
Tier 1: Generics	Generic medications are effective, low-cost alternatives to brand-name medications. They're expected to work the same as brand-name medications, and meet the same Food and Drug Administration (FDA) requirements.
Tier 2: Preferred brands	These are preferred brand-name medications because they're safe, effective alternatives to more expensive brands.
Tier 3: Non-preferred brands	Non-preferred brand-name medications cost more than preferred brands, so you'll pay more if you use them instead of any generics or preferred brands.



IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION COVERAGE

- If you or your provider should request a brand-name medication to be dispensed when there is a generic equivalent medication available—also known as a “Dispense as Written” prescription—you’ll pay the brand copayment plus the difference in cost between the brand-name and generic medications. This difference in cost is also referred to as an ancillary fee.
- Ancillary fees will be waived for brand-name versions of select medications for treatment of seizures (carbamazepine and phenytoin), heart rhythm disorders (digoxin, flecainide, and quinidine), blood thinners (warfarin), asthma (theophylline), transplant immunosuppressants (cyclosporine, sirolimus, and tacrolimus), bipolar disorder (lithium), and thyroid supplementation (levothyroxine sodium).
- Certain medications can be filled in supplies that last longer than 30 days. For some of these medications, you’ll be charged for more than one 30-day copayment per fill. For example, if you fill a prescription for a 90-day supply of Estrin, you’ll be charged three 30-day copayments.
- Your plan covers you for the following medications with a valid prescription: proton pump inhibitors (PPIs), such as omeprazole and Prilosec, as well as over-the-counter versions of these medications; and over-the-counter versions of h2 blockers, such as ranitidine.
- The over-the-counter naloxone and Narcan nasal sprays are covered at no cost when purchased at an in-network pharmacy.¹ In life-threatening situations, these products can be used to reverse an overdose from opioids. To learn more, visit [cdc.gov/stop-overdose/caring/naloxone.html](https://www.cdc.gov/stop-overdose/caring/naloxone.html).

Learn more about your coverage

To learn more, call Team Blue Member Service at the number on your ID card,
Monday through Friday, 8:00 a.m. to 6:00 p.m. ET.

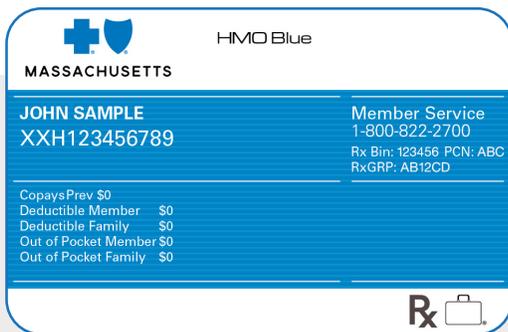
1. In some cases, a prescription from your doctor may still be required when purchasing the over-the-counter nasal sprays outside of Massachusetts.

COMPOUNDED MEDICATIONS

Compounded medications are made to order by a pharmacist when existing, commercially available medications don't meet your specific needs as determined by your provider. Covered compounded medications that require a prescription will be processed at your highest pharmacy benefit tier, regardless of the ingredients in the medication. Some compounded medications may need prior authorization, have quality care dosing guidelines, or require an exception.

COVERED MEDICATIONS LIST CHANGES

Our covered medications list may change from time to time. This may include changing medications to a non-covered status, changing medication tier status, applying quality care dosing limitations, and/or moving medications to a specialty pharmacy. Affected members will be notified of these changes at least 60 days in advance of the change.



Sample ID card for illustrative purposes only.

YOUR ID CARD

Your ID card contains important information about your pharmacy benefits. Be sure to bring the card with you and give it to the pharmacist when you fill a prescription.

PREVENTIVE MEDICATIONS

The following list includes prescription and over-the-counter medications that are covered at no cost to you when they're prescribed by your provider:

- **Bowel preparations** (includes generic medications, or brand-name medications without a generic equivalent, and over-the-counter evacuants when they're prescribed by your doctor) are covered for members ages 50 to 75 prior to colorectal screening exams
- **Breast cancer preventive medications** (tamoxifen and raloxifene) are covered for members ages 35 and older without a prior diagnosis of breast cancer
- **Erythromycin eye ointment** is covered for infants up to 12 months old
- **Fluoride supplements** are covered for children ages 6 months through 16 years
- **Generic aspirin** (81mg)
- **Generic contraceptives**, or brand-name medications without a generic equivalent (includes prescription contraceptives and over-the-counter products such as female condoms, sponges, and spermicide) are covered for members up to age 54
- **Generic folic acid** (includes prescription and over-the-counter) is covered for members up to age 54
- **Generic iron** is covered for infants up to 12 months old
- **Generic smoking cessation** (such as nicotine gum, lozenges, and patches), or brand-name medications without a generic equivalent, are covered for up to a 168-day supply per calendar year
- **Generic Vitamin D** (up to 800 IU per day) is covered for members ages 65 and older
- **Various vaccines** are covered (age requirements vary by vaccine type)

This list is up to date as of January 1, 2026.



QUALITY CARE DOSING

Our quality care dosing program helps to ensure that the quantity and dosage of the medications you receive meet the FDA's regulations, clinical standards, and manufacturer's guidelines. When you fill a prescription for one of the following medications, it's checked electronically in two ways:

DOSE CONSOLIDATION

Checks to see whether you're taking two or more pills a day that can be replaced with one pill providing the same daily dosage.

RECOMMENDED MONTHLY DOSING LEVEL

Checks to see that your monthly dosage is consistent with the FDA's and manufacturer's monthly dosing recommendations and clinical information.



You may fill a quantity up to the allowed limit, but quantities greater than the allowed limit will be denied.

Note: Your provider may request an exception for medications that are subject to quality care dosing when medically necessary. Some medications on this list may also be subject to step therapy and/or prior authorization requirements, or be considered a specialty medication. Check the corresponding pages to determine coverage requirements.

This list of medications in our quality care dosing program is up to date as of January 1, 2026, and may change from time to time.

For the most current list of medications subject to quality care dosing, along with associated dosing limits, use our **Medication Lookup** tool at bluecrossma.org/medication.

QUALITY CARE DOSING

Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Stratterra (PA17)
 Subsys * (PA)
 Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
 Tudorza
 Valacylovir
 Valtrex
 Venlafaxine ER capsule
 Venlafaxine ER tablet (ST)
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle

Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Stratterra (PA17)
 Subsys * (PA)

Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
 Tud
 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellb
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle
 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv

Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle
 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv



PRIOR AUTHORIZATION

Before coverage is approved for certain medications, your provider must first request prior authorization. Using clinical-based medical standards, the prior authorization process ensures that you meet certain medical criteria, and that the medication being prescribed is necessary to treat you.

Our prior authorization program includes step therapy. Refer to the step therapy section in this guide for more information.

Note: Some medications on this list may also be subject to step therapy and/or quality care dosing requirements, or be considered a specialty medication. Check the corresponding pages to determine coverage requirements.

This list of medications that require prior authorization is up to date as of January 1, 2026, and may change from time to time.

For the most current list of medications that require prior authorization, use our **Medication Lookup** tool at bluecrossma.org/medication.

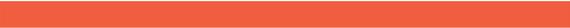
PRIOR AUTHORIZATION

Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Stratterra (PA17)
 Subsys * (PA)
 Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
 Tudorza
 Valacylovir
 Valtrex
 Venlafaxine ER capsule
 Venlafaxine ER tablet (ST)
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle

Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
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 Zegerid * (PA)
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 Zetonna *
 Zocor * (ST)
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 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Stratterra (PA17)
 Subsys * (PA)

Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
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 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
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 Zolmitriptan ODT
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 Zolpidem ER
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 Zubsolv
 Ventolin HFA *
 Veramyst *
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 Viibryd * (ST)
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 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *

Zaleplon
 Zegerid * (PA)
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 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
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 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
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 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv



STEP THERAPY

Step therapy, which is a key part of our prior authorization program, ensures that your provider prescribes you an effective and affordable medication treatment. Before coverage is allowed for certain second-step medications, your provider must first prescribe a more affordable, yet clinically appropriate first-step medication. Some medications may go through multiple steps before being approved.

Note: Some medications on this list may also be subject to quality care dosing requirements, or be considered a specialty medication. Check the corresponding pages to determine coverage requirements.

This list of medications in our step therapy program is up to date as of January 1, 2026, and may change from time to time.

For the most current list of medications that require step therapy, use our **Medication Lookup** tool at bluecrossma.org/medication.

STEP THERAPY

Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Strattera (PA17)
 Subsys * (PA)
 Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
 Tudorza
 Valacylovir
 Valtrex
 Venlafaxine ER capsule
 Venlafaxine ER tablet (ST)
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle

Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
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 Zocor * (ST)
 Zofran *
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 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
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 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Strattera (PA17)
 Subsys * (PA)

Sumatriptan
 Sumavel Dosepro *
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 Symbyax (ST)
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 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
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 Wellbutrin XL * (ST)
 Xopenex HFA *
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 Zegerid * (PA)
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 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv

SPECIALTY PHARMACY MEDICATIONS

In our formulary, some medications are classified as specialty medications. These medications are usually used to treat complex health conditions. We've developed a network of specialty pharmacies that are experienced in dispensing these medications. You're required to fill most specialty medications through one of the pharmacies listed below. However, if a highly specialized medication isn't available at one of our specialty pharmacies, we'll cover the cost of the medication when it's filled at an in-network pharmacy. For a list of specialty medications, see the following pages.

SPECIALTY NETWORK PHARMACY CONTACT INFORMATION

Accredo®

1-877-988-0058

Fax: 1-800-391-9707

accredo.com

Walgreens Specialty Pharmacy

1-888-347-3416

Fax: 1-877-231-8302

walgreensspecialtyrx.com

CVS Specialty™

1-866-846-3096

Fax: 1-800-323-2445

cvsspecialty.com

SPECIALTY NETWORK PHARMACY CONTACT INFORMATION FOR FERTILITY MEDICATIONS

CVS Specialty

1-866-846-3096

Fax: 1-800-323-2445

cvsspecialty.com

Freedom Fertility Pharmacy

1-866-297-9452

Fax: 1-888-660-4283

freedomfertility.com

Village Fertility Pharmacy

Boston (Waltham), MA location only

1-877-334-1610

Fax: 1-877-334-1602

vfppharmacygroup.com

Note: Some medications on this list may also be subject to step therapy, prior authorization, and/or quality care dosing requirements. Check the corresponding pages to determine coverage requirements.

This list of specialty medications is up to date as of January 1, 2026, and may change from time to time.

For the most current specialty medication and specialty pharmacy network information, use our **Medication Lookup** tool at bluecrossma.org/medication.

SPECIALTY PHARMACY MEDICATIONS

Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Strattera (PA17)
 Subsys * (PA)
 Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
 Tudorza
 Valacylovir
 Valtrex
 Venlafaxine ER capsule
 Venlafaxine ER tablet (ST)
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle

Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Restasis (PA)
 Rhinocort Aqua *
 Ritalin LA *
 Rizatriptan
 Rozerem (ST)
 Sancuso *
 Sarafem * (ST)
 Selferma
 Serevent Diskus
 Sertraline
 Silenor * (ST)
 Simcor * (ST)
 Simponi (PA) (SP)
 Simvastatin
 Sonata (ST)
 Spiriva
 Sporanox *
 Strattera (PA17)
 Subsys * (PA)

Sumatriptan
 Sumavel Dosepro *
 Symbicort (ST)
 Symbyax (ST)
 Terazosin
 Terbinafine
 Terbinex *
 Tranexamic Acid
 Treximet *
 Triamcinolone (nasal spray)
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 Vytorin * (ST)
 Vyvanse *
 Wellb
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
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 Ventolin HFA *
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 Vigamox
 Viibryd * (ST)
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 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv

Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
 Zocor * (ST)
 Zofran *
 Zofran ODT *
 Zolmitriptan
 Zolmitriptan ODT
 Zoloft * (ST)
 Zolpidem
 Zolpidem ER
 Zolpimist * (ST)
 Zubsolv
 Ventolin HFA *
 Veramyst *
 Vigamox
 Viibryd * (ST)
 Vivelle
 Vivelle-Dot
 Vytorin * (ST)
 Vyvanse *
 Wellbutrin SR * (ST)
 Wellbutrin XL * (ST)
 Xopenex HFA *
 Zaleplon
 Zegerid * (PA)
 Zetia (ST)
 Zetonna *
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 Zubsolv



MEDICATION INDEX

This index is a list of the medications referenced in this guide.

MEDICATION INDEX

Restasis (PA)	Vivelle-Dot	Sumatriptan	Zaleplon
Rhinocort Aqua *	Vytorin * (ST)	Sumavel Dosepro *	Zegerid * (PA)
Ritalin LA *	Vyvance *	Symbicort (ST)	Zetia (ST)
Rizatriptan	Wellbutrin SR * (ST)	Symbyax (ST)	Zetonna *
Rozerem (ST)	Wellbutrin XL * (ST)	Terazosin	Zocor * (ST)
Sancuso *	Xopenex HFA *	Terbinafine	Zofran *
Sarafem * (ST)	Zaleplon	Terbinex *	Zofran ODT *
Selferma	Zegerid * (PA)	Tranexamic Acid	Zolmitriptan
Serevent Diskus	Zetia (ST)	Treximet *	Zolmitriptan ODT
Sertraline	Zetonna *	Triamcinolone (nasal spray)	Zoloft * (ST)
Silenor * (ST)	Zocor * (ST)	Tud	Zolpidem
Simcor * (ST)	Zofran *	Vivelle-Dot	Zolpidem ER
Simponi (PA) (SP)	Zofran ODT *	Vytorin * (ST)	Zolpimist * (ST)
Simvastatin	Zolmitriptan	Vyvance *	Zubsolv
Sonata (ST)	Zolmitriptan ODT	Wellb	Ventolin HFA *
Spiriva	Zoloft * (ST)	Zegerid * (PA)	Veramyst *
Sporanox *	Zolpidem	Zetia (ST)	Vigamox
Strattera (PA17)	Zolpidem ER	Zetonna *	Viibryd * (ST)
Subsys * (PA)	Zolpimist * (ST)	Zocor * (ST)	Vivelle
Sumatriptan	Zubsolv	Zofran *	Vivelle-Dot
Sumavel Dosepro *	Restasis (PA)	Zofran ODT *	Vytorin * (ST)
Symbicort (ST)	Rhinocort Aqua *	Zolmitriptan	Vyvance *
Symbyax (ST)	Ritalin LA *	Zolmitriptan ODT	Wellbutrin SR * (ST)
Terazosin	Rizatriptan	Zoloft * (ST)	Wellbutrin XL * (ST)
Terbinafine	Rozerem (ST)	Zolpidem	Xopenex HFA *
Terbinex *	Sancuso *	Zolpidem ER	Zaleplon
Tranexamic Acid	Sarafem * (ST)	Zolpimist * (ST)	Zegerid * (PA)
Treximet *	Selferma	Zubsolv	Zetia (ST)
Triamcinolone (nasal spray)	Serevent Diskus	Ventolin HFA *	Zetonna *
Tudorza	Sertraline	Veramyst *	Zocor * (ST)
Valacylovir	Silenor * (ST)	Vigamox	Zofran *
Valtrex	Simcor * (ST)	Viibryd * (ST)	Zofran ODT *
Venlafaxine ER capsule	Simponi (PA) (SP)	Vivelle	Zolmitriptan
Venlafaxine ER tablet (ST)	Simvastatin	Vivelle-Dot	Zolmitriptan ODT
Ventolin HFA *	Sonata (ST)	Vytorin * (ST)	Zoloft * (ST)
Veramyst *	Spiriva	Vyvance *	Zolpidem
Vigamox	Sporanox *	Wellbutrin SR * (ST)	Zolpidem ER
Viibryd * (ST)	Strattera (PA17)	Wellbutrin XL * (ST)	Zolpimist * (ST)
Vivelle	Subsys * (PA)	Xopenex HFA *	Zubsolv



Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. It does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS 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 or other formats)
- 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, call Member Service at the number on your ID card.

If you believe that Blue Cross Blue Shield of Massachusetts has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with the Civil Rights Coordinator by mail at Civil Rights Coordinator, Blue Cross Blue Shield of Massachusetts, 125 Technology Place, Hingham, MA 02043; phone at **1-800-472-2689** (TTY: **711**); fax at **1-617-246-3616**; or email at **civilrightscordinator@bcbsma.com**.

If you need help filing a grievance, the Civil Rights Coordinator 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, online at **ocrportal.hhs.gov**; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC 20201; by phone at **1-800-368-1019** or **1-800-537-7697** (TDD).

Complaint forms are available at **hhs.gov**.

PROFICIENCY OF LANGUAGE ASSISTANCE SERVICES

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Chinese/简体中文: 注意: 如果您讲中文, 我们可向您免费提供语言协助服务。请拨打您 ID 卡上的号码联系会员服务部 (TTY 号码: **711**)。

Haitian Creole/Kreyòl Ayisyen: ATANSYON: Si ou pale kreyòl ayisyen, sèvis asistans nan lang disponib pou ou gratis. Rele nimewo Sèvis Manm nan ki sou kat Idantifikasyon w lan (Sèvis pou Malantandan TTY: **711**).

Vietnamese/Tiếng Việt: LƯU Ý: Nếu quý vị nói Tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ được cung cấp cho quý vị miễn phí. Gọi cho Dịch vụ Hội viên theo số trên thẻ ID của quý vị (TTY: **711**).

Russian/Русский: ВНИМАНИЕ: если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Позвоните в отдел обслуживания клиентов по номеру, указанному в Вашей идентификационной карте (телетайп: **711**).

Arabic/العربية:

انتباه: إذا كنت تتحدث اللغة العربية، فتتوفر خدمات المساعدة اللغوية مجاناً بالنسبة لك. اتصل بخدمات الأعضاء على الرقم الموجود على بطاقة هويتك (جهاز الهاتف النصي للصم والبكم "TTY": **711**).

Mon-Khmer, Cambodian/ខ្មែរ: ការជូនជំនួយ: ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាឥតគិតថ្លៃ គឺអាចរកបានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិកតាមលេខនៅលើប័ណ្ណសម្គាល់សមាជិក (TTY: **711**)។

French/Français: ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le Service adhérents au numéro indiqué sur votre carte d'assuré (TTY: **711**).

Italian/Italiano: ATTENZIONE: se parlate italiano, sono disponibili per voi servizi gratuiti di assistenza linguistica. Chiamate il Servizio per i membri al numero riportato sulla vostra scheda identificativa (TTY: **711**).

Korean/한국어: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드에 있는 전화번호(TTY: **711**)를 사용하여 회원 서비스에 전화하십시오.

Greek/Ελληνικά: ΠΡΟΣΟΧΗ: Εάν μιλάτε Ελληνικά, διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε την Υπηρεσία Εξυπηρέτησης Μελών στον αριθμό της κάρτας μέλους σας (ID card) (TTY: **711**).

Polish/Polski: UWAGA: Osoby posługujące się językiem polskim mogą bezpłatnie skorzystać z pomocy językowej. Należy zadzwonić do Działu obsługi ubezpieczonych pod numer podany na identyfikatorze (TTY: **711**).

Hindi/हिंदी: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो भाषा सहायता सेवाएँ, आप के लिए नि:शुल्क उपलब्ध हैं। सदस्य सेवाओं को आपके आई.डी. कार्ड पर दिए गए नंबर पर कॉल करें।टी.टी.वाई.: **711**).

Gujarati/ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમને ભાષાકીય સહાયતા સેવાઓ વિના મૂલ્યે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડ પર આપેલા નંબર પર Member Service ને કોલ કરો (TTY: **711**).

Tagalog/Tagalog: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tawagan ang Mga Serbisyo sa Miyembro sa numerong nasa iyong ID card (TTY: **711**).

Japanese/日本語: お知らせ: 日本語をお話しになる方は無料の言語アシスタンスサービスをご利用いただけます。IDカードに記載の電話番号を使用してメンバーサービスまでお電話ください (TTY: **711**)。

German/Deutsch: ACHTUNG: Wenn Sie Deutsche sprechen, steht Ihnen kostenlos fremdsprachliche Unterstützung zur Verfügung. Rufen Sie den Mitgliederdienst unter der Nummer auf Ihrer ID-Karte an (TTY: **711**).

Persian/پارسیان:

توج: اگر زبان شما فارسی است، خدمات کمک زبانی ب صورت رایگان در اختیار شما قرار می گیرد. با شماره تلفن مندرج بروی کارت شناسایی خود با بخش «خدمات اعضا» تماس بگیرید (TTY: **711**).

Lao/ພາສາລາວ: ຂໍອວນໃສ່ໃຈ: ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການສະມາຊິກທີ່ໝາຍເລກໂທລະສັບຢູ່ໃນບັດຂອງທ່ານ (TTY: **711**).

Navajo/Diné Bizaad: BAA ÁKOHWIINDZIN DOOÍGÍ: Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíik'e bee níká'a'doowólgo éí ná'ahoot'i'. Díí bee anítahígí ninaaltsoos bine'déé' nóomba biká'ígííj'í' b'éésh bee hodíílnih (TTY: **711**).



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