

USE OUR PREFERRED MEDICARE ADVANTAGE NETWORK PHARMACIES TO HELP PATIENTS SAVE MONEY AND IMPROVE ADHERENCE

Provider's guide to Medicare Advantage medication management



**Preferred Medicare H0354-001, H0354-024 (HMO)
Cigna Achieve Medicare H0354-027 (HMO C-SNP)**
(Phoenix, Tucson)

Consider a formulary medication on a lower copay tier.

All Medicare Advantage patients receive an Annual Notice of Change which lists medications that Cigna covers. Please review this list at **Cigna.com** > Medicare > Member Resources and Services > [Medicare Drug List Formulary](#) to determine if there is an alternative medication that offers a lower copay.

Consider a **90-day supply** of a medication to help patients save money and time.

Copay savings at Preferred Pharmacies.

- **\$0 copay** for 90-day supply of Tier 1 and Tier 2 medications at preferred mail.
- **Savings** for 90-day supply of Tier 1 and Tier 2 at preferred retail pharmacies.
 - Medicare rules require application of deductibles, or coinsurance for Coverage Gap and Catastrophic phases.

Cigna Preferred Home Delivery Pharmacy:

- The Express Scripts PharmacySM e-prescribe or call **1-877-860-0982**

PATIENTS WITH LOW INCOME SUBSIDY (LIS)

LIS level	Deductible	Generic copay	Brand copay
1	\$0	\$3.95	\$9.85
2	\$0	\$1.35	\$4
3	\$0	\$0	\$0
4	\$99	15% coinsurance	15% coinsurance

LIS copays are applicable in all benefit phases. The maximum copay for a 90-day supply is the same as the maximum copay for a 30-day supply.

Over 32,000 pharmacies included in the Preferred Network

Cigna Preferred Network Pharmacies, patients will save **\$5** per month.

When it comes to your patient's health, finding a trusted pharmacy matters. We provide tools to help your patients find in-network pharmacies quickly at **Cigna.com** > Medicare > Resources > [Pharmacy Directories](#).

PREFERRED NETWORK PHARMACIES

Includes approximately 200 local independent pharmacies

- Albertsons Market Pharmacy
- Costco
- King Soopers Pharmacy
- Safeway
- Sam's Club
- Walgreens
- Walmart Pharmacy

PROVIDER'S GUIDE TO MEDICARE ADVANTAGE MEDICATION MANAGEMENT

(continued)

Preferred Medicare H0354-001, H0354-024 (HMO)

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DRUG NAME AND STRENGTH	TIER	DRUG NAME AND STRENGTH	TIER
Diabetes Adherence Measure		Hypertension Adherence Measure	
Glimepiride 1, 2,4 mg	1	Amlodipine/benazepril 2.5/10, 5/10, 5/20, 10/20, 5/40, 10/40mg	1
Glipizide 2.5, 5, 10 mg	1	Amlodipine/valsartan 5/160, 10/160, 5/320, 10/320	1
Glipizide-metformin 500, 850, 1,000 mg	1	Amlodipine/valsartan/HCTZ 5/160/12.5, 5/160/25, 10/160/12.5, 10/160/25, 10/320/25mg	1
Metformin 500, 750, 1,000 mg	1	Benazepril 5, 10, 20, 40mg	1
Metformin ER 750, 850 mg	1	Benazepril/HCTZ 5/6.25, 10/12.5, 20/12.5, 20/25mg	1
Nateglinide 60, 120 mg	1	Candesartan 4, 8, 16, 32mg	1
Pioglitazone 15, 30, 45 mg	1	Candesartan/HCTZ 16/12.5, 32/12.5, 32/25mg	1
Pioglitazone-metformin 15-500, 15-850 mg mg	1	Enalapril 2.5, 5, 10, 20mg	1
Repaglinide 0.5,1, 2 mg	1	Enalapril/HCTZ 5/12.5, 10/25mg	1
Acarbose 25, 50, 100 mg	2	Fosinopril 10, 20, 40mg	1
BYDUREON BCISE 2 mg/0.85 mL	3‡	Fosinopril/HCTZ 10/12.5, 20/12.5mg	1
GLYXAMBI 10-5 mg	3‡	Irbesartan 75, 150, 300mg	1
INVOKAMET and INVOKAMET XR	3‡	Irbesartan/HCTZ 150/12.5, 300/12.5mg	1
INVOKANA	3‡	Lisinopril 2.5, 5, 10, 20, 30, 40mg	1
JANUMET and JANUMET XR	3	Lisinopril/HCTZ 10/12.5, 20/12.5, 20/25mg	1
JANUVIA 25, 50, 100 mg	3	Losartan 25, 50, 100mg	1
JARDIANCE 10, 25 mg	3	Losartan/HCTZ 50/12.5, 100/12.5, 100/25mg	1
JENTADUETO and JENTADUETO XR	3	Moexipril 7.5, 15mg	1
Metformin oral solution 500 mg/5 mL	3‡	Olmesartan 5, 20, 40mg	1
OZEMPIC	3‡	Olmesartan/HCTZ 20/12.5, 40/12.5, 40/25mg	1
RYBELSUS 3, 7, 14 mg	3‡	Perindopril 2, 4, 8mg	1
SYNJARDY and SYNJARDY XR	3	Quinapril 5, 10, 20, 40mg	1
TRADJENTA 5 mg	3	Quinapril/HCTZ 10/12.5, 20/12.5, 20/25mg	1
TRIJARDY XR	3	Ramipril 1.25, 2.5, 5, 10mg	1
TRULICITY	3	Telmisartan 20, 40, 80mg	1
VICTOZA	3	Telmisartan/amlodipine 40/5, 40/10, 80/5, 80/10mg	1
Miglitol 25, 50,100 mg	4	Telmisartan/HCTZ 40/12.5, 80/12.5, 80/25mg	1
SYMLINPEN	5†	Trandolapril 1,2,4mg	1
Statin Adherence Measure		Valsartan 40, 80, 160, 320mg	1
Atorvastatin 10, 20, 40, 80mg	1	Valsartan/HCTZ 80/12.5, 160/12.5, 160/25, 320/12.5, 320/25mg	1
Lovastatin 10, 20mg, 40mg	1	TEKTURNA HCT 150/12.5, 150/25, 300/12.5, 300/25mg	3
Pravastatin 10, 20, 40, 80mg	1	Aliskiren 150, 300mg	4
Rosuvastatin 5, 10, 20, 40mg	1	EDARBI 40, 80mg	4
Simvastatin 5, 10, 20, 40, 80mg	1	EDARBYCLOR 40/12.5, 40/25mg	4
LIVALO 1, 2, 4mg	3		
Ezetimibe/Simvastatin 10/10, 10/20, 10/40, 10/80mg	4		

Highlighted drugs indicate Tier 1 preferred generic drugs. †Prior authorization or Step Therapy rules apply. ‡ Medication is covered on Tier 6, Select Care Tier for the Achieve Chronic Special Needs formulary.

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