NOTIFICATION OF FORMULARY CHANGES*
The following summary describes changes to the 2027 Presbyterian Dual Plus (HMO D-SNP) formulary.

The formulary may change at any time. You will receive notice when required.

For the most recent list of drugs, information on obtaining a coverage determination or exception, or other resources, visit **www.phs.org/Medicare** or contact our Presbyterian Customer Service Center at:



myPRES app or
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info@phs.org



(505) 923-7675 or
1-855-465-7737
(TTY 711)



October 1 - March 31: 8 a.m. to 8 p.m., seven days a week (except holidays)

April 1 - September 30: 8 a.m. to 8 p.m., Monday - Friday (except holidays)

Positive and Neutral Formulary Changes

Effective Date of Change	Drug Name	Description of Change	Tier	Additional Information	Formulary Alternative(s) and Tier (if applicable for FORMULARY DELETIONs)
01/01/2027	ABIGALE (1-0.5 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	ABIGALE LO (0.5-0.1 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	ADAPALENE (0.1 %) EXTERNAL CREAM	FORMULARY ADDITION	4		
01/01/2027	AJOVY (225 MG/1.5ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	4	PA, QL (1.5 ML PER 28 DAYS)	
01/01/2027	AJOVY (225 MG/1.5ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	FORMULARY ADDITION	4	PA, QL (1.5 ML PER 28 DAYS)	
01/01/2027	ALYQ (20 MG) ORAL TABLET	TIER DECREASE	4	PA, QL (2 EA PER 1 DAY), NDS	
01/01/2027	AMJEVITA-PED 10KG TO <15KG (10 MG/0.2ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	TIER DECREASE	4	PA	
01/01/2027	AMJEVITA-PED 15KG TO <30KG (20 MG/0.2ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	TIER DECREASE	4	PA, NDS	
01/01/2027	AMMONIUM LACTATE (12 %) EXTERNAL CREAM	FORMULARY ADDITION	2		
01/01/2027	ARBLI (10 MG/ML) ORAL SUSPENSION	FORMULARY ADDITION	4		
01/01/2027	ARIPIPRAZOLE (10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG) ORAL TABLET	TIER DECREASE	2	QL (1 EA PER 1 DAY)	
01/01/2027	ASTAGRAF XL (0.5 MG, 1 MG, 5 MG) ORAL CAPSULE EXTENDED	FORMULARY	2	PA B/D	

Effective Date of Change	Drug Name	Description of Change	Tier	Additional Information	Formulary Alternative(s) and Tier (if applicable for FORMULARY DELETIONs)
	RELEASE 24 HOUR	ADDITION			
01/01/2027	BESREMI PEN (500 MCG/0.5ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY ADDITION	5	PA, QL (1 ML PER 28 DAYS), NDS	
01/01/2027	BREO ELLIPTA (100-25 MCG/ACT, 200-25 MCG/ACT, 50-25 MCG/INH) INHALATION AEROSOL POWDER BREATH ACTIVATED	FORMULARY ADDITION	3	QL (60 EA PER 30 DAYS)	
01/01/2027	BRIVIACT (10 MG, 100 MG, 25 MG, 50 MG, 75 MG) ORAL TABLET	FORMULARY ADDITION	5	ST, QL (2 EA PER 1 DAY), NDS	
01/01/2027	BRIVIACT (10 MG/ML) ORAL SOLUTION	FORMULARY ADDITION	5	ST, QL (20 ML PER 1 DAY), NDS	
01/01/2027	CALCIUM ACETATE (PHOS BINDER) (667 MG) ORAL CAPSULE	FORMULARY ADDITION	2		
01/01/2027	CALCIUM ACETATE (PHOS BINDER) (667 MG) ORAL TABLET	FORMULARY ADDITION	2		
01/01/2027	CARBAMAZEPINE (200 MG) ORAL TABLET CHEWABLE	FORMULARY ADDITION	2		
01/01/2027	CHLORPROMAZINE HCL (10 MG, 50 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	CHLORPROMAZINE HCL (100 MG, 200 MG, 25 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	CHLORPROMAZINE HCL (100 MG/ML) ORAL CONCENTRATE	FORMULARY ADDITION	4		
01/01/2027	COLISTIMETHATE SODIUM (CBA) (150 MG) INJECTION SOLUTION RECONSTITUTED	TIER DECREASE	4	NDS	
01/01/2027	CYSTADANE ORAL POWDER	FORMULARY	5		

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		ADDITION			
01/01/2027	DAPTOMYCIN (500 MG) INTRAVENOUS SOLUTION RECONSTITUTED	TIER DECREASE	4	NDS	
01/01/2027	DASATINIB (20 MG) ORAL TABLET	QL INCREASED	5	PA, QL (3 EA PER 1 DAY), NDS	
01/01/2027	DESVENLAFAXINE ER (100 MG, 50 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER DECREASE	2	QL (1 EA PER 1 DAY)	
01/01/2027	DESVENLAFAXINE SUCCINATE ER (100 MG, 25 MG, 50 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER DECREASE	2	QL (1 EA PER 1 DAY)	
01/01/2027	DIHYDROERGOTAMINE MESYLATE (4 MG/ML) NASAL SOLUTION	TIER DECREASE	4	ST, QL (8 ML PER 28 DAYS), NDS	
01/01/2027	DOTTI (0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR) TRANSDERMAL PATCH TWICE WEEKLY	PA REMOVED	a4		
01/01/2027	DULOXETINE HCL (120 MG) ORAL CAPSULE DELAYED RELEASE PARTICLES	PA REMOVED	4	QL (1 EA PER 1 DAY)	
01/01/2027	DULOXETINE HCL (20 MG, 30 MG, 60 MG) ORAL CAPSULE DELAYED RELEASE PARTICLES	TIER DECREASE	2	QL (2 EA PER 1 DAY)	
01/01/2027	DULOXETINE HCL (40 MG) ORAL CAPSULE DELAYED RELEASE PARTICLES	TIER DECREASE	2	QL (3 EA PER 1 DAY)	

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01/01/2027	ELETRIPTAN HYDROBROMIDE (20 MG, 40 MG) ORAL TABLET	FORMULARY ADDITION	4	ST, QL (18 EA PER 30 DAYS)	
01/01/2027	ELIQUIS (0.15 MG) ORAL CAPSULE SPRINKLE	FORMULARY ADDITION	3	QL (28 EA PER 7 DAYS)	
01/01/2027	ELIQUIS (0.5 MG) ORAL TABLET SOLUBLE	FORMULARY ADDITION	3	QL (28 EA PER 7 DAYS)	
01/01/2027	ELIQUIS (1.5 MG PACK) (3 X 0.5 MG) ORAL TABLET SOLUBLE	FORMULARY ADDITION	3	QL (84 EA PER 7 DAYS)	
01/01/2027	ELIQUIS (2 MG PACK) (4 X 0.5 MG) ORAL TABLET SOLUBLE	FORMULARY ADDITION	3	QL (112 EA PER 7 DAYS)	
01/01/2027	ENTYVIO PEN (108 MG/0.68ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	ENVARSUS XR (0.75 MG, 1 MG, 4 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	FORMULARY ADDITION	4	PA B/D	
01/01/2027	ERAXIS (100 MG) INTRAVENOUS SOLUTION RECONSTITUTED	TIER DECREASE	4	NDS	
01/01/2027	ERGOTAMINE-CAFFEINE (1-100 MG) ORAL TABLET	QL INCREASED	3	QL (40 EA PER 28 DAYS)	
01/01/2027	ERZOFRI (117 MG/0.75ML) INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	PA CHANGED	5	PA B/D, QL (0.75 ML PER 28 DAYS), NDS	
01/01/2027	ERZOFRI (156 MG/ML) INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	PA CHANGED	5	PA B/D, QL (1 ML PER 28 DAYS), NDS	
01/01/2027	ERZOFRI (234 MG/1.5ML) INTRAMUSCULAR SUSPENSION	PA CHANGED	5	PA B/D, QL (1.5 ML PER 28 DAYS), NDS	

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	PREFILLED SYRINGE				
01/01/2027	ERZOFRI (351 MG/2.25ML) INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	PA CHANGED	5	PA B/D, QL (2.25 ML PER 28 DAYS), NDS	
01/01/2027	ERZOFRI (39 MG/0.25ML) INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	TIER DECREASE, PA CHANGED	4	PA B/D, QL (0.25 ML PER 28 DAYS), NDS	
01/01/2027	ERZOFRI (78 MG/0.5ML) INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE	PA CHANGED	5	PA B/D, QL (0.5 ML PER 28 DAYS), NDS	
01/01/2027	ESLICARBAZEPINE ACETATE (200 MG) ORAL TABLET	TIER DECREASE	4	ST	
01/01/2027	ESLICARBAZEPINE ACETATE (400 MG) ORAL TABLET	TIER DECREASE	4	ST, NDS	
01/01/2027	ESTRADIOL (2 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	ESTRADIOL-NORETHINDRONE ACET (0.5-0.1 MG, 1-0.5 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	EVAMIST (1.53 MG/SPRAY) TRANSDERMAL SOLUTION	PA REMOVED	4		
01/01/2027	FEBUXOSTAT (40 MG, 80 MG) ORAL TABLET	PA REMOVED	3	QL (1 EA PER 1 DAY)	
01/01/2027	FILSPARI (200 MG, 400 MG) ORAL TABLET	FORMULARY ADDITION	5	PA, QL (1 EA PER 1 DAY), NDS	
01/01/2027	FLUTICASONE FUROATE-VILANTEROL (100-25 MCG/ACT, 200-25 MCG/ACT) INHALATION AEROSOL POWDER BREATH ACTIVATED	FORMULARY ADDITION	3		

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01/01/2027	FYAVOLV (0.5-2.5 MG-MCG, 1-5 MG-MCG) ORAL TABLET	PA REMOVED	4		
01/01/2027	GABAPENTIN (200 MG) ORAL CAPSULE	FORMULARY ADDITION	3	QL (2 EA PER 1 DAY), NDS	
01/01/2027	IMATINIB MESYLATE (100 MG, 400 MG) ORAL TABLET	TIER DECREASE	3	PA, QL (2 EA PER 1 DAY), NDS	
01/01/2027	IMIQUIMOD (5 %) EXTERNAL CREAM	TIER DECREASE	2		
01/01/2027	INSULIN DEGLUDEC FLEXTOUCH (100 UNIT/ML, 200 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY ADDITION	3	QL (45 ML PER 30 DAYS)	
01/01/2027	ITRACONAZOLE (10 MG/ML) ORAL SOLUTION	TIER DECREASE	4	NDS	
01/01/2027	JIDEYTRO (100 MG) ORAL TABLET	FORMULARY ADDITION	5	PA, QL (1 EA PER 1 DAY), NDS	
01/01/2027	JIDEYTRO (25 MG) ORAL TABLET	FORMULARY ADDITION	5	PA, QL (3 EA PER 1 DAY), NDS	
01/01/2027	JINTELI (1-5 MG-MCG) ORAL TABLET	PA REMOVED	4		
01/01/2027	KETOPROFEN (75 MG) ORAL CAPSULE	FORMULARY ADDITION	2		
01/01/2027	LEQEMBI IQLIK (360 MG/1.8ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	3	PA, QL (7.2 ML PER 28 DAYS), NDS	
01/01/2027	LEQEMBI IQLIK (500 MG DOSE) (2 X 250 MG/1.25ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	3	PA, QL (10 ML PER 28 DAYS), NDS	

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01/01/2027	LINZESS (145 MCG, 290 MCG, 72 MCG) ORAL CAPSULE	TIER DECREASE	3	QL (1 EA PER 1 DAY)	
01/01/2027	LURASIDONE HCL (120 MG, 20 MG, 40 MG, 60 MG) ORAL TABLET	TIER DECREASE	2	QL (1 EA PER 1 DAY)	
01/01/2027	LURASIDONE HCL (80 MG) ORAL TABLET	TIER DECREASE	2	QL (2 EA PER 1 DAY)	
01/01/2027	LYLLANA (0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR) TRANSDERMAL PATCH TWICE WEEKLY	PA REMOVED	3		
01/01/2027	MESALAMINE ER (250 MG) ORAL CAPSULE EXTENDED RELEASE	FORMULARY ADDITION	4		
01/01/2027	MESNA (400 MG) ORAL TABLET	TIER DECREASE	4	NDS	
01/01/2027	METHENAMINE HIPPURATE (1 GM) ORAL TABLET	QL REMOVED	2		
01/01/2027	MIMVEY (1-0.5 MG) ORAL TABLET	PA REMOVED	4		
01/01/2027	NORETHINDRONE-ETH ESTRADIOL (0.5-2.5 MG-MCG) ORAL TABLET	PA REMOVED	4		
01/01/2027	NORETHINDRONE-ETH ESTRADIOL (1-5 MG-MCG) ORAL TABLET	PA REMOVED	4		
01/01/2027	NUCALA (100 MG/ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	NUCALA (100 MG/ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	FORMULARY ADDITION	5	PA, NDS	

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01/01/2027	OFEV (100 MG, 150 MG) ORAL CAPSULE	FORMULARY ADDITION	5	PA, QL (2 EA PER 1 DAY), LA, NDS	
01/01/2027	OZEMPIC (0.25 OR 0.5 MG/DOSE) (2 MG/3ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY ADDITION	3	PA, QL (3 ML PER 28 DAYS)	
01/01/2027	OZEMPIC (1 MG/DOSE) (4 MG/3ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY ADDITION	3	PA, QL (3 ML PER 28 DAYS)	
01/01/2027	OZEMPIC (1.5 MG, 4 MG, 9 MG) ORAL TABLET	FORMULARY ADDITION	3	PA, QL (1 EA PER 1 DAY)	
01/01/2027	OZEMPIC (2 MG/DOSE) (8 MG/3ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY ADDITION	3	PA, QL (3 ML PER 28 DAYS)	
01/01/2027	PERAMPANEL (10 MG, 12 MG, 4 MG, 6 MG, 8 MG) ORAL TABLET	TIER DECREASE	4	ST, QL (1 EA PER 1 DAY), NDS	
01/01/2027	PHYRAGO (20 MG) ORAL TABLET	QL INCREASED	5	PA, QL (3 EA PER 1 DAY)	
01/01/2027	POMALYST (1 MG, 2 MG, 3 MG, 4 MG) ORAL CAPSULE	FORMULARY ADDITION	5	PA, QL (21 EA PER 28 DAYS), NDS	
01/01/2027	PREMARIN (0.3 MG, 0.45 MG, 0.625 MG, 0.9 MG, 1.25 MG) ORAL TABLET	PA REMOVED	3		
01/01/2027	PRETOMANID (200 MG) ORAL TABLET	FORMULARY ADDITION	4	QL (1 EA PER 1 DAY)	
01/01/2027	PREZISTA (600 MG) ORAL TABLET	FORMULARY ADDITION	4	QL (2 EA PER 1 DAY), NDS	
01/01/2027	PYLERA (140-125-125 MG) ORAL CAPSULE	FORMULARY ADDITION	3	QL (240 EA PER 365 DAYS), NDS	
01/01/2027	REDEMPLO (25 MG/0.5ML) SUBCUTANEOUS SOLUTION	FORMULARY ADDITION	5	PA, QL (0.5 ML PER 84 DAYS), NDS	

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	PREFILLED SYRINGE				
01/01/2027	REZDIFFRA (100 MG, 60 MG, 80 MG) ORAL TABLET	LIMITED ACCESS REMOVED	5	PA, QL (1 EA PER 1 DAY), NDS	
01/01/2027	RILPIVIRINE HCL (25 MG) ORAL TABLET	NDS REMOVED	5	QL (1 EA PER 1 DAY)	
01/01/2027	RINVOQ (15 MG, 30 MG, 45 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	FORMULARY ADDITION	5	PA, QL (1 EA PER 1 DAY), NDS	
01/01/2027	RIVASTIGMINE (13.3 MG/24HR, 4.6 MG/24HR, 9.5 MG/24HR) TRANSDERMAL PATCH 24 HOUR	TIER DECREASE	3	ST, QL (1 EA PER 1 DAY)	
01/01/2027	RYBELSUS (14 MG, 3 MG, 7 MG) ORAL TABLET	FORMULARY ADDITION	3	PA, QL (1 EA PER 1 DAY)	
01/01/2027	SACUBITRIL-VALSARTAN (24-26 MG) ORAL TABLET	QL INCREASED	3	QL (6 EA PER 1 DAY)	
01/01/2027	SEVELAMER CARBONATE (0.8 GM, 2.4 GM) ORAL PACKET	FORMULARY ADDITION	4		
01/01/2027	SEVELAMER CARBONATE (800 MG) ORAL TABLET	FORMULARY ADDITION	4		
01/01/2027	SEVELAMER HCL (400 MG, 800 MG) ORAL TABLET	FORMULARY ADDITION	4		
01/01/2027	SIVEXTRO (200 MG) INTRAVENOUS SOLUTION RECONSTITUTED	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	SIVEXTRO (200 MG) ORAL TABLET	FORMULARY ADDITION	5	PA, QL (1 EA PER 1 DAY), NDS	
01/01/2027	SPRITAM (250 MG, 500 MG) ORAL TABLET DISINTEGRATING SOLUBLE	QL REMOVED	4		

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01/01/2027	SYMPAZAN (5 MG) ORAL FILM	TIER DECREASE	4	ST, QL (2 EA PER 1 DAY), NDS	
01/01/2027	TARPEYO (4 MG) ORAL CAPSULE DELAYED RELEASE	FORMULARY ADDITION	5	PA, QL (4 EA PER 1 DAY), NDS	
01/01/2027	TOBI PODHALER (28 MG) INHALATION CAPSULE	FORMULARY ADDITION	5	QL (8 EA PER 1 DAY), NDS	
01/01/2027	TOPIRAMATE (50 MG) ORAL CAPSULE SPRINKLE	FORMULARY ADDITION	2		
01/01/2027	TOREMIFENE CITRATE (60 MG) ORAL TABLET	TIER DECREASE	4	QL (1 EA PER 1 DAY), NDS	
01/01/2027	TRADJENTA (5 MG) ORAL TABLET	TIER DECREASE	3	QL (1 EA PER 1 DAY)	
01/01/2027	TREMFYA (100 MG/ML, 200 MG/2ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	TREMFYA ONE-PRESS (100 MG/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	TREMFYA PEN (200 MG/2ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	TREMFYA-CD/UC INDUCTION (200 MG/2ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	5	PA, NDS	
01/01/2027	TROSPIUM CHLORIDE ER (60 MG) ORAL CAPSULE EXTENDED RELEASE 24 HOUR	TIER DECREASE	2	QL (1 EA PER 1 DAY)	
01/01/2027	VELSIPITY (2 MG) ORAL TABLET	FORMULARY ADDITION	5	PA, QL (1 EA PER 1 DAY), NDS	

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01/01/2027	VELTASSA (1 GM) ORAL PACKET	FORMULARY ADDITION	4	QL (1 EA PER 1 DAY)	
01/01/2027	VELTASSA (25.2 GM, 8.4 GM) ORAL PACKET	PA REMOVED	4	QL (1 EA PER 1 DAY)	
01/01/2027	VENLAFAXINE HCL ER (150 MG, 37.5 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER DECREASE	2	QL (2 EA PER 1 DAY)	
01/01/2027	VENLAFAXINE HCL ER (225 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER DECREASE	2	QL (1 EA PER 1 DAY)	
01/01/2027	VENLAFAXINE HCL ER (75 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER DECREASE	2	QL (3 EA PER 1 DAY)	
01/01/2027	VOQUEZNA DUAL PAK (500-20 MG) ORAL THERAPY PACK	FORMULARY ADDITION	4	PA, NDS	
01/01/2027	VOQUEZNA TRIPLE PAK (500-500-20 MG) ORAL THERAPY PACK	FORMULARY ADDITION	4	PA, NDS	
01/01/2027	VORICONAZOLE (200 MG) INTRAVENOUS SOLUTION RECONSTITUTED	TIER DECREASE	4	PA, NDS	
01/01/2027	VOSEVI (400-100-100 MG) ORAL TABLET	FORMULARY ADDITION	5	QL (1 EA PER 1 DAY), NDS	
01/01/2027	VRAYLAR (0.5 MG, 0.75 MG, 1.5 MG, 3 MG, 4.5 MG, 6 MG) ORAL CAPSULE	TIER DECREASE, PA REMOVED	3	QL (1 EA PER 1 DAY), NDS	
01/01/2027	WEGOVY (0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	3	PA, QL (2 ML PER 28 DAYS)	

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01/01/2027	WEGOVY (1.5 MG, 25 MG, 4 MG, 9 MG) ORAL TABLET	FORMULARY ADDITION	3	PA, QL (1 EA PER 1 DAY)	
01/01/2027	WEGOVY (1.7 MG/0.75ML, 2.4 MG/0.75ML) SUBCUTANEOUS SOLUTION AUTO-INJECTOR	FORMULARY ADDITION	3	PA, QL (3 ML PER 28 DAYS)	
01/01/2027	XDEMVY (0.25 %) OPHTHALMIC SOLUTION	QL INCREASED	5	QL (30 ML PER 180 DAYS), NDS	
01/01/2027	XIFAXAN (200 MG, 550 MG) ORAL TABLET	TIER DECREASE	3	PA, QL (3 EA PER 1 DAY), NDS	
01/01/2027	XIGDUO XR (10-1000 MG, 10-500 MG, 5-500 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	FORMULARY ADDITION	3	QL (1 EA PER 1 DAY)	
01/01/2027	XIGDUO XR (5-1000 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	FORMULARY ADDITION	3	QL (2 EA PER 1 DAY)	
01/01/2027	ZENBEXUS (0.75 MG, 1 MG) ORAL CAPSULE	FORMULARY ADDITION	5	PA, QL (1 EA PER 1 DAY), NDS	
01/01/2027	ZOLPIDEM TARTRATE ER (12.5 MG, 6.25 MG) ORAL TABLET EXTENDED RELEASE	QL INCREASED	2	QL (30 EA PER 30 DAYS), NDS	

NEGATIVE FORMULARY CHANGES

EFFECTIVE DATE OF CHANGE	DRUG NAME	DESCRIPTION OF CHANGE	TIER	ADDITIONAL INFORMATION	FORMULARY ALTERNATIVE(S) AND TIER (IF APPLICABLE FOR FORMULARY DELETIONS)	MEMBER NOTIFICATION
01/01/2027	ABILIFY MAINTENA (300 MG) INTRAMUSCULAR PREFILLED SYRINGE	PA ADDED	5	PA B/D, NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	ABILIFY MAINTENA (300 MG, 400 MG) INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	PA ADDED	5	PA B/D, NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	ABILIFY MAINTENA (400 MG) INTRAMUSCULAR PREFILLED SYRINGE	PA ADDED	4	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	ARISTADA (1064 MG/3.9ML, 441 MG/1.6ML, 662 MG/2.4ML, 882 MG/3.2ML) INTRAMUSCULAR PREFILLED SYRINGE	PA ADDED	5	PA B/D, NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	ARISTADA INITIO (675 MG/2.4ML) INTRAMUSCULAR PREFILLED SYRINGE	PA ADDED	5	PA B/D, NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	BUCAPSOL (7.5 MG) ORAL CAPSULE	QL ADDED	4	QL (2 EA PER 1 DAY)		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	DAPAGLIFLOZ BASE-METFORMIN ER (10-1000 MG, 10-500 MG, 5-1000 MG, 5-500 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	FORMULARY DELETION			XIGDUO XR (10-1000 MG, 10-500 MG, 5-500 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR: (T3, QL 1 PER 1 DAY), XIGDUO XR 5-1000 MG ORAL TABLET EXTENDED RELEASE 24 HOUR: (T3, QL 2 PER 1 day), INVOKAMET (50-500 MG, 50-1000 MG, 150-500 MG, 150-1000 MG) ORAL TABLET: (T4, QL 2 PER 1 DAY), INVOKAMET XR (50-500 MG, 50-1000 MG, 150-500 MG, 150-1000 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR (T4, QL 2 PER 1 DAY)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	DIFICID (40 MG/ML) ORAL SUSPENSION RECONSTITUTED	FORMULARY DELETION			FIDAXOMICIN (200 MG) ORAL TABLET: (T5, QL 56 PER 180 DAYS, NDS), VANCOMYCIN (25 MG-ML, 50 MG-ML, 250 MG-5ML) ORAL SOLUTION RECONSTITUTED: (T3), VANCOMYCIN (125 MG, 250 MG) ORAL CAPSULE: (T4)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	ENDOCET (2.5-325 MG) ORAL TABLET	TIER INCREASE	3	QL (6 EA PER 1 DAY)		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FIASP (100 UNIT/ML) INJECTION SOLUTION	FORMULARY DELETION			INSULIN ASPART (100 UNIT/ML) INJECTION SOLUTION: (T3, QL 50 ML PER 30 DAYS), NOVOLOG (100 UNIT/ML) INJECTION SOLUTION: (T3, QL 50 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FIASP (100 UNIT/ML) SUBCUTANEOUS SOLUTION	FORMULARY DELETION			INSULIN ASPART (100 UNIT/ML) INJECTION SOLUTION: (T3, QL 50 ML PER 30 DAYS), NOVOLOG (100 UNIT/ML) INJECTION SOLUTION: (T3, QL 50 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	FIASP FLEXTOUCH (100 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY DELETION			INSULIN ASPART FLEXPEN (100 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T3, QL 45 ML PER 30 DAYS), NOVOLOG FLEXPEN (100 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T3, QL 45 ML PER 30 DAYS), NOVOLOG FLEXPEN RELION (100 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T3, QL 45 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FIASP PENFILL (100 UNIT/ML) SUBCUTANEOUS SOLUTION CARTRIDGE	FORMULARY DELETION			INSULIN ASPART PENFILL (100 UNIT/ML) SUBCUTANEOUS SOLUTION CARTRIDGE: (T3, 45 ML PER 30 DAYS), NOVOLOG PENFILL (100 UNIT/ML) SUBCUTANEOUS SOLUTION CARTRIDGE: (T3, 45 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FIASP PUMPCART (100 UNIT/ML) SUBCUTANEOUS SOLUTION CARTRIDGE	FORMULARY DELETION			INSULIN ASPART PENFILL (100 UNIT/ML) SUBCUTANEOUS SOLUTION CARTRIDGE: (T3, 45 ML PER 30 DAYS), NOVOLOG PENFILL (100 UNIT/ML) SUBCUTANEOUS SOLUTION CARTRIDGE: (T3, 45 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	FIDAXOMICIN (200 MG) ORAL TABLET	QL DECREASED	5	QL (56 EA PER 180 DAYS), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FLUPHENAZINE DECANOATE (25 MG/ML) INJECTION SOLUTION	PA ADDED	4	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FLUPHENAZINE HCL (2.5 MG/ML) INJECTION SOLUTION	PA ADDED	4	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	FORTEO (560 MCG/2.24ML, 600 MCG/2.4ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY DELETION			TERIPARATIDE (560 MCG/2.24 ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T5, QL 2.48 ML PER 28 DAYS, PA, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	HALOPERIDOL DECANOATE (100 MG/ML, 50 MG/ML, 50 MG/ML(1ML)) INTRAMUSCULAR SOLUTION	PA ADDED	2	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	HALOPERIDOL LACTATE (5 MG/ML, 5 MG/ML(1 ML PREFILLED SYRINGE)) INJECTION SOLUTION	PA ADDED	2	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	MECLIZINE HCL (25 MG) ORAL TABLET	FORMULARY DELETION			SCOPOLAMINE (1 MG/3 DAYS) PATCH 72 HOUR (T4, PA, QL 10 PER 30 DAYS), ONDANSETRON (4 MG, 8 MG) ORAL TABLET: (T2, PA), PROMETHAZINE (12.5 MG, 25 MG) RECTAL SUPPOSITORY: (T4)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	MEDPURA HYDROCORTISONE (1 %) EXTERNAL CREAM	TIER INCREASE	6			--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	NINTEDANIB ESYLATE (100 MG, 150 MG) ORAL CAPSULE	FORMULARY DELETION			OFEV (100 MG, 150 MG) ORAL CAPSULE: (T5, PA, QL 2 PER 1 DAY, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	NUEDEXTA (20-10 MG) ORAL CAPSULE	PA ADDED	5	PA, QL (2 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	OCREVUS (300 MG/10ML) INTRAVENOUS SOLUTION	FORMULARY DELETION			GLATOPA 20 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE: (T3, QL 1 ML PER 1 DAY, NDS), GLATOPA 40 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE: (T3, QL 12 ML PER 28 DAYS, NDS), TERIFLUNOMIDE (7 MG, 14 MG) TABLET: (T2, QL 1 PER 1 DAY, NDS), FINGOLIMOD 0.5 MG ORAL CAPSULE: (T4)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	OLANZAPINE (10 MG) INTRAMUSCULAR SOLUTION RECONSTITUTED	PA ADDED	2	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	OXYBUTYNIN CHLORIDE (5 MG/5ML) ORAL SYRUP	PA ADDED	2	PA		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PAXLOVID (150/100) (10 X 150 MG & 10 X 100MG) ORAL TABLET THERAPY PACK	TIER INCREASE	5	QL (60 EA PER 365 DAYS)		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	PAXLOVID (300/100) (20 X 150 MG & 10 X 100MG) ORAL TABLET THERAPY PACK	TIER INCREASE	5	QL (90 EA PER 365 DAYS)		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PENTASA (250 MG) ORAL CAPSULE EXTENDED RELEASE	GENERIC SUBSTITUTION			MESALAMINE ER (250 MG) ORAL CAPSULE EXTENDED RELEASE: (T4)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	POMALIDOMIDE (1 MG, 2 MG, 3 MG, 4 MG) ORAL CAPSULE	FORMULARY DELETION			POMALYST (1 MG, 2 MG, 3 MG, 4 MG) ORAL CAPSULE: (T5, PA, QL 21 PER 28 DAYS, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PREGABALIN (100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG) ORAL CAPSULE	TIER INCREASE	3	QL (3 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PREGABALIN (20 MG/ML) ORAL SOLUTION	TIER INCREASE	3	NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PREGABALIN (225 MG, 300 MG) ORAL CAPSULE	TIER INCREASE	3	QL (2 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PREVYMIS (240 MG) ORAL TABLET	PA ADDED, ST REMOVED	5	PA, QL (1 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	PREVYMIS (480 MG) ORAL TABLET	PA ADDED	5	PA, ST, QL (1 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	PROLIA (60 MG/ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	FORMULARY DELETION			ALENDRONATE (35 MG, 70 MG) ORAL TABLET: (T1)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	RISPERIDONE MICROSPHERES ER (12.5 MG) INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	PA ADDED	4	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	RISPERIDONE MICROSPHERES ER (25 MG) INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	PA ADDED	4	PA B/D, NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	RISPERIDONE MICROSPHERES ER (37.5 MG, 50 MG) INTRAMUSCULAR SUSPENSION RECONSTITUTED ER	PA ADDED	5	PA B/D, NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	STELARA (45 MG/0.5ML) SUBCUTANEOUS SOLUTION	FORMULARY DELETION			USTEKINUMAB 45 MG/0.5ML SUBCUTANEOUS SOLUTION (T5, PA, NDS) YESINTEK 45 MG/0.5ML SUBCUTANEOUS SOLUTION (T5, PA, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	STELARA (45 MG/0.5ML, 90 MG/ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	FORMULARY DELETION			USTEKINUMAB (45 MG/0.5ML, 90 MG/ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE: (T5, PA, NDS) IMULDOSA (45 MG/0.5 ML, 90 MG/ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE: (T5, PA, NDS) STEQEYMA 45 MG/0.5ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE: (T5, PA, NDS) STEQEYMA 90 MG/ML SUBCUTANEOUS SOLUTION PREFILLED SYRINGE: (T5, PA) YESINTEK (45 MG/0.5 ML, 90 MG/ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE (T5, PA, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TICAGRELOR (90 MG) ORAL TABLET	TIER INCREASE	3			--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TOLVAPTAN (HYPONATREMIA) (30 MG) ORAL TABLET	PA ADDED	5	PA, QL (2 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	TRAMADOL HCL (100 MG) ORAL TABLET	TIER INCREASE	3	QL (4 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TRAMADOL HCL (50 MG) ORAL TABLET	TIER INCREASE	3	QL (8 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TRAMADOL HCL ER (100 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER INCREASE	3	QL (3 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TRAMADOL HCL ER (200 MG) ORAL TABLET EXTENDED RELEASE 24 HOUR	TIER INCREASE	3	QL (1 EA PER 1 DAY), NDS		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TRAVOPROST (BAK FREE) (0.004 %) OPHTHALMIC SOLUTION	FORMULARY DELETION			LATANOPROST 0.005% OPHTHALMIC SOLUTION: (T2) LUMIGAN 0.004% BAK FREE OPHTHALMIC SOLUTION: (T3)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TRESIBA (100 UNIT/ML) SUBCUTANEOUS SOLUTION	FORMULARY DELETION			INSULIN DEGLUDEC FLEXTOUCH (100 UNIT/ML, 200 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T3, QL 45 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	TRESIBA FLEXTOUCH (100 UNIT/ML, 200 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	GENERIC SUBSTITUTION			INSULIN DEGLUDEC FLEXTOUCH (100 UNIT/ML, 200 UNIT/ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T3, QL 45 ML PER 30 DAYS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2027	TYMLOS (3120 MCG/1.56ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR	FORMULARY DELETION			TERIPARATIDE (560 MCG/2.24 ML) SUBCUTANEOUS SOLUTION PEN-INJECTOR: (T5, QL 2.48 ML PER 28 DAYS, PA, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	UDENYCA (6 MG/0.6ML) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE	FORMULARY DELETION			ZARXIO (300 MCG/0.5 ML, 480 MCG/0.8 ML) SOLUTION PREFILLED SYRINGE (T5, PA, NDS)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	VELTASSA (16.8 GM) ORAL PACKET	FORMULARY DELETION			VELTASSA (1 GM, 8.4 GM, 25.2 GM) ORAL PACKET: (T4, QL 1 PER 1 DAY)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	XGEVA (120 MG/1.7ML) SUBCUTANEOUS SOLUTION	FORMULARY DELETION				--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	YF-VAX (2.5 ML IN 1 VIAL, MULTI-DOSE) SUBCUTANEOUS INJECTABLE	FORMULARY DELETION			YF-VAX SUBCUTANEOUS INJECTABLE: (T3) YF-VAX SUBCUTANEOUS SUSPENSION: (T3)	--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2027	ZIPRASIDONE MESYLATE (20 MG) INTRAMUSCULAR SOLUTION RECONSTITUTED	PA ADDED	3	PA B/D		--Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

B/D = This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination, **NDS =** Drug is limited to a one-month supply, PA Pending CMS approval = Prior Authorization required, **QL** = Quantity Limit, **SP** = Specialty Pharmacy required, **ST** = Step

Therapy. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan.

Limitations, copayments, and restrictions may apply.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

Learn about Presbyterian's Nondiscrimination Notice and Interpreter Services.

Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.

Notice of Availability

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
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Navajo Diné	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
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Urdu اردو	توجہ دیں: اگر آپ اردو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ 1-855-592-7737 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. ومتاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم 1-855-592-7737 (TTY: 711) (خدمة الهاتف النصي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DİKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.