Preferred Drug List update

2024 — 3rd quarter

The UnitedHealthcare Community Plan Preferred Drug List (PDL) is a list of prescription drugs covered by your health plan. It has recently been updated. To see which drugs are covered, find your PDL under the Pharmacies and Prescriptions section on myuhc.com. You can call the number on the back of your member ID card if you need help.

If you take one of the drugs below, ask your doctor if another drug will work for you. Your doctor may need to write a prescription for the new drug. If needed, your doctor can ask UnitedHealthcare Community Plan for a prior authorization. If the prior authorization is approved, we will continue to cover this drug.

Changes on July 1, 2024

Drugs added to the Preferred Drug List

Drug/Product Name	Comments
acyclovir 5% topical ointment	Indicated for the treatment of recurrent herpes labialis (cold sores) or initial episode of genital herpes in immunocompromised patients.
amlodipine-benazepril hcl capsules	Indicated for the treatment of high blood pressure.
amlodipine-olmesartan tablets	Indicated for the treatment of high blood pressure.
amlodipine-valsartan tablets	Indicated for the treatment of high blood pressure.
Epogen® injection	Indicated for the treatment of Chronic Kidney Disease (CKD) and reduction of donor blood transfusions in patients undergoing elective, noncardiac, nonvascular surgery Prior authorization is required.
irbesartan-hydrochlorothiazide tablets	Indicated for the treatment of high blood pressure.

Drugs added to the Preferred Drug List (continued)

Drug/Product Name	Comments
olmesartan- hydrochlorothiazide tablets	Indicated for the treatment of high blood pressure.
Procrit® injection	Indicated for the treatment of Chronic Kidney Disease (CKD) and reduction of donor blood transfusions in patients undergoing elective, noncardiac, nonvascular surgery Prior authorization is required.
testosterone gel pump 1.62%	Indicated for replacement therapy in males for conditions associated with a deficiency or absence of testosterone. Prior authorization is required.
valsartan-hydrochlorothiazide tablets	Indicated for the treatment of high blood pressure.

Changes to coverage within the Preferred Drug List

Drug/Product Name	Comments
testosterone cypionate injection	Indicated for replacement therapy in males for conditions associated with a deficiency or absence of testosterone. Remains preferred. Prior authorization is required.
testosterone enanthate injection	Indicated for replacement therapy in males for conditions associated with a deficiency or absence of testosterone. Remains preferred. Prior authorization is required.

Contact us

We're here to help make these changes as easy as possible. If you have any questions or need help, please call Member Services toll-free at **1-800-414-9025.** Thank you.

United Healthcare Community Plan

Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-414-9025, TTY/PA RELAY 711.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-414-9025, TTY/PA RELAY 711.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-414-9025, TTY/PA RELAY 711.

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