Metropolitan Nashville Public Schools

2025 Cigna True Choice Medicare (PPO) Formulary Addendum

2025 Enhanced Drug List Addendum

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Medicare Performance Network

Please read: This document contains information about the policies and criteria and any additional coverage offered with your plan.

Please visit **CignaMedicare.com/group/MAresources** to view the comprehensive 2025 Enhanced Drug List.

The drug list found on our website will be updated each month.

Are there any restrictions on my 2025 Cigna True Choice Medicare (PPO) coverage?

Some covered drugs may have additional requirements or limits on coverage. You can identify these by looking to the right of the name of the drug on the drug list located on our website. The requirements and limits for your plan are the following:

*	Opioid medication available as a 7-day supply or less for first time opioid user. For continued use this drug may only be available as a one-month supply.
^	This prescription drug has an administrative prior authorization requirement that is not waived. This drug may be covered under different benefits depending on circumstances.
+	This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not apply to your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.
B/D PA	This prescription drug has a Part B versus D administrative prior authorization requirement. This drug may be covered under Medicare Part B or D depending on circumstances.
LA	Limited Availability. This prescription may be available only at certain pharmacies. For more information, please call Customer Service.
V	This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).
PA	This drug requires prior authorization.
QL	This drug has quantity limits.
ST	This drug has step therapy requirements.

Where can I find drug list for my plan?

You can visit **CignaMedicare.com/group/MAresources** to view the current list of covered drugs for the **2025 Enhanced Drug List**. While there, you can also view documents that explain our prior authorization and step therapy restrictions as well as other useful plan information. To locate the drug list you need, simply visit the location above and search for the **2025 Enhanced Drug List.**

What additional coverage is available with my plan?

The following preventive benefits are covered at a $0 copay (deductible does not apply):

- **Adherence Package**

Your plan covers additional drugs not normally covered in a Medicare Prescription Drug Plan as indicated in the Formulary Drug List by the **+** symbol. Please see your 2025 Formulary document for details. If a plan deductible applies, any non-Part D coverage added to the plan will not be subject to the plan deductible. The cost-share for these drugs is the same as the cost-shares in the initial coverage phase based on the drug classification. The cost-share you pay on these drugs do not count toward your annual True Out-of-Pocket (TrOOP).

Covered Non-Part D Drugs:

- **Prescription Vitamins** - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- **Cough and Cold Drugs** - Drugs used for the relief of cough or cold symptoms
- **Erectile Dysfunction Drugs^** - Drugs used for the treatment of sexual or erectile dysfunction
- **Courtesy Drugs/DESI Buy Up Courtesy Drugs**: Drugs normally covered under commercial pharmacy plans but are excluded by CMS. DESI (Drug Efficacy Study Implementation) Drugs: Drugs that were introduced between 1938-1962 and approved for safety but not effectiveness. DESI drugs are not "grandfathered" or generally recognized as safe and effective (GRAS/E).

^Some drugs are subject to prior authorization and quantity limitations even though these limitations may be waived in other treatment categories. Please review your 2025 formulary for more information.

Important Message About What You Pay for Insulin

You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. If your insulin is on a tier where cost-sharing is lower than $35 you will pay the lower cost for your insulin.

Important Message About What You Pay for Vaccines

Our plan covers most Part D vaccines at no cost to you. If your plan has a Part D deductible, this will apply even if you haven't paid your deductible. Call Customer Service for more information.

Covered Diabetic Test Strips and Meters
You will not pay more than $0 for Preferred Products.

Covered Diabetic Lancets and Control Solutions
You will not pay more than $0 for this benefit.

2025 Erectile Dysfunction and Lifestyle Supplemental Benefits

Drug Name	Drug Tier	Requirements / Limits
Sexual Dysfunction Supplemental Benefits		
ADDYI	2	QL 30/30,+
CAVERJECT VIALS	2	QL 6/30,+
CAVERJECT IMPULSE	2	QL 6/30,+
CIALIS 2.5 MG, 5 MG	2	PA, **^,** QL 8/30,+
CIALIS 10 MG, 20 MG	2	PA, **^,** QL 8/30,+
EDEX 10 MCG, 20 MCG, 40 MCG CARTRIDGES	2	QL 6/30,+
IFE-BIMIX 30/1 150-5 MG/5 ML	2	+
MUSE 250 MCG, 500 MCG, 1000 MCG URETHRAL SUPPOSITORY	2	QL 6/30,+
sildenafil 25 mg, 50 mg, 100 mg tablets (generic Viagra)	1	QL 8/30,+
STENDRA 50 MG, 100 MG, 200 MG TABLETS	2	QL 8/30,+
tadalafil 2.5 mg, 5 mg (generic Cialis)	1	PA, ^, QL 8/30,+
tadalafil 10 mg, 20 mg (generic Cialis)	1	PA, ^, QL 8/30,+
TRI-MIX 150 MG-5 MG-50 MCG VL	2	+
vardenafil tab 2.5 mg, 5 mg, 10 mg, 20 mg tablets	1	QL 8/30,+
vardenafil odt tab	1	QL 8/30,+
VIAGRA 25 MG, 50 MG, 100 MG	2	QL 8/30,+
VYLEESI	2	QL 30/30,+

2025 Cough and Cold Buy Up (Prescription Only)

Drug Name	Drug Tier	Requirements / Limits
Cough and Cold Supplemental Benefits		
benzonatate capsules 100mg, 150 mg, 200mg	1	+
benzonatate pearle 100 mg cap	1	+
BROMFED DM 2-30-10 MG/5 ML SYR	2	+
bromphen-pse-dm 2-30-10 mg/5ml syr	1	+
CAPCOF LIQUID	2	+
codeine-guaifen 10-100 mg/5 ml	1	+
CODITUSSIN AC LIQUID	2	+
CODITUSSIN DAC LIQUID	2	+
g tussin ac liquid	1	+
guaiatussin ac liquid	1	+
guaifen-codeine 100-10mg/5ml	1	+
GUAIFEN-COD 100-10MG/ML, 200-20MG/10ML	2	+
guaifenesin ac cough syrup	1	+
guaifenesin dac oral solution	1	+
guaifenesin-codeine syrup (generics)	1	+
HISTEX-AC SYRUP	2	+
HYCODAN 5 MG-1.5 MG TABLET	2	+
HYCODAN 5 MG-1.5 MG/5 ML CUP	2	+
HYCODAN 5 MG-1.5 MG/5 ML SOLN	2	+
hydrocodone-chlorphen er susp	1	+
HYDROCODONE-HOMATROP 5 ML CUP	2	+
hydrocodone-homatropine 5-1.5	1	+
hydrocodone-homatropine soln	1	+
hydromet 5mg-1.5mg/5ml soln	1	+
MAR-COF BP LIQUID	2	+
Cough and Cold Supplemental Benefits		
MAR-COF CG LIQUID	2	+

Drug Name	Drug Tier	Requirements / Limits
MAXI-TUSS AC LIQUID	2	+
MAXI-TUSS CD LIQUID	2	+
m-clear wc liquid	1	+
M-END PE LIQUID	2	+
NINJACOF-XG LIQUID	2	+
OBREDON 2.5-200 MG/5 ML SOLN	2	+
pcm la tablet	1	+
pe-guai drops	1	+
POLY-TUSSIN AC LIQUID	2	+
promethazine-codeine syrup, solution	1	+
promethazine-dm solution	1	+
promethazine-dm syrup 6.25-15mg/5ml	1	+
promethazine-pe-codeine syrup	1	+
promethazine-vc codeine solution	1	+
RESPA A.R. TABLET SA	2	+
TUXARIN ER 8-54.3 MG TABLET	2	+
TUZISTRA XR 14.7-2.8 MG/5 ML	2	+
virtussin ac 10-100 MG/5 ml liquid	1	+
virtussin ac w-alc 10-100 MG/5	1	+
virtussin dac liquid	1	+

2025 Prescription Vitamins Supplemental Benefits

Drug Name	Drug Tier	Requirements / Limits
Prescription Vitamins Supplemental Benefits		
ACCRUFER 30 MG CAPSULE	2	+
AQUASOL A 100,000 UNITS/2ML VIAL	2	+
ascorbic acid 500 mg/ml vial	1	+
AZESCHEW CHEW	2	+
BACMIN CAPLET	2	+
B-12 COMPLIANCE INJ KIT	2	+
b-complex 100 injection	1	+
cyanocobalamin 1,000 mcg/ml	1	+
cyanocobalamin 500 mcg spray	1	+
DERMACINRX PUREFOLIX TABLET	2	+
dodex 1,000 mcg/ml, 10,000 mcg/10 ml, 30,000 mcg/30ml	1	+
DRISDOL 1.25 MG (50,000 UNIT)	2	+
DUET DHA 400 COMBO PACK, BALANCED	2	+
FERAHEME 510 MG/17 ML VIAL	2	+
FERRLECIT 62.5 MG/5 ML VIAL	2	+
FERUMOXYTOL 510 MG/17 ML VIAL	2	+
folic acid 1 mg tablet	1	+
folic acid 5 mg/ml vial	1	+
hydroxocobalamin 1,000 mcg/ml	1	+
INFED 100 MG/2ML VIAL	2	+
INFUVITE ADULT, PEDIATRIC	2	+
INJECTAFER 100 MG/2 ML VIAL	2	+
INJECTAFER 750 MG/15 ML VIAL	2	+
KOSHER PRENATAL PLUS IRON TAB	2	+
MEPHYTON 5 MG TABLET	2	+
METHYLCOBALAMIN 10,000 MCG VIAL	2	+
MONOFERRIC 1,000 MG/10 ML VIAL	2	+

Drug Name	Drug Tier	Requirements / Limits
mynatal capsule	1	+
mynatal plus capsule	1	+
mynatal-z captab	1	+
NASCOBAL 500 MCG NASAL SPRAY	2	+
NEEVODHA CAPSULE	2	+
NEONATAL FE TABLET	2	+
NEONATAL PLUS VITAMIN TABLET	2	+
NESTABS ABC PRENATAL COMBO PK	2	+
newgen tablet	1	+
OBSTETRIX EC CAPLET	2	+
OBTREX DHA PRENATAL VITAMIN	2	+
PHYSICIANS EZ USE B-12 KIT	2	+
PHYTONADIONE 1 MG/0.5 ML SYRINGE	2	+
PHYTONADIONE 10 MG/ML AMPUL	2	+
phytonadione 5mg tablet	*1*	*+*
POTABA 500 MG CAPSULE	2	+
prena1 chew tablet	1	+
prena1 pearl softgel	1	+
prena1 true combo pack	1	+
prenatabs fa, rx tablet	1	+
prenatal-u capsule	1	+
PRENATE ELITE TABLET	2	+
PRENATE STAR TABLET	2	+
pyridoxine 100 mg/ml vial	1	+
R-NATAL OB SOFTGEL	2	+
ROCALTROL 1 MCG/ML ORAL SOLN	2	+
sod fer gluc cplx 62.5 mg/5 ml	1	+
thiamine 200 mg/2 ml vial	1	+
TRIFERIC 27.2 MG/5 ML AMPULE	2	+
TRIFERIC 272 MG POWDER PACKET	2	+

Drug Name	Drug Tier	Requirements / Limits
trinatal rx 1 tablet	1	+
trinate tablet	1	+
TRINAZ TABLET	2	+
TRISTART DHA SOFTGEL	2	+
VENOFER 100 MG/5 ML VIAL	2	+
VENOFER 200 MG/10 ML VIAL	2	+
VENOFER 50 MG/2.5 ML VIAL	2	+
VITAFOL NANO TABLET	2	+
VITALIPID N INFANT AMPULE	2	+
VITLIPID N ADULT AMPULE	2	+
VITATRUE COMBO PACK	2	+
vitamin D2 1.25mg (50,000 unit) RX	1	+
vitamin K1 10 mg/ml, 1mg/0.5ml ampule	1	+
VITAPEARL SOFTGEL	2	+
VITATRUE COMBO PACK	2	+
zatean pn dha capsule	1	+
zatean pn plus softgel	1	+
zingiber tablet	1	+
ZIPHEX TABLET	2	+

2025 Adherence Package

Preventive drugs are used to improve outcomes for asthma, blood pressure with selected heart drugs, blood thinners, high cholesterol, diabetes, Part D covered diabetic supplies, osteoporosis, and prenatal vitamins. If you have questions about which drugs are right for you, talk to your doctor. **You do not have to pay a copay or coinsurance for the preventive drugs on this list** if filled at a pharmacy in the Cigna Healthcare Medicare network. All quantity limits, prior authorization and step therapy in the full drug list apply.

Asthma

Inhalation Solns (PART D Only)	**Inhalers and Inhalation Devices**		
albuterol solution ^	*albuterol HFA*	COMBIVENT RESPMT	SEREVENT DISKUS
budesonide susp ^	ADVAIR HFA	fluticasone HFA, DISKUS	PERFOROMIST
cromolyn sod soln ^	ANORO ELLIPTA	*fluticasone-salmeterol inh*	TRELEGY ELLIPTA
formoterol soln ^	ARNUITY ELLIPTA	INCRUSE ELLIPTA	VENTOLIN HFA
ipratropium-albut ^	ATROVENT HFA INH	*ipratropium bromide inh*	WIXELA INHUB
levalbuterol soln ^	BREO ELLIPTA	*levalbuterol HFA*	

Oral Products				
albuterol tab, syrp	*montelukast tabs*	*theophylline ER, CR*	*theophylline elixir, soln*	*zafirlukast tab*

Blood Pressure/Selected Heart Drugs

acebutolol cap	*captopril tab, -hctz*	*guanfacine*	*nebivolol tabs*	*telmisartan-amlodipine*
acetazolamide ir, er	CARTIA XT	*hydralazine tab*	*nicardipine cap*	*telmisartan-hctz*
aliskiren tab	*carvedilol tab*	*hydrochlorothiazide*	*nifedipine er tab*	*terazosin cap*
amiloride tab	*carvedilol er cap*	*indapamide tab*	*nimodipine cap*	*TIADYLT ER CAP*
amiloride-hctz	*chlorthalidone tab*	*irbesartan tab*	*nisoldipine er tab*	*timolol maleate tab*
amlodipine tab	*clonidine tab, patch*	*irbesartan-hctz*	*olmesartan*	*torsemide tab*
amlodipine-atorv	DILT-XR	*isradipine cap*	*olm-aml-hctz*	*trandolapril tab*
Amlodipine-benz	*diltiazem tab*	KERENDIA TABS	*olmesartan-hctz*	*trandolapril-verap er*
amlodipine-olmes	*diltiazem cd*	*labetalol tab*	*perindopril tab*	*triamterene caps*
amlodipine-valsart.	*diltiazem er*	*lisinopril tab*	*pindolol tab*	*triamterene-hctz*
amlodipine-val-hctz	*doxazosin tab*	*lisinopril-hctz*	*prazosin cap*	*valsartan tab*
atenolol tab	EDARBI	*losartan tab*	*propranolol,er*	*valsartan-hctz*
atenolol-chlorthalid	EDARBYCLOR	*losartan-hctz*	*quinapril tab*	*verapamil cap pellet*
benazepril tab	*enalapril tab*	MATZIM LA	*quinapril-hctz*	*verapamil tab, er*
benazepril-hctz	*enalapril-hctz*	*methazolamide tab*	*ramipril cap*	*verapamil sr cap*
betaxolol tab	ENTRESTO	*metolazone tab*	*sotalol tab*	*verapamil tab*
bisoprolol tab	*eplerenone tab*	*metoprolol succ er*	*sotalol af tab*	
bisoprolol-hctz	*ethacrynic acid tab*	*metoprolol tart tab*	*spironolactone tab*	
bumetanide tab	*felodipine er*	*metoprolol-hctz*	*spironolactone-hctz*	
BYSTOLIC	*fosinopril tab*	*minoxidil tab*	TAZTIA XT	
candesartan tab	*fosinopril-hctz*	*moexipril tab*	*telmisartan tab*	

candesartan-hctz	*furosemide oral*	*nadolol tab*

^This prescription drug has a Part B versus D administrative prior authorization requirement.

2025 Adherence Package Continued

Blood Thinners

aspirin-dipyridam er	*clopidogrel tab*	ELIQUIS	*prasugrel tab*	XARELTO susp
BRILINTA	*dabigatran caps*	ELIQUIS START PK	*warfarin tab*	XARELTO SRT PK
cilostazol tab	*dipyridamole tab*	JANTOVEN tab	XARELTO tabs	

Cholesterol

atorvastatin tab	*ezetimibe-simvast*	*fluvastatin cap,er tb*	NEXLETOL	*pitavastatin tab*
				pravastatin tab
cholestyramine, light	*fenofibrate cap*	*gemfibrozil tab*	NEXLIZET	*prevalite pwd pkt*
colesevelam pck,tab	*(not 30 mg, 90mg)*	*icosapent ethyl*	NIACOR	*rosuvastatin tab*
colestipol granule, tab	*fenofibrate tab*	LIVALO	*niacin, er RX*	*simvastatin tab*
ezetimibe	*fenofibric acid, dr*	*lovastatin tabs*	*omega-3 ethyl est RX*	VASCEPA

Diabetes

Oral Products				
acarbose tabs	*glyburide-metformin*	JENTADUETO	*pioglitazone tab*	*saxagliptin-metfm er*
FARXIGA	GLYXAMBI	*metformin er osm*	*pioglitazone-glimpir*	SYNJARDY tab
glimepiride tab	JANUMET tab	*metformin tab*	*pioglitazone-metfm*	SYNJARDY XR tab
glipizide ER, XL, tab	JANUMET XR	*metformin er tab*	*repaglinide tab*	TRADJENTA
glipizide-metformin	JANUVIA	*miglitol tab*	RYBELSUS tab	TRIJARDY XR
glyburide tb,micro tb	JARDIANCE	*nateglinide tab*	*saxagliptin*	XIGDUO XR
Insulins				
HUMALOG JR KWK	*insulin lispro JR*	HUMULIN 70/30 vial	LYUMJEV	TRESIBA
HUMALOG KWKPN	*insulin lispro KWKPN*	HUMULIN N	SOLIQUA PEN	XULTOPHY PEN
HUMALOG vial	*insulin lispro vial*	HUMULIN R	TOUJEO MAX	
HUMALOG MIX KWKPN	*insulin lispro mix 75/25 KWKPN*	LANTUS VIALS	TOUJEO SOLOSTR	
HUMALOG MIX vial	HUMULIN 70/30 KWKPN	LANTUS SOLOSTR	TRESIBA FLXTCH	
Injectable Non-Insulin				
BYDUREON BCISE	MOUNJARO PEN	OZEMPIC	TRULICITY	VICTOZA PEN

Diabetic Supplies

ALCOHOL SWABS	INSULIN PEN NDLE	OMNIPOD pks	OMNIPOD STR KIT	VGO 20, 30, 40
GAUZE PADS 2 X 2	INSULIN SYRGES	OMNIPOD DASH		

Osteoporosis

alendronate	*ibandronate tab*	*raloxifene tab*	*risedronate dr tab*
calcitonin-salmon	*pamidronate inj*	*risedronate tab*	*zoledronic acid inj*

Prenatal Vitamins

Formulary Prescription Prenatal Vitamins

2025 Diabetic Glucose Testing Supplies

Drug Name	Medical Benefit	Requirements/Limits
BLOOD GLUCOSE MONITORING DEVICES & SUPPLIES		
PREFERRED DIABETIC METERS		
DEXCOM G6 RECEIVER	Part B $0 Copay	QL (1 EA/ 2 years)
DEXCOM G6 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
DEXCOM G6 TRANSMITTER	Part B $0 Copay	
DEXCOM G7 RECEIVER	Part B $0 Copay	QL (1 EA/ 2 years)
DEXCOM G7 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
DEXCOM RECEIVER KIT	Part B $0 Copay	QL (1 EA/ 2 years)
FREESTYLE GLUCOSE METER	Part B $0 Copay	QL (1 EA/ 2 years)
FREESTYLE FREEDOME LITE METER	Part B $0 Copay	QL (1 EA/ 2 years)
FREESTYLE LIBRE 14 DAY SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 14 DAY READER	Part B $0 Copay	QL (1 EACH /2 years)
FREESTYLE LIBRE 2 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 2 READER	Part B $0 Copay	QL (1 EACH/ 2 years)
FREESTYLE LIBRE 3 SENSOR	Part B $0 Copay	QL (3 UNITS/ 30 day fill)
FREESTYLE LIBRE 3 READER	Part B $0 Copay	QL (1 EACH/ 2 years)
FREESTYLE LITE GLUCOSE METER	Part B $0 Copay	QL (1 EACH/ 2 years)
FREESTYLE PRECISION NEO METER	Part B $0 Copay	QL (1 EACH/ 2 years)
ONETOUCH ULTRA2 GLUCOSE SYST	Part B $0 Copay	QL (1 EACH/ 2 years)
ONETOUCH VERIO FLEX METER	Part B $0 Copay	QL (1 EACH/ 2 years)
ONETOUCH VERIO REFLECT METER	Part B $0 Copay	QL (1 EACH/ 2 years)
PREFERRED DIABETIC GLUCOSE TEST STRIPS		
FREESTYLE LITE GLUCOSE TEST STRIPS	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)
FREESTYLE PREC NEO TEST STRIPS	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)
ONETOUCH ULTRA TEST STRIP	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)
ONETOUCH VERIO TEST STRIP	Part B $0 Copay	QL (200 STRIPS/ 30 day fill)

2025 Covered Diabetic Lancets and Control Solutions

All lancing devices, lancets, and control solutions for diabetic blood sugar monitoring are covered. Below are examples of products available at the time the list was created.

Drug Name	Medical Benefit	Requirements/Limits
DIABETIC SUPPLIES MISCELLANEOUS		
CONTROL SOLUTIONS (EXAMPLES)		
FREESTYLE CONTROL SOLUTIONS	Part B $0 Copay	
ONETOUCH CONTROL SOLUTIONS	Part B $0 Copay	
LANCETS AND LANCING DEVICES (EXAMPLES)		
ACTI-LANCE LANCETS	Part B $0 Copay	
BD LANCETS DEVICES	Part B $0 Copay	
BD LANCETS	Part B $0 Copay	
E-Z JECT LANCETS	Part B $0 Copay	
FREESTYLE LANCETS	Part B $0 Copay	
LANCING DEVICES	Part B $0 Copay	
LANCETS	Part B $0 Copay	
MEDLANCE PLUS LANCETS	Part B $0 Copay	
ONETOUCH LANCET DEVICES	Part B $0 Copay	
ONETOUCH LANCETS	Part B $0 Copay	

1-888-281-7867 (TTY 711)

October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. Messaging service used weekends, after hours, and on federal holidays. Customer service also has free language interpreter services available for non-English speakers.

CignaMedicare.com/group/MAresources