



January 2026

Cigna Healthcare National Preferred Formulary Clinical update

For January 2026, we are making the following changes to achieve better drug affordability and improved pharmacy plan performance for clients and customers.

Single-Source Brand and Generic Removals*

Drug Class	Impacted Medications	Preferred Alternatives(s)
ANTIINFECTIVES Antibiotic Agents for Urinary Tract Infections	fosfomycin	nitrofurantoin macro, nitrofurantoin mono/macro, sulfamethoxazole/trimethoprim, trimethoprim
Antivirals	penciclovir cream, DENAVIR, XERESE	acyclovir oral or cream, famciclovir, valacyclovir
AUTONOMIC & CENTRAL NERVOUS SYSTEM Antiparkinsonism Agents	NOURIANZ	cabergoline, entacapone, pramipexole, rasagiline, ropinirole
Movement Disorders Therapy	AUSTEDO, AUSTEDO XR	INGREZZA, INGREZZA SPRINKLE
Narcotic Analgesics & Combinations	NUCYNTA ER, OXYCODONE ER, OXYCONTIN , XTAMPZA ER	hydrocodone bitartrate er, hydromorphone er, morphine sulfate er, oxymorphone hcl er, HYSINGLA ER
CARDIOVASCULAR Angiotensin Receptor Blockers (ARBs) and Combinations	telmisartan/amlodipine	amlodipine/olmesartan, amlodipine/valsartan
Diuretics	triamterene, DYRENIUM	amiloride hcl, eplerenone, spironolactone
DERMATOLOGICAL Rosacea Agents (Topical)	EPSOLAY, ZILXI	azelaic acid, ivermectin topical, metronidazole topical, sodium sulfacetamide/sulfur, FINACEA FOAM
Topical Agents for Acne	CABTREO, TWYNEO	adapalene, adapalene/benzoyl peroxide, benzoyl peroxide gel, clindamycin topical, clindamycin/benzoyl peroxide, tretinoin, tretinoin micro
Topical Antifungals	naftifine, oxiconazole , ECOZA, ERTACZO, LULICONAZOLE, LUZU, NAFTIN , OXISTAT LOTION, SULCONAZOLE, XOLEGEL	ciclopirox, clotrimazole, econazole, ketoconazole
	ciclopirox 8% treatment kit	ciclopirox 8% topical solution, tavaborole topical solution
Miscellaneous Topical Dermatological Agents	crotamiton	permethrin



Single-Source Brand and Generic Removals* (continued)

Drug Class	Impacted Medications	Preferred Alternatives(s)
DIABETES Blood Glucose Meters & Test Strips	ASCENSIA (CONTOUR) ELI LILLY (TEMPO) LIFESCAN (ONETOUCH SOLUTIONS STARTER, ULTRA, ULTRA2, VERIO, VERIO FLEX)⁴ ROCHE (ACCU-CHEK) ALL OTHER METERS & TEST STRIPS THAT ARE NOT LISTED AS PREFERRED	ABBOTT FREESTYLE KITS/METERS (FREESTYLE FREEDOM, FREESTYLE FREEDOM LITE, FREESTYLE INSULINX, FREESTYLE LITE) ABBOTT FREESTYLE TEST STRIPS (FREESTYLE, FREESTYLE INSULINX, FREESTYLE LITE, FREESTYLE PRECISION NEO) ABBOTT PRECISION XTRA METERS, TEST STRIPS TRIVIDIA METERS (TRUE METRIX AIR, TRUE METRIX, TRUE METRIX GO)TRIVIDIA TEST STRIPS (TRUE METRIX, TRUETRACK)
Insulins	U-100: ADMELOG, APIDRA, FIASP, HUMALOG VIAL , INSULIN ASPART, NOVOLOG, RELION NOVOLOG Inhalation: AFREZZA	U-100: HUMALOG (CARTRIDGE, KWIKPEN, JUNIOR KWIKPEN), HUMALOG TEMPO, INSULIN LISPRO, LYUMJEV KWIKPEN & VIAL, LYUMJEV TEMPO U-200: HUMALOG KWIKPEN, LYUMJEV KWIKPEN
EAR/NOSE Nasal Antihistamines and Combination Products	azelastine/fluticasone , DYMISTA	azelastine nasal plus fluticasone nasal
GASTROINTESTINAL Antidiarrheal Agents	opium tincture , MYTESI	diphenoxylate/atropine, loperamide
MUSCULOSKELETAL & RHEUMATOLOGY Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	COXANTO, DICLOFENAC 35MG CAPSULES, DOLOBID, FENOPROFEN 200MG CAPSULES, FENOPRON, KETOROLAC NASAL SPRAY, OXAPROZIN 300 MG CAPSULES, RELAFEN DS, SPRIX , TIVORBEX, ZORVOLEX	generic oral nonsteroidal anti-inflammatory drugs
OBSTETRICAL & GYNECOLOGICAL Miscellaneous Gynecological Agents	paroxetine mesylate	paroxetine hcl, paroxetine hcl ext-release
OPHTHALMIC Antiglaucoma Agents (Ophthalmic Prostaglandins)	tafluprost drops, travoprost drops , DURYSTA, IDOSE TR, IYUZEH, LUMIGAN,TRAVATAN Z, VYZULTA, XELPROS, ZIOPTAN	bimatoprost drops, latanoprost drops
RENAL Phosphate Binders	FERRIC CITRATE, FOSRENOL POWDER PACKETS, VELPHORO , XPHOZAH	calcium acetate, lanthanum, sevelamer carbonate, sevelamer hcl
RESPIRATORY Pulmonary Anti-Inflammatory Inhalers	ALVESCO, ARMONAIR DIGIHALER, ARNUITY ELLIPTA , FLOVENT DISKUS, FLOVENT HFA, FLUTICASONE PROPIONATE DISKUS, FLUTICASONE PROPIONATE HFA, PULMICORT FLEXHALER	ASMANEX HFA, ASMANEX TWISTHALER, QVAR REDIHALER
MISCELLANEOUS AGENTS Immunosuppressant Agents	JYLAMVO, TREXALL , XATMEP	methotrexate tablets
	OTREXUP, RASUVO	methotrexate injection
Weight Loss	SAXENDA, ZEPBOUND VIALS	WEGOVY, ZEPBOUND PENS

Indication Based Management

Drug Class	Impacted Medications	Preferred Alternatives(s)
Adalimumab Products for Inflammatory Conditions [†]	DALIMUMAB-AACF, IDACIO ADALIMUMAB-AATY, YUFLYMA ADALIMUMAB-FKJP, HULIO ABRILADA AMJEVITA CYLTEZO HADLIMA HUMIRA HYRIMOZ YUSIMRY	ADALIMUMAB-ADAZ ADALIMUMAB-ADB (by Boehringer Ingelheim & Quallent) ADALIMUMAB-RYVK (by Quallent), SIMLANDI
Tocilizumab Products for Inflammatory Conditions [†]	ACTEMRA SC	TYENNE SC
Ustekinumab Products for Inflammatory Conditions [‡]	TULFI SC, PYZCHIVA SC, STELARA SC² , STEQEYMA SC, USTEKINUMAB SC, USTEKINUMAB-AEKN SC, WEZLANA SC	SELARSDI SC, USTEKINUMAB-TTWE SC (by Quallent), YESINTEK SC
Referenced excluded medications for Inflammatory Conditions [‡] as indicated	KINERET, SILIQ	See below for Preferred Alternatives

Drug Class	Other Medications	Preferred Alternatives(s)
Inflammatory Conditions [†]	All other Brand Name medications for Inflammatory Conditions may require a trial of one or more Preferred medications as part of the Formulary exceptions process	ADALIMUMAB-ADAZ, ADALIMUMAB-ADB (by Boehringer Ingelheim & Quallent), ADALIMUMAB-RYVK (by Quallent), ENBREL, OMVOH SC, OTEZLA, RINVOQ, RINVOQ LQ, SELARSDI SC, SIMLANDI, SKYRIZI, SOTYKTU, TALTZ, TREMIFYA SC, USTEKINUMAB-TTWE SC (by Quallent), VELSIPITY, XELJANZ, XELJANZ SOLUTION, XELJANZ XR, YESINTEK SC, ZYMFENTRA Preferred for Non-Radiographic Axial Spondyloarthritis (nr-axSpA) only: CIMZIA, TALTZ Preferred after use of one Preferred Medication: CIMZIA (for Crohn's Disease only), SIMPONI 100MG, TYENNE SC

Multi-Source Brand Removals*

The generic equivalents of the following brand-name medications are covered on the National Preferred Formulary. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance.

BRILINTA
ENDARI

OXTELLAR XR
PROLENSA

PROMACTA
REVLIMID¹

SYMBICORT
TASIGNA

THIOLA EC
VYVANSE³

Non-Preferred to Preferred

INGREZZA, INGREZZA SPRINKLE

Preferred to Non-Preferred

ONE TOUCH CONTROL SOLUTION

Customer communications

Less than 1% of customers will be affected by these changes.

Changes will be effective January 2026 for customers currently using these medications, unless otherwise indicated. We will send letters to impacted customers in early November 2025 to give them ample time to discuss the change with their doctors. Reminder notifications will go out by mid-December 2025.

Health care provider communications

To build awareness and help impacted providers talk with their Cigna Healthcare® patients, we will:

- Send patient-specific letters that outline important formulary changes and covered drug alternatives
- Post information on our provider portal



Medications in **bold** are new exclusions for January 1, 2026.

*If a customer and/or prescriber believes any of the products that will no longer be covered as preferred options are medically necessary, then Cigna Healthcare will review requests for a medical necessity exception.

1. Exclusion impacts new starts January 1, 2026 and existing utilizers April 1, 2026.
2. Continuation of Therapy applies through June 30, 2026; Excluded for all utilizers effective July 1, 2026.
3. Pending generic availability.
4. Exclusion impacts new starts October 13, 2025 and existing utilizers January 1, 2026.

‡ Please note that formulary and product placement for treatment of Inflammatory and Atopic Conditions in the Inflammatory and Atopic Conditions Care Value (IACCV) Program are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.

This document is intended to provide current information as of the time it was published. It does not supersede contractual obligations and other detailed plan documents or contracts. This information is subject to change.

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, the customer may be required to use an in-network pharmacy to fill the prescription or the prescription may not be covered or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements.

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