Medications covered in the Medication Assistance Program

Drug name	Generic product name
ACARBOSE oral tablet	ACARBOSE 25, 50,100 mg
BYDUREON BCISE® (subcutaneous auto injector)	EXENATIDE 2 mg/0.85 ml
BYDUREON® (subcutaneous pen-injection)	EXENATIDE 2 mg
BYETTA® PREFILLED PEN (subcutaneous solution pen-injector)	EXENATIDE 5 mcg/0.02 ml, 10 mcg/0.04 ml
CYCLOSET® oral tablet (prior authorization required)	BROMOCRIPTINE 0.8 mg
FARXIGA® oral tablet	DAPAGLIFLOZIN 5, 10 mg
GLIMEPIRIDE oral tablet	GLIMEPIRIDE 1, 2, 4 mg
GLIPIZIDE ER oral tablet	GLIPIZIDE 2.5, 5, 10 mg
GLIPIZIDE oral tablet	GLIPIZIDE 5, 10 mg
GLIPIZIDE-METFORMIN oral tablet	GLIPIZIDE-METFORMIN 2.5 mg-250, 2.5 mg-500, 5 mg–500 mg
GLYXAMBI® oral tablet	EMPAGLIFLOZIN-LINAGLIPTIN 10 mg–5 mg, 25 mg–5 mg
JANUMET® oral tablet	METFORMIN-SITAGLIPTIN 500 mg–50 mg, 1000 mg–50 mg
JANUMET® XR oral tablet	METFORMIN-SITAGLIPTIN 500 mg–50 mg, 1000 mg-50 mg, 1000 mg–100 mg
JANUVIA® oral tablet	SITAGLIPTIN 25, 50, 100 mg
JARDIANCE® oral tablet	EMPAGLIFLOZIN 10, 25 mg
JENTADUETO® oral tablet	LINAGLIPTIN-METFORMIN 2.5 mg–500 mg, 2.5 mg–850 mg, 2.5 mg–1000 mg
JENTADUETO® XR oral tablet	LINAGLIPTIN-METFORMIN 2.5 mg–1000 mg, 5 mg–1000 mg
METFORMIN HCL ER oral tablet	METFORMIN 500, 750, 1000 mg
METFORMIN HCL oral tablet	METFORMIN 500, 850, 1000 mg, 500 mg/ 5 ml

Medications covered in the Medication Assistance Program

Drug name	Generic product name
MIGLITOL oral tablet	MIGLITOL 25, 50, 100 mg
NATEGLINIDE oral tablet	NATEGLINIDE 60, 120 mg
OZEMPIC® (subcutaneous solution pen-injector)	SEMAGLUTIDE 0.25, 0.5, 1 mg
PIOGLITAZONE HCL oral tablet	PIOGLITAZONE 15, 30, 45 mg
PIOGLITAZONE HCL- GLIMEPIRIDE oral tablet	PIOGLITAZONE-GLIMEPIRIDE 30 mg–2 mg, 30 mg–4 mg
PIOGLITAZONE HCL- METFORMIN HCL oral tablet	PIOGLITAZONE-METFORMIN 15 mg–500 mg, 15 mg–850 mg
REPAGLINIDE oral tablet	REPAGLINIDE 0.5, 1, 2 mg
RIOTMET™ ER (oral suspension reconstituted)	METFORMIN ER 500 mg/ 5 ml
RYBELSUS® oral tablet	SEMAGLUTIDE 3, 7, 14 mg
SYMLINPEN® 60 & 120 (subcutaneous solution pen-injector) (Prior authorization required)	PRAMLINTIDE 1500 mcg/1.5 ml & 2700 mcg/2.7 ml
SYNJARDY® oral tablet	EMPAGLIFLOZIN-METFORMIN 5 mg–500 mg, 5 mg-1000 mg, 12.5 mg–500 mg, 12.5 mg–1000 mg
SYNJARDY® XR oral tablet	EMPAGLIFLOZIN-METFORMIN 5 mg–1000 mg, 10 mg–1000 mg,12.5 mg–1000 mg, 25 mg–1000 mg
TRADJENTA® oral tablet	LINAGLIPTIN 5 mg
TRIJARDY® XR oral tablet	EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN 5 mg–2.5 mg–1000 mg, 10 mg–5 mg–1000mg, 12.5 mg–2.5 mg–1000 mg, 25 mg–5 mg–1000 mg
TRULICITY® (subcutaneous solution pen-injector)	DULAGLUTIDE 0.75 mg/0.5 ml,1.5 mg/0.5 ml
VICTOZA® (subcutaneous solution pen-injector)	LIRAGLUTIDE 18 mg/3 ml
XIGDUO® XR oral tablet	DAPAGLIFLOZIN-METFORMIN 5mg–500mg, 10mg– 500mg, 2.5mg–1000mg, 5mg–1000mg, 10mg–1000mg

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Medication Assistance Program–Application form

How to qualify

Before you fill out the application, please make sure you qualify for the program. Here are the rules:

- You must be part of the Optum Care Network-Utah.
- You must have diabetes. (Your doctor has told you that you have diabetes.)
- You must live in the United States.
- Your income must be at, or below, 350% of the federal poverty level. To figure out if your income meets this rule, see below.

How to figure out if your income qualifies you

Are you in a Medicaid program? If yes, you can skip this section. (You'll need to prove that you're in a Medicaid program.) Go to "Next steps" below.

To find out if your income qualifies you:

- Figure out your total gross annual household income. It is what you earn before taxes and after deductions.
- Does anyone live with you and support you, or help support you? Then add what they earn to your income.
- Add up the number of people who live with you.
- Take the numbers you've figured out above and find them in the chart below

Persons in family/household	Your income must be at or below this number (350% of the federal poverty level[1])
1	$45,080
2	$60,970
3	$76,860
4	$92,750
5	$108,640
6	$124,530
7	$140,420

(Continued on back)

If the chart shows that you don't qualify, you might still qualify. Here are some examples:

- You can't work because you are very sick, or you have big medical bills.
- You have a family emergency, or have lost your job or your income.

If one of these things has happened, call us. You can reach us at **1-801-982-4008, TTY 711**.

Next steps

If you meet the rules shown above, please do this:

1. Fill out and sign the program application form.
2. Place all your papers in the postage paid envelope we've included with this application. Your papers must include:
   - The signed application form
   - Copies of papers that prove your income (see "Proof of income" below)

If you want to fax your papers, our fax number is **1-866-732-1680, TTY 711**.

IMPORTANT: Keep copies of all the papers you send to us.
Once your application arrives in our office, we will give you an answer in 30 days.

Proof of income

Here are examples of proof showing your income.

- Do you have Medicaid or a Low Income Subsidy (LIS)? If yes, please give proof from your state or the federal government. This is the only proof of income you will need.
- Your current paycheck stubs or W-2 forms. We will need to see them for everyone in your household who supports or helps support you.
- The first page of your federal tax return (Form 1040 or 1040EZ). It must be last year's return. It should show your adjusted gross income.
   - If your income has changed from the year prior due to retirement/occupation change, please provide documents that reflect your current income (paycheck stubs, Social Security, pension, bank statements or other income statements).
- Are you retired? If yes, please send your Social Security, pension or other income statements. A current bank statement is enough.

IMPORTANT: What if you don't send proof of income with your application? You can still send them later; however, you must send them within 30 days of sending your application.

[1] The income numbers in the chart are based on data from the U.S. Department of Health and Human Services. You can find the data here: **https://aspe.hhs.gov/poverty-guidelines.**

Please complete items 1–9, sign on the back and return in the enclosed envelope.

OPTUM®

1. Name: ____

2. Health plan member ID. You can find it on your health plan ID card: ____________________

3. Address: ____

4. Telephone: ____

5. Date of birth: ____

6. E-mail (optional): ____

7. Name of spouse (optional): ____

8. Spouse date of birth (optional): ____

9. Number of people in your household (circle one): **1 2 3 4 5 6 7**

I understand that:

- When I sign below, I am saying that my answers and my proof-of-income papers are complete, true and accurate to the best of my knowledge.
- I must give the correct proof-of-income papers within 30 days of sending this application. If I don't, I won't qualify for the medication assistance program.
- Completing this application does not guarantee that I will qualify under the Medication Assistance Program.
- Optum may check that the information I gave is correct. Optum also may ask for more financial information.
- If my financial status changes, I must call the Medication Assistance Program right away. (The number is **1-801-982-4008, TTY 711**.)
- If the Medication Assistance Program helps me pay for medicine, I will not sell, trade, barter, transfer or give that medicine to anyone else.
- Optum Care Network has the right to change or cancel the Medication Assistance Program at any time.
- If I leave my UnitedHealthcare® Medicare Advantage plan, I will no longer qualify for this program.

- Only Optum Care Network may decide who qualifies for the Medication Assistance Program. There is no guarantee that the Medication Assistance Program will help pay for my medicines. There is no guarantee that Optum will offer me any **Medication Assistance Program Eligibility**.
- I must be in the coverage gap (often called the "donut hole") to qualify for the Medication Assistance Program. Here are the rules of the coverage gap:
  - Most Medicare Advantage plans with prescription drug coverage (Part D) have a coverage gap.
  - Typically, you enter the coverage gap when you and your plan have spent a certain amount of money for covered drugs.
  - Once you enter the coverage gap, you'll need to pay all your prescription drug costs, up to a yearly limit.
  - Once you've spent your yearly limit, the coverage gap ends. At that point, your plan may help pay for covered drugs again.

Signature of patient:

X____ Date: ____________________________________

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us, such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 1-888-794-1622, TTY 711. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-888-794-1622, TTY 711.
請注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電：1-888-794-1622, TTY 711。

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