

Changes to Healthfirst Medicare Plan's Formulary

Healthfirst may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Or, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. We may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made. Also, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we may immediately remove the drug from our formulary and provide notice to members who take the drug.

Before we make other changes during the year to our Drug List that affect members currently taking a drug and that require us to provide advance notice, we will notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

If you are affected by a change in drug coverage or restriction, you or your prescriber can ask us to make an exception and continue to cover the drug in the way you would like. The notice we provide you will also include information on the steps to request an exception. To learn more about coverage decisions and how to ask for an exception, see your ***Evidence of Coverage*** or call Member Services at 1-855-771-1081 for additional information. (TTY users should call 1-888-542-3821).

The table below outlines changes to our formulary that may impact you.

| Name of Affected Drug | Description for Change | Reason for Change | Alternative Drug | Alternative Drug Copay* | Effective Date |
|-----------------------|---------------------------------|-------------------------------|--|-------------------------|----------------|
| ALBUTEROL TAB ER | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ALBUTEROL TAB | Tier 4 | 08/01/2021 |
| ALINIA SUSP 100/5ML | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | NITAZOXANIDE TAB 500MG | Tier 5 | 08/01/2021 |
| ALINIA TAB 500MG | Deletion Of Drug From Formulary | Generic Available | NITAZOXANIDE TAB 500MG | Tier 5 | 05/01/2021 |
| AMINOSYN II INJ 10% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PREMASOL SOLN 10% | Tier 4 | 01/01/2021 |
| ANADROL-50 TAB 50MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PROCRIT INJ | Tier 5 | 05/01/2021 |
| ATRIPLA TAB | Deletion Of Drug From Formulary | Generic Available | EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300MG | Tier 5 | 01/01/2021 |
| BANZEL SUSP 40MG/ML | Deletion Of Drug From Formulary | Generic Available | RUFINAMIDE SUS 40MG/ML | Tier 5 | 05/01/2021 |

| Name of Affected Drug | Description for Change | Reason for Change | Alternative Drug | Alternative Drug Copay* | Effective Date |
|-------------------------------------|---------------------------------|-------------------------------|--|-------------------------|----------------|
| CAPTOPRIL & HYDROCHLOROTHIAZIDE TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | LISINOPRIL & HYDROCHLOROTHIAZIDE TAB | Tier 1 | 08/01/2021 |
| CIPRODEX SUSP 0.3-0.1% | Deletion Of Drug From Formulary | Generic Available | CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1% | Tier 3 | 01/01/2021 |
| COLOCORT ENEMA 100MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HYDROCORTISONE ENEMA 100 MG/60ML | Tier 4 | 01/01/2021 |
| COUMADIN TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | WARFARIN TAB | Tier 1 | 01/01/2021 |
| D5W/NACL INJ 0.225% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | D5W/NACL INJ 0.2% | Tier 3 | 01/01/2021 |
| DEMSEER CAP 250MG | Deletion Of Drug From Formulary | Generic Available | METYROSINE CAP 250MG | Tier 5 | 05/01/2021 |
| DEPO-PROVERA INJ 400/ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 02/01/2021 |
| DIDANOSINE CAP 200MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ABACAVIR TAB 300MG | Tier 3 | 04/01/2021 |
| DIDANOSINE CAP 250MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ABACAVIR TAB 300MG | Tier 3 | 04/01/2021 |
| DIDANOSINE CAP 400MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ABACAVIR TAB 300MG | Tier 3 | 04/01/2021 |
| DOCETAXEL INJ 200MG/10ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | DOCETAXEL INJ 160MG/8ML | Tier 5 | 02/01/2021 |
| EMTRIVA CAP 200MG | Deletion Of Drug From Formulary | Generic Available | EMTRICITABINE CAP 200 MG | Tier 3 | 01/01/2021 |
| GLEOSTINE CAP | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | Consult Your Health Care Provider | | 02/01/2021 |
| HUMIRA INJ 10MG/0.2ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HUMIRA INJ 10/0.1ML | Tier 5 | 03/01/2021 |
| HUMIRA KIT 20MG/0.4ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HUMIRA INJ 20/0.2ML | Tier 5 | 03/01/2021 |
| JADENU SPRINKLE GRANULES | Deletion Of Drug From Formulary | Generic Available | DEFERASIROX GRANULES PACKET | Tier 5 | 01/01/2021 |
| JUXTAPID CAP 40MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | JUXTAPID CAP 20MG | Tier 5 | 01/01/2021 |
| JUXTAPID CAP 60MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | JUXTAPID CAP 20MG | Tier 5 | 01/01/2021 |
| KIONEX SUSP 15GM/60 | Deletion Of Drug From Formulary | Manufacturer Discontinuation | SPS SUS 15GM/60 | Tier 3 | 02/01/2021 |
| KLOR-CON SPRINKLE CAP ER | Deletion Of Drug From Formulary | Manufacturer Discontinuation | POTASSIUM CHLORIDE CAP ER | Tier 3 | 02/01/2021 |
| KUVAN POWDER | Deletion Of Drug From Formulary | Generic Available | SAPROPTERIN POWDER | Tier 5 | 05/01/2021 |
| KUVAN TAB 100MG | Deletion Of Drug From Formulary | Generic Available | SAPROPTERIN TAB 100MG | Tier 5 | 05/01/2021 |
| LORCET HD TAB 10-325MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HYDROCODONE-ACETAMINOPHEN TAB 10-325MG | Tier 3 | 01/01/2021 |
| LORCET PLUS TAB 7.5-325MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HYDROCODONE-ACETAMINOPHEN TAB 7.5-325MG | Tier 3 | 01/01/2021 |
| LORCET TAB 5-325MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HYDROCODONE-ACETAMINOPHEN TAB 5-325MG | Tier 3 | 01/01/2021 |
| MAPROTILINE TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | MIRTAZAPINE TAB 15MG | Tier 2 | 09/01/2021 |

| Name of Affected Drug | Description for Change | Reason for Change | Alternative Drug | Alternative Drug Copay* | Effective Date |
|---|---------------------------------|-------------------------------|---|-------------------------|----------------|
| METOPROLOL INJ 1MG/ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | METOPROLOL INJ 5MG/5ML | Tier 3 | 02/01/2021 |
| NEPHRAMINE INJ 5.4% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PROSOL INJ 20% | Tier 4 | 06/01/2021 |
| NORMOSOL -M INJ /D5W | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | ISOLYTE-P INJ /D5W | Tier 4 | 05/01/2021 |
| NORMOSOL -R INJ | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | ISOLYTE-S INJ | Tier 4 | 01/01/2021 |
| ONE VITE TAB 1MG PLUS | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | PRENATAL TAB 27-1MG | Tier 3 | 01/01/2021 |
| PEGASYS INJ PROCLICK | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PEGASYS INJ | Tier 5 | 02/01/2021 |
| PHOSPHOLINE SOLN 0.125%OP | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PILOCARPINE OPHTH SOLN | Tier 3 | 08/01/2021 |
| PROPRANOLOL & HYDROCHLOROTHIAZIDE TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | METOPROLOL & HYDROCHLOROTHIAZIDE TAB | Tier 3 | 09/01/2021 |
| ROWEEPRA XR TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | LEVETIRACETAM TAB ER 24HR | Tier 3 | 02/01/2021 |
| SAPHRIS SL TAB | Deletion Of Drug From Formulary | Generic Available | ASENAPINE MALEATE SL TAB | Tier 4 | 05/01/2021 |
| SODIUM POLYSTYRENE SULFONATE ORAL SUSP 15 GM/60ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | SPS SUS 15GM/60 | Tier 3 | 02/01/2021 |
| SUMATRIPTAN PREFILLED SYRINGE 6 MG/0.5ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | SUMATRIPTAN AUTO-INJECTOR 6 MG/0.5ML | Tier 4 | 06/01/2021 |
| SYLATRON KIT | Deletion Of Drug From Formulary | Manufacturer Discontinuation | INTRON A INJ | Tier 5 | 01/01/2021 |
| SYMFI LO TAB | Deletion Of Drug From Formulary | Generic Available | EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 400-300-300MG | Tier 5 | 05/01/2021 |
| SYMFI TAB | Deletion Of Drug From Formulary | Generic Available | EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 600-300-300MG | Tier 5 | 05/01/2021 |
| TRUVADA TAB 133-200 | Deletion Of Drug From Formulary | Generic Available | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 133-200 | Tier 5 | 05/01/2021 |
| TRUVADA TAB 100-150 | Deletion Of Drug From Formulary | Generic Available | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 100-150 | Tier 5 | 05/01/2021 |
| TRUVADA TAB 167-250 | Deletion Of Drug From Formulary | Generic Available | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 167-250 | Tier 5 | 05/01/2021 |
| TRUVADA TAB 200-300MG | Deletion Of Drug From Formulary | Generic Available | EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300MG | Tier 5 | 01/01/2021 |
| TYKERB TAB 250MG | Deletion Of Drug From Formulary | Generic Available | LAPATINIB TAB 250MG | Tier 5 | 05/01/2021 |

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your physician can determine if one of the alternatives listed here is appropriate for you given the individualized nature of drug therapy. Please consult your physician to confirm if this is an appropriate drug for you.

Coverage is provided by Healthfirst Health Plan, Inc.

Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2021 and from time-to-time during the year.

Healthfirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY 1-888-867-4132). 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-305-0408 (TTY 1-888-542-3821).