

Changes to Healthfirst 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 Customer Care at 1-888-260-1010 (TTY: 711), 24 hours a day, 7 days a week.

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
ALINIA TAB 500MG	Deletion Of Drug From Formulary	Generic Available	NITAZOXANIDE TAB 500MG	Tier 1	05/01/2021
AMINOSYN II INJ 10%	Deletion Of Drug From Formulary	Manufacturer Discontinuation	PREMASOL SOLN 10%	Tier 1	01/01/2021
ANADROL-50 TAB 50MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	PROCRIT INJ	Tier 1	05/01/2021
ATRIPLA TAB	Deletion Of Drug From Formulary	Generic Available	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300MG	Tier 1	01/01/2021
BANZEL SUSP 40MG/ML	Deletion Of Drug From Formulary	Generic Available	RUFINAMIDE SUS 40MG/ML	Tier 1	05/01/2021
CIPRODEX SUSP 0.3-0.1%	Deletion Of Drug From Formulary	Generic Available	CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	Tier 1	01/01/2021
COLOCORT ENEMA 100MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCORTISONE ENEMA 100 MG/60ML	Tier 1	01/01/2021
COUMADIN TAB	Deletion Of Drug From Formulary	Manufacturer Discontinuation	WARFARIN TAB	Tier 1	01/01/2021

Name of Affected Drug	Description for Change	Reason for Change	Alternative Drug	Alternative Drug Copay*	Effective Date
D5W/NACL INJ 0.225%	Deletion Of Drug From Formulary	Manufacturer Discontinuation	D5W/NACL INJ 0.2%	Tier 1	01/01/2021
DEMSEER CAP 250MG	Deletion Of Drug From Formulary	Generic Available	METYROSINE CAP 250MG	Tier 1	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 1	04/01/2021
DIDANOSINE CAP 250MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	ABACAVIR TAB 300MG	Tier 1	04/01/2021
DIDANOSINE CAP 400MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	ABACAVIR TAB 300MG	Tier 1	04/01/2021
DOCETAXEL INJ 200MG/10ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	DOCETAXEL INJ 160MG/8ML	Tier 1	02/01/2021
EMTRIVA CAP 200MG	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE CAP 200 MG	Tier 1	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 1	03/01/2021
HUMIRA KIT 20MG/0.4ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HUMIRA INJ 20/0.2ML	Tier 1	03/01/2021
JADENU SPRINKLE GRANULES	Deletion Of Drug From Formulary	Generic Available	DEFERASIROX GRANULES PACKET	Tier 1	01/01/2021
JUXTAPID CAP 40MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	JUXTAPID CAP 20MG	Tier 1	01/01/2021
JUXTAPID CAP 60MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	JUXTAPID CAP 20MG	Tier 1	01/01/2021
KIONEX SUSP 15GM/60	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SPS SUS 15GM/60	Tier 1	02/01/2021
KLOR-CON SPRINKLE CAP ER	Deletion Of Drug From Formulary	Manufacturer Discontinuation	POTASSIUM CHLORIDE CAP ER	Tier 1	02/01/2021
KUVAN POWDER	Deletion Of Drug From Formulary	Generic Available	SAPROPTERIN POWDER	Tier 1	05/01/2021
KUVAN TAB 100MG	Deletion Of Drug From Formulary	Generic Available	SAPROPTERIN TAB 100MG	Tier 1	05/01/2021
LORCET HD TAB 10-325MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCODONE-ACETAMINOPHEN TAB 10-325MG	Tier 1	01/01/2021
LORCET PLUS TAB 7.5-325MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325MG	Tier 1	01/01/2021
LORCET TAB 5-325MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCODONE-ACETAMINOPHEN TAB 5-325MG	Tier 1	01/01/2021
METOPROLOL INJ 1MG/ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	METOPROLOL INJ 5MG/5ML	Tier 1	02/01/2021
NORMOSOL -M INJ /D5W	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	ISOLYTE-P INJ /D5W	Tier 1	05/01/2021
NORMOSOL -R INJ	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	ISOLYTE-S INJ	Tier 1	01/01/2021
ONE VITE TAB 1MG PLUS	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	PRENATAL TAB 27-1MG	Tier 1	01/01/2021
PEGASYS INJ PROCLICK	Deletion Of Drug From Formulary	Manufacturer Discontinuation	PEGASYS INJ	Tier 1	02/01/2021

Name of Affected Drug	Description for Change	Reason for Change	Alternative Drug	Alternative Drug Copay*	Effective Date
ROWEEPRA XR TAB	Deletion Of Drug From Formulary	Manufacturer Discontinuation	LEVETIRACETAM TAB ER 24HR	Tier 1	02/01/2021
SAPHRIS SL TAB	Deletion Of Drug From Formulary	Generic Available	ASENAPINE MALEATE SL TAB	Tier 1	05/01/2021
SODIUM POLYSTYRENE SULFONATE ORAL SUSP 15 GM/60ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SPS SUS 15GM/60	Tier 1	02/01/2021
SYLATRON KIT	Deletion Of Drug From Formulary	Manufacturer Discontinuation	INTRON A INJ	Tier 1	01/01/2021
SYMFI LO TAB	Deletion Of Drug From Formulary	Generic Available	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 400-300-300MG	Tier 1	05/01/2021
SYMFI TAB	Deletion Of Drug From Formulary	Generic Available	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DF TAB 600-300-300MG	Tier 1	05/01/2021
TRUVADA TAB 133-200	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 133-200	Tier 1	05/01/2021
TRUVADA TAB 100-150	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 100-150	Tier 1	05/01/2021
TRUVADA TAB 167-250	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 167-250	Tier 1	05/01/2021
TRUVADA TAB 200-300MG	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300MG	Tier 1	01/01/2021
TYKERB TAB 250MG	Deletion Of Drug From Formulary	Generic Available	LAPATINIB TAB 250MG	Tier 1	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).