

Changes to the CareFirst BlueCross BlueShield Medicare Advantage Enhanced (HMO) Formulary

CareFirst BlueCross BlueShield Medicare Advantage Enhanced (HMO) 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 855- 290-5744 (TTY: 711), 8:00 a.m.-8:00 p.m. ET, 7 days a week from October 1 through March 31 and 8:00 a.m.-8:00 p.m. ET, Monday through Friday from April 1 through September 30.

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

| Name of Affected Drug | Description of Change | Reason for Change | Alternative Drug(s) * | Alternative Drug(s) Cost-Sharing Tier | Effective Date |
|--|---------------------------------|------------------------------|---|---------------------------------------|----------------|
| AMABELZ TAB 1-0.5MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ESTRADIOL & NORETHINDRONE ACETATE TAB 1-0.5 MG; MIMVEY TAB 1-0.5 MG | Tier 3 | 03/01/2024 |
| CEFACLOR SUS 125/5ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CEFACLOR SUS 250MG/5ML | Tier 4 | 02/01/2024 |
| CEFACLOR SUS 375/5ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CEFACLOR SUS 250MG/5ML | Tier 4 | 02/01/2024 |
| CEFTAZIDIME/ SOL D5W 1GM | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CEFTAZIDIME INJ | Tier 4 | 02/01/2024 |
| CEFTAZIDIME/ SOL D5W 2GM | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CEFTAZIDIME INJ | Tier 4 | 02/01/2024 |
| CIPROFLOXACIN HCL TAB 100 MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CIPROFLOXACIN HCL TAB 250 MG | Tier 1 | 02/01/2024 |
| CLINDAMYCIN INJ 300MG/2ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CLINDAMYCIN INJ 600MG/4ML | Tier 3 | 02/01/2024 |
| EMCYT CAP 140MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 05/01/2024 |
| FLEBOGAMMA DIF INJ 10GM/100ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | BIVIGAM INJ 10GM/100ML; GAMMAPLEX INJ 10GM/100ML; OCTAGAM INJ 10GM/100ML; PRIVIGEN INJ 10GM/100ML | Tier 5 | 03/01/2024 |
| FLEBOGAMMA DIF INJ 2.5GM/50ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | OCTAGAM INJ 2.5GM/50ML | Tier 5 | 03/01/2024 |
| FLEBOGAMMA DIF INJ 20GM/200ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | GAMMAPLEX INJ 20GM/200ML; OCTAGAM INJ 20GM/200ML; PRIVIGEN INJ 20GM/200ML | Tier 5 | 03/01/2024 |
| FLEBOGAMMA DIF INJ 5GM/50ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | BIVIGAM INJ 5GM/50ML; GAMMAPLEX INJ 5GM/50ML; OCTAGAM INJ 5GM/50ML; PRIVIGEN INJ 5GM/50ML | Tier 5 | 03/01/2024 |
| GVOKE PFS INJ PREF SYRINGE 0.5 MG/0.1ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | GVOKE PFS INJ PREF SYRINGE 1MG/0.2ML; GVOKE HYPOPEN; GVOKE KIT | Tier 3 | 03/01/2024 |
| HUMIRA PEN INJ CD/UC/HS | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HUMIRA PEN INJ 40MG/0.8ML | Tier 5 | 04/01/2024 |
| NEVIRAPINE TAB ER 100MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | NEVIRAPINE TAB ER 400MG | Tier 4 | 02/01/2024 |
| OLOPATADINE DROPS 0.1% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | AZELASTINE HCL OPTH SOLN 0.05% | Tier 3 | 02/01/2024 |
| PAROMOMYCIN CAP 250MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 04/01/2024 |
| PENICILLIN G PROCAINE INJ SUSP 600000UNIT/ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PENICILLIN G POTASSIUM INJ SOLR 5000000 UNIT, 20000000 UNIT | Tier 4 | 03/01/2024 |
| RISPERDAL CONSTA INJ 12.5MG | Deletion Of Drug From Formulary | Generic Available | RISPERIDONE INJ 12.5MG ER | Tier 4 | 05/01/2024 |
| RISPERDAL CONSTA INJ 25MG | Deletion Of Drug From Formulary | Generic Available | RISPERIDONE INJ 25MG ER | Tier 4 | 05/01/2024 |
| RISPERDAL CONSTA INJ 37.5MG | Deletion Of Drug From Formulary | Generic Available | RISPERIDONE INJ 37.5MG ER | Tier 5 | 05/01/2024 |
| RISPERDAL CONSTA INJ 50MG | Deletion Of Drug From Formulary | Generic Available | RISPERIDONE INJ 50MG ER | Tier 5 | 05/01/2024 |
| STAVUDINE CAP | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ABACAVIR TAB; EMTRICITABINE CAP; LAMIVUDINE 150 MG, 300 MG TAB; ZIDOVUDINE TAB | Tier 3 | 01/01/2024 |

| Name of Affected Drug | Description of Change | Reason for Change | Alternative Drug(s) * | Alternative Drug(s) Cost-Sharing Tier | Effective Date |
|------------------------------|---------------------------------|------------------------------|------------------------------|--|-----------------------|
| SYMJEPI INJ 0.15MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | EPINEPHRINE INJ 0.15MG | Tier 3 | 02/01/2024 |
| SYMJEPI INJ 0.3MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | EPINEPHRINE INJ 0.3MG | Tier 3 | 02/01/2024 |
| SYNRIBO INJ 3.5MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ICLUSIG TAB; SCEMBLIX TAB | Tier 5 | 02/01/2024 |
| TRICARE TAB PRENATAL | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PRENATAL TAB 27-1MG | Tier 3 | 01/01/2024 |
| VOTRIENT TAB 200MG | Deletion Of Drug From Formulary | Generic Available | PAZOPANIB HCL TAB 200 MG | Tier 5 | 05/01/2024 |

*Alternative drug(s) are drugs that you could consider with your prescriber. Only your prescriber can determine alternative drugs that are appropriate for you given the individualized nature of drug therapy. Please consult your prescriber to confirm if this is an appropriate drug for you.