CareFirst Medicare Advantage

Upcoming CareFirst Medicare Formulary Updates

CareFirst BlueCross BlueShield Group Advantage (PPO) strives to provide affordable, accessible care to our members. We conduct a review of our formularies and make changes to encourage utilization of safe and clinically cost-effective drugs.

This document provides a list of formulary changes effective January 1, 2025. It is not inclusive of all formulary changes. You can view a complete list of covered drugs and utilization management programs on our website. Please visit the website for more information: Group Medicare Advantage Prescription Drug Coverage | CareFirst BlueCross BlueShield Medicare

Formulary Drug Removals

Below is a list of commonly prescribed medications that will no longer be covered, along with covered drug alternatives. This list is not all inclusive. If you need a non-formulary drug to be covered for medical necessity reasons, you or your providers may submit a coverage determination request (more information below).

Product	Drug Class	Covered Alternative(s)*
diclofenac gel 1%	Nonsteroidal Anti-inflammatory Drug (NSAID)	diclofenac solution 1.5%
ENTYVIO INJ	Autoimmune Agent	IDACIO INJ, ADALIMUMAB-AACF INJ, HUMIRA INJ, SKYRIZI INJ, STELARA INJ
FLOVENT HFA/ FLOVENT DISKUS	Steroid Inhalants	fluticasone (generic FLOVENT), ALVESCO AER
INSULIN GLARGINE 100 units/ml VIAL	Diabetes	BASAGLAR KWIKPEN INJ, TOUJEO SOLOSTAR INJ, TOUJEO MAX SOLOSTAR INJ, TRESIBA INJ, TRESIBA FLEXTOUCH INJ, LANTUS INJ, SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ
LEVEMIR VIAL/FLEXPEN	Diabetes	BASAGLAR KWIKPEN INJ, TOUJEO SOLOSTAR INJ, TOUJEO MAX SOLOSTAR INJ, TRESIBA INJ, TRESIBA FLEXTOUCH INJ, LANTUS INJ, SEMGLEE INJ, INSULIN GLARGINE SOLOSTAR INJ 300 UNIT/ML, INSULIN GLARGINE MAX SOLOSTAR INJ 300 UNIT/ML, INSULIN GLARGINE-YFGN INJ

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Formulary Drug Tier Changes

Below is a list of commonly prescribed medications that will move to a higher tier, along with covered drug alternatives. This list is not all inclusive. If you need a drug covered at a lower cost-share tier, you or your providers may submit a coverage determination request (more information below).

Product	Drug Class	Covered Alternative(s)*
ALPHAGAN P SOL 0.1%	Antiglaucoma	brimonidine sol
ALREX	Anti-inflammatory	loteprednol sus 0.2% (generic of ALREX)
BYDUREON BCISE	Diabetes	liraglutide (generic VICTOZA), MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY
ENSTILAR	Dermatology	calcipotriene-betamethasone dipropionate ointment, calcipotriene-betamethasone dipropionate suspension
OXYCONTIN	Opioids	fentanyl patch, hydrocodone bitartrate er, hydromorphone hcl er, methadone hcl, morphine sulfate er, oxymorphone hydrochloride, tramadol hcl er
VICTOZA	Diabetes	liraglutide (generic VICTOZA), MOUNJARO, OZEMPIC, RYBELSUS, TRULICITY

Utilization Management Changes

Below is a list of medications that will require utilization management including prior authorization.

Product	Drug Class	Note
edarbyclor	Blood Pressure	Step Therapy
eletriptan	Migraines	Step Therapy
risedronate DR tablet	Osteoporosis	Step Therapy
Ivermectin cream	Dermatology	Prior Authorization
tacrolimus ointment	Dermatology	Prior Authorization
terbinafine tablet	Antifungal	Prior Authorization
VERQUVO	Heart Failure	Prior Authorization

Brand names are CAPITALIZED.

Frequently Asked Questions:

- **Does CareFirst have preferred blood glucose monitors and test strips?**
  - Yes, Group Advantage has preferred test strips and blood glucose monitors. OneTouch and Accu-Chek are the preferred test strips and blood glucose monitors covered at network pharmacies with a valid prescription.

- **Where can you find information on drug coverage?**
  - Website- Prescription Drug Plan Management | CareFirst BlueCross BlueShield Medicare

- **What is a coverage determination?**
  A Coverage Determination is a decision CareFirst makes about your benefit and coverage and the amount you will pay. If a drug is not covered or there are restrictions or limits on a drug, you or your prescriber may request a coverage determination. To ensure you receive your prescription drug when you need it, a standard review will be completed in 72 hours or less, and an expedited review will be completed in 24 hours or less.

- **How to Request a Coverage Determination?**
  The member, prescriber or member's appointed representative may request a coverage decision and/or exception any of the following ways:

  - **Phone:** Contact customer service for any requests including making an oral request related to Coverage Determination and Appeals. Our customer service team is available 24/7/365 at 888-970-0917
  - **Fax:** 855-633-7673
  - **Online:** Coverage Determination Form English | Spanish
  - **Mail:** CVS Caremark Coverage Determinations/Exceptions
    P.O. Box 52000
    MC109
    Phoenix, AZ 85072-2000