



Upcoming Changes to Blue MedicareRxSM Value Plus (PDP)'s Formulary

Blue MedicareRx Value Plus 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, depending on the type of change, there may be different options to consider. For example:

You may be able to use another drug on our Drug List to treat your medical condition. Alternative drug(s) are provided below to help your prescriber to find a covered drug that might work for you. Ask your prescriber if one of the possible alternative drug(s) is right for you.

You, your prescriber, or your authorized representative may also ask for an exception.

The table below outlines upcoming 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 |
|-----------------------|---------------------------------|-------------------------------|-----------------------|---------------------------------------|----------------|
| AMINOSYN-PF INJ 7% | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | TROPHAMINE INJ 10% | Tier 4 | 05/01/2022 |
| BEKYREE TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | KARIVA TAB 28 DAY | Tier 3 | 02/01/2022 |
| CHANTIX PAK 1MG | Deletion Of Drug From Formulary | Generic Available | VARENICLINE TAB 1MG | Tier 4 | 05/01/2022 |

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|--------------------------|---------------------------------|---|------------------------------------|---------------------------------------|----------------|
| CHANTIX TAB | Deletion Of Drug From Formulary | Generic Available | VARENICLINE TAB | Tier 4 | 05/01/2022 |
| CYCLAFEM TAB 1/35 | Deletion Of Drug From Formulary | Manufacturer Discontinuation | NORTREL TAB 1/35 | Tier 3 | 02/01/2022 |
| CYCLAFEM TAB 7/7/7 | Deletion Of Drug From Formulary | Manufacturer Discontinuation | NORTREL TAB 7/7/7 | Tier 3 | 02/01/2022 |
| DEXILANT CAP DR | Deletion Of Drug From Formulary | Generic Available | DEXLANSOPRAZOLE CAP DR | Tier 4 | 08/01/2022 |
| DUREZOL EMU 0.05% | Deletion Of Drug From Formulary | Generic Available | DIFLUPREDNATE EMU 0.05% | Tier 3 | 05/01/2022 |
| FARYDAK CAP | Deletion Of Drug From Formulary | Manufacturer Discontinuation | XPOVIO PAK | Tier 5 | 06/01/2022 |
| FREAMINE HBC INJ 6.9% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | FREAMINE III INJ 10% | Tier 4 | 01/01/2022 |
| INTELENCE TAB 100MG | Deletion Of Drug From Formulary | Generic Available | ETRAVIRINE TAB 100MG | Tier 5 | 01/01/2022 |
| INTELENCE TAB 200MG | Deletion Of Drug From Formulary | Generic Available | ETRAVIRINE TAB 200MG | Tier 5 | 01/01/2022 |
| IVERMECTIN TAB 3MG | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 03/01/2022 |
| KALETRA TAB 100-25MG | Deletion Of Drug From Formulary | Generic Available | LOPINAVIR-RITONAVIR TAB 100-25 MG | Tier 4 | 01/01/2022 |
| KALETRA TAB 200-50MG | Deletion Of Drug From Formulary | Generic Available | LOPINAVIR-RITONAVIR TAB 200-50 MG | Tier 4 | 01/01/2022 |
| MINITRAN TD PATCH | Deletion Of Drug From Formulary | Manufacturer Discontinuation | NITROGLYCERIN TD PATCH | Tier 3 | 02/01/2022 |
| MONDOXYNE NL CAP 100MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | DOXYCYCLINE MONOHYDRATE CAP 100 MG | Tier 2 | 02/01/2022 |
| NARCAN SPR | Deletion Of Drug From Formulary | Generic Available | NALOXONE HCL SPR | Tier 3 | 05/01/2022 |
| PREVIFEM TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | SPRINTEC 28 TAB 28 DAY | Tier 3 | 07/01/2022 |
| SUTENT CAP | Deletion Of Drug From Formulary | Generic Available | SUNITINIB CAP | Tier 5 | 01/01/2022 |
| TRILYTE SOLN | Deletion Of Drug From Formulary | Manufacturer Discontinuation | GAVILYTE-N SOLN FLAVOR PACK | Tier 2 | 01/01/2022 |
| TRI-PREVIFEM TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | TRI-SPRINTEC TAB | Tier 3 | 04/01/2022 |
| UKONIQ TAB 200MG | Deletion Of Drug From Formulary | Market Removal | Consult Your Health Care Provider | | 08/01/2022 |
| VIMPAT TAB | Deletion Of Drug From Formulary | Generic Available | LACOSAMIDE TAB | Tier 4 | 08/01/2022 |
| XCOPRI TAB PACK 50-200MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | XCOPRI TAB | Tier 4 | 01/01/2022 |
| ZARAH TAB 3-0.03MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | SYEDA TAB 3-0.03MG | Tier 3 | 03/01/2022 |

* 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.

**Applies to new starts

Blue MedicareRx (PDP) is a Prescription Drug Plan with a Medicare Contract. Blue MedicareRx Value Plus (PDP) and Blue MedicareRx Premier (PDP) are two Medicare Prescription Drug Plans available to service residents of Connecticut, Massachusetts, Rhode Island, and Vermont.

Coverage is available to residents of the service area or members of an employer or union group and separately issued by one of the following plans: Anthem Blue Cross® and Blue Shield® of Connecticut, Blue Cross Blue Shield of Massachusetts, Blue Cross and Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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