## Changes to Elderplan's Formulary

**Elderplan** 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 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 1-866-490-2102 (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 of Change | Reason for Change | Alternative Drug(s) * | Alternative Drug(s) Cost-Sharing Tier | Effective Date |
|---|---|---|---|---|---|
| AVITA GEL 0.025% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | TRETINOIN GEL 0.025% | Tier 1 | 07/01/2023 |
| BYDUREON BC INJ | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 10/01/2023 |
| BYETTA INJ 10MCG | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 10/01/2023 |
| CALCITRIOL INJ 1MCG/ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CALCITRIOL SOL 1MCG/ML | Tier 1 | 07/01/2023 |
| CAZIANT PAK | Deletion Of Drug From Formulary | Manufacturer Discontinuation | VELIVET PAK | Tier 1 | 01/01/2023 |
| DALIRESP TAB | Deletion Of Drug From Formulary | Generic Available | ROFLUMILAST TAB | Tier 1 | 05/01/2023 |
| DIGOX TAB 0.125MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | DIGOXIN TAB 0.125MG | Tier 1 | 01/01/2023 |
| DIGOX TAB 0.25MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | DIGOXIN TAB 0.25MG | Tier 1 | 01/01/2023 |
| ELLA TAB 30MG | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | Consult Your Health Care Provider | | 04/01/2023 |
| ESBRIET CAP 267MG | Deletion Of Drug From Formulary | Generic Available | PIRFENIDONE CAP 267 MG | Tier 1 | 05/01/2023 |
| GILENYA CAP 0.5MG | Deletion Of Drug From Formulary | Generic Available | FINGOLIMOD CAP 0.5MG | Tier 1 | 05/01/2023 |
| HETLIOZ CAP 20MG | Deletion Of Drug From Formulary | Generic Available | TASIMELTEON CAP 20MG | Tier 1 | 05/01/2023 |
| KYNMOBI FILM | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 08/01/2023 |
| LARISSIA TAB | Deletion Of Drug From Formulary | Manufacturer Discontinuation | AVIANE TAB | Tier 1 | 02/01/2023 |
| LEVO-T TAB | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | LEVOTHYROXINE SODIUM TAB | Tier 1 | 08/01/2023 |
| LIDOCAINE HCL GEL 2% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | GLYDO GEL 2% | Tier 1 | 07/01/2023 |
| MYORISAN CAP | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CLARAVIS CAP | Tier 1 | 07/01/2023 |
| NORVIR SOLN 80MG/ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | NORVIR PACKET 100MG | Tier 1 | 04/01/2023 |
| OZEMPIC INJ | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 10/01/2023 |
| PASER PACKETS 4GM | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 03/01/2023 |
| PRENATAL VIT TAB LOW IRON | Deletion Of Drug From Formulary | Manufacturer Discontinuation | PRENATAL TAB 27-1MG | Tier 1 | 03/01/2023 |
| PROCALAMINE INJ 3% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CLINIMIX INJ 4.25/D5W | Tier 1 | 08/01/2023 |
| PROCTO-PAK CRE 1% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | HYDROCORTISONE PERIANAL CREAM 1% | Tier 1 | 09/01/2023 |
| ROSADAN CREAM 0.75% | Deletion Of Drug From Formulary | Manufacturer Discontinuation | METRONIDAZOLE CREAM 0.75% | Tier 1 | 03/01/2023 |
| RYBELSUS TAB | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 10/01/2023 |

| Name of Affected Drug | Description of Change | Reason for Change | Alternative Drug(s) * | Alternative Drug(s) Cost-Sharing Tier | Effective Date |
|---|---|---|---|---|---|
| SYNERCID INJ 500MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 09/01/2023 |
| TOPOSAR INJ 100/5ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ETOPOSIDE INJ 20MG/ML | Tier 1 | 09/01/2023 |
| TOPOSAR INJ 1GM/50ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | ETOPOSIDE INJ 1GM/50ML | Tier 1 | 09/01/2023 |
| TRULICITY INJ | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 10/01/2023 |
| VICTOZA INJ | Prior Authorization Added** | PA Added To Ensure Use Is For A Part D Covered Indication | Consult Your Health Care Provider | | 10/01/2023 |

*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.

**If you are currently taking this drug, this change will not affect your coverage for this drug for the rest of the plan year.