CareFirst BlueCross BlueShield
Medicare Advantage
P.O. Box 915
Owings Mills, MD 21117-5559
carefirst.com/mddsnp

Changes to CareFirst BlueCross BlueShield Advantage DualPrime (HMO-SNP) Formulary

CareFirst BlueCross BlueShield Advantage DualPrime (HMO-SNP) 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 410-779-9932 or toll-free at 1-844-386-6762 (TTY: 711), 8 am – 8 pm EST, 7 days a week, October 1 through March 31 and Monday through Friday, April 1 through September 30.

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
AMINOSYN-PF INJ 7%	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	TROPHAMINE INJ 10%	Tier 1	05/01/2022
BEKYREE TAB	Deletion Of Drug From Formulary	Manufacturer Discontinuation	KARIVA TAB 28 DAY	Tier 1	02/01/2022
BYSTOLIC TAB	Deletion Of Drug From Formulary	Generic Available	NEBIVOLOL TAB	Tier 1	05/01/2022
CHANTIX PAK 1MG	Deletion Of Drug From Formulary	Generic Available	VARENICLINE TAB 1MG	Tier 1	05/01/2022
CHANTIX TAB	Deletion Of Drug From Formulary	Generic Available	VARENICLINE TAB	Tier 1	05/01/2022
CYCLAFEM TAB 1/35	Deletion Of Drug From Formulary	Manufacturer Discontinuation	NORTREL TAB 1/35	Tier 1	02/01/2022
CYCLAFEM TAB 7/7/7	Deletion Of Drug From Formulary	Manufacturer Discontinuation	NORTREL TAB 7/7/7	Tier 1	02/01/2022
DUREZOL EMU 0.05%	Deletion Of Drug From Formulary	Generic Available	DIFLUPREDNATE EMU 0.05%	Tier 1	05/01/2022
FAYOSIM TAB	Deletion Of Drug From Formulary	Manufacturer Discontinuation	RIVELSA TAB	Tier 1	02/01/2022
FREAMINE HBC INJ 6.9%	Deletion Of Drug From Formulary	Manufacturer Discontinuation	FREAMINE III INJ 10%	Tier 1	01/01/2022
INTELENCE TAB 100MG	Deletion Of Drug From Formulary	Generic Available	ETRAVIRINE TAB 100MG	Tier 1	01/01/2022
INTELENCE TAB 200MG	Deletion Of Drug From Formulary	Generic Available	ETRAVIRINE TAB 200MG	Tier 1	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 1	01/01/2022
KALETRA TAB 200-50MG	Deletion Of Drug From Formulary	Generic Available	LOPINAVIR-RITONAVIR TAB 200-50 MG	Tier 1	01/01/2022
MIBELAS 24 CHEW FE	Deletion Of Drug From Formulary	Manufacturer Discontinuation	NORETHINDRONE ACE-ETH ESTRADIOL-FE CHEW TAB 1 MG-20 MCG (24)	Tier 1	02/01/2022
MINITRAN TD PATCH	Deletion Of Drug From Formulary	Manufacturer Discontinuation	NITROGLYCERIN TD PATCH	Tier 1	02/01/2022
MONDOXYNE NL CAP 100MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	DOXYCYCLINE MONOHYDRATE CAP 100 MG	Tier 1	02/01/2022
NARCAN SPR	Deletion Of Drug From Formulary	Generic Available	NALOXONE HCL SPR	Tier 1	05/01/2022

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Cost-Sharing Tier	Effective Date
SUTENT CAP	Deletion Of Drug From Formulary	Generic Available	SUNITINIB CAP	Tier 1	01/01/2022
TRILYTE SOLN	Deletion Of Drug From Formulary	Manufacturer Discontinuation	GAVILYTE-N SOLN FLAVOR PACK	Tier 1	01/01/2022
TRI-PREVIFEM TAB	Deletion Of Drug From Formulary	Manufacturer Discontinuation	TRI-SPRINTEC TAB	Tier 1	04/01/2022
XCOPRI TAB PACK 50-200MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	XCOPRI TAB	Tier 1	01/01/2022
ZARAH TAB 3-0.03MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SYEDA TAB 3-0.03MG	Tier 1	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