Changes to INTEGRITY's Formulary January 2021

Neighborhood INTEGRITY 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 1-844-812-6896 (TTY: 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and holidays, you may be asked to leave a message.

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

Name of Affected Drug	Description for Change	Reason for Change	Alternative Drug	Alternative Drug Copay*	Effective Date
AMINOSYN II INJ 10%	Deletion Of Drug From Formulary	Manufacturer Discontinuation	PREMASOL SOLN 10%	Tier 2	01/01/2021
ATRIPLA TAB	Deletion Of Drug From Formulary	Generic Available	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DF TAB 600-200-300MG	Tier 2	01/01/2021
CIPRODEX SUSP 0.3-0.1%	Deletion Of Drug From Formulary	Generic Available	CIPROFLOXACIN-DEXAMETHASONE OTIC SUSP 0.3-0.1%	Tier 1	01/01/2021
COLOCORT ENEMA 100MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCORTISONE ENEMA 100 MG/60ML	Tier 1	01/01/2021
COUMADIN TAB	Deletion Of Drug From Formulary	Manufacturer Discontinuation	WARFARIN TAB	Tier 1	01/01/2021
D5W/NACL INJ 0.225%	Deletion Of Drug From Formulary	Manufacturer Discontinuation	D5W/NACL INJ 0.2%	Tier 1	01/01/2021
EMTRIVA CAP 200MG	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE CAP 200 MG	Tier 1	01/01/2021
GLEOSTINE CAP	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider		01/01/2021
JADENU SPRINKLE GRANULES	Deletion Of Drug From Formulary	Generic Available	DEFERASIROX GRANULES PACKET	Tier 2	01/01/2021

Name of Affected Drug	Description for Change	Reason for Change	Alternative Drug	Alternative Drug Copay*	Effective Date
JUXTAPID CAP 40MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	JUXTAPID CAP 20MG	Tier 2	01/01/2021
JUXTAPID CAP 60MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	JUXTAPID CAP 20MG	Tier 2	01/01/2021
LORCET HD TAB 10-325MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCODONE-ACETAMINOPHEN TAB 10-325MG	Tier 1	01/01/2021
LORCET PLUS TAB 7.5-325MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCODONE-ACETAMINOPHEN TAB 7.5-325MG	Tier 1	01/01/2021
LORCET TAB 5-325MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HYDROCODONE-ACETAMINOPHEN TAB 5-325MG	Tier 1	01/01/2021
NORMOSOL -R INJ	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	ISOLYTE-S INJ	Tier 2	01/01/2021
ONE VITE TAB 1MG PLUS	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	PRENATAL TAB 27-1MG	Tier 2	01/01/2021
SYLATRON KIT	Deletion Of Drug From Formulary	Manufacturer Discontinuation	INTRON A INJ	Tier 2	01/01/2021
TRUVADA TAB 200-300MG	Deletion Of Drug From Formulary	Generic Available	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB 200-300MG	Tier 2	01/01/2021

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your physician can determine if one of the alternatives listed here is appropriate for you given the individualized nature of drug therapy. Please consult your physician to confirm if this is an appropriate drug for you.

Medical Benefit Changes

Drug Name	Benefit	Description of Coding Change
Afamelanotide implant, 1 mg	Medical Benefit	Prior Authorization Required
Brexucabtagene autoleucel	Medical Benefit	Prior Authorization Required
Esketamine, nasal spray, 1 mg	Medical Benefit	Prior Authorization Required
Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	Medical Benefit	Prior Authorization Required
HEMOSTATIC AGT GASTROINTESTINAL TOP	Medical Benefit	Prior Authorization Required
INJ CASIRIVIMAB & IMDEVIMAB 2400 MG	Medical Benefit	Product - Not Covered (Provided by Federal Government)

		Administration – Authorization Required
INJECTION BAMLANIVIMAB- 700 MG	Medical Benefit	Product - Not Covered (Provided by Federal Government) Administration – Authorization Required
Injection, belantamab mafodontin-blmf, 0.5 mg	Medical Benefit	Prior Authorization Required
Injection, cefiderocol, 5 mg	Medical Benefit	No Prior Authorization Required
Injection, daratumumab, 10 mg and hyaluronidase-fihj	Medical Benefit	Prior Authorization Required
Injection, immune globulin (asceniv), 500 mg	Medical Benefit	Prior Authorization Required
Injection, inebilizumab-cdon, 1 mg	Medical Benefit	Prior Authorization Required
Injection, lurbinectedin, 0.1 mg	Medical Benefit	Prior Authorization Required
Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	Medical Benefit	Prior Authorization Required
Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	Medical Benefit	Prior Authorization Required
Injection, sacituzumab govitecan-hziy, 2.5 mg	Medical Benefit	Prior Authorization Required
Injection, tafasitamab-cxix, 2 mg	Medical Benefit	Prior Authorization Required
Injection, viltolarsen, 10 mg	Medical Benefit	Prior Authorization Required
Mitomycin pyelocalyceal instillation, 1 mg	Medical Benefit	Prior Authorization Required