2018 MEDICARE ADVANTAGE FORMULARY CHANGES

Helpful Questions & Answers

TexanPlus® HMO, TexanPlus® HMO-POS, Today's Options® PPO, Today's Options® PFFS, and TexanPlus® HMO-SNP are Medicare Advantage plans with a Medicare contract. TexanPlus® HMO-SNP is a Medicare Advantage plan with a Medicare contract and a contract with the State Medicaid Program. Enrollment in these plans depends on contract renewal.

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General Information

What is happening?

Our Medicare Advantage (MA) Formulary (list of covered drugs) is changing for 2018. We make changes to the Formulary each year.

This change may affect covered drugs in one of the following ways:

- Some drugs are being removed
- Some drugs are changing tiers
- Some drugs will have utilization changes/coverage restrictions

Our Formularies include mostly the same drugs. The Formularies primarily differ in the way generic drugs are placed within the tiers.

Why is the Formulary changing?

These changes are being made to address a variety of factors, such as cost and safety for our members. Similar adjustments are made to the Formulary each year. This year, some of the impact comes from changes to drugs considered to be High-Risk by the Centers for Medicare & Medicaid Services (CMS).

What are High-Risk Medications (HRMs)?

High-Risk Medications are medications identified by CMS and other national organizations, including but not limited to, the American Geriatrics Society (AGS), the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA) to have a higher risk of side effects in persons age 65 years or older and therefore may pose a safety concern. These drugs should be carefully evaluated before use by members who are 65 years or older.

When will the change go into effect?

The Formulary changes go into effect on January 1, 2018. Members will not experience a change to their prescription medications until this date.

When will members learn about changes to their drugs?

Members learned about drug changes when they received their Annual Notice of Change (ANOC) (September) and in a separate notification (October/November).

How are covered drugs affected by the Formulary change?

Drugs that are now available on the Formulary may be affected in one of these ways:

1. Some drugs will be removed and will not be covered by the plan in 2018. To learn more, please see the “Removed Drugs” section.
   a. These drugs will need prior plan approval to be covered.
   b. Some of these drugs may be considered High-Risk Medications. Members should discuss these drugs with their doctor (or other prescriber).
2. Some drugs will be changing to a new Formulary tier and may cost more for members to fill.
   a. Drugs on our 2018 Formulary are grouped into five tiers, each of which has a different copay or coinsurance amount. When drugs are moved from one tier to another, copay and coinsurance amounts may be affected. Note: this change does not apply to TexanPlus Star (HMO SNP).
   b. To learn more, please see the “Tier Changes” section.

3. Some drugs will have new coverage restrictions (such as Prior Authorizations, Quantity Limits, and/or Step Therapy).
   a. These drugs will need prior plan approval or have other coverage requirements in 2018.
   b. Some of these drugs may be considered High-Risk Medications. Members should discuss these drugs with their doctor (or other prescriber).
   c. To learn more, please see the "Utilization Requirements" section.

When will members be notified of the Formulary change?

Members will learn that the formulary has changes when they receive their Annual Notice of Change (ANOC). All members affected by a Formulary change will receive a separate written notification. This mailing will include:

- A personalized letter that lists any/all prescriptions filled by the member in the past six months that will be affected by Formulary changes.
- An additional page with "Helpful Information."
- A full-color insert promoting the 2018 Mail Order benefit (available to all members). Members of TexanPlus HMO (Dallas/ Fort Worth), and Today's Options® PFFS/PPO will also learn about the savings available to them through Preferred Retail Pharmacies.
- Members of TexanPlus HMO (Dallas/ Fort Worth), and Today's Options® PFFS/PPO who fill their medication(s) at Walmart will also receive a pharmacy network disruption letter notifying those members that Walmart will no longer be a preferred pharmacy in 2018.

For more information about Mail Order/Preferred Pharmacies, see our Mail Order/Preferred Pharmacy FAQ.

What should members do if they are notified about changes to their drugs?

It's important for members to discuss these changes with their doctors (or other prescribers) before the end of the year. Their doctors may be able to suggest other drugs on the Formulary that can treat their condition.

Members should also show their doctors:

- The letter they received from their plan alerting them to the drug changes, and
- Our 2018 Formulary.

Where can members find the 2018 Formulary?

Members can find our 2018 Formulary in their 2018 Annual Notice of Change and Evidence of Coverage (ANOC/EOC) packet or by visiting our plan website. They may also call Member Services at the telephone number listed on the back of their Member ID card.

Are any alternative drugs available?

Yes, in some cases. If available, we will suggest one or more drugs that may be good alternatives for drugs being removed. Members should consult with their doctors (or other prescribers) as soon as possible to determine if the alternative drugs are appropriate for treating their condition(s).

Please note that alternative medications are based on common U.S. Food and Drug Administration (FDA)-approved indications for the drugs that will not be covered on our 2018 Formulary.

How do members obtain alternative drugs?

If the doctor (or other prescriber) approves another drug on our Formulary, the member should request a new prescription immediately so he or she can fill the medication beginning on January 1.

What if a doctor doesn't approve an alternative drug?

- If the doctor (or other prescriber) feels that none of the drugs listed on our Formulary is right for treating the condition, a "Coverage Decision" or "Exception" can be requested**.** To learn more, please see the "Coverage Decisions" section.

- Under certain circumstances, we can offer members a Transition Fill, or temporary supply of a drug, when the drug is not on the Formulary or when it is restricted in some way. The temporary supply gives members time to speak with their providers about the change in their drug coverage. To learn more, please see our "Transition Fills" section.

Are there any Federal programs that can help members save money on their drugs?

Yes, Medicare beneficiaries may be entitled to Federal assistance known as "Extra Help," which can help them pay for some of their Medicare prescription drug plan costs. To qualify for Extra Help, a person must be receiving Medicare, have limited resources and income, and reside in one of the 50 States or the District of Columbia.

How can members determine if they are entitled to "Extra Help"?

Members can learn if they are eligible for Extra Help by contacting Medicare or Social Security as follows:

- Medicare: call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- Social Security: 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

Members can also call their state Medicaid office.

Removed Drugs

What is happening?

On January 1, 2018, some drugs will be removed from the Formulary and will not be covered by their plan in 2018. Several of these drugs are considered to be High-Risk Medications.

Which categories of drugs are being removed from the Formulary?

- Removed Drugs
  - Alternatives are available for other drugs that are being removed from the Formulary.
  - Before starting an alternative drug, members must request a Coverage Decision. To learn more, see our "Coverage Decisions" section.

Which specific drugs are being removed from the Formulary?

See the chart that follows for key drug removals for TexanPlus HMO/HMO-POS and TexanPlus HMO-SNP:

KEY REMOVED DRUG(S)*
TEXANPLUS HMO/HMO-POS/HMO-SNP
Lantus
Toujeo
Pataday
Fluoxetine tablet
Epipen 2-PAK
Axiron

*This is not a comprehensive list of drug removals

See chart that follows for key drug removals for TexanPlus HMO in Dallas/Fort Worth and Today's Options PFFS:

KEY REMOVED DRUG(S)*
TEXANPLUS HMO (DALLAS/ FORT WORTH) TODAY'S OPTIONS PFFS
Lantus
Toujeo
Mometasone nasal spray
Pataday
Fenofibric acid capsule
Fluoxetine tablet
Epipen 2-PAK
Nexium granules

*This is not a comprehensive list of drug removals

See chart that follows for key drug removals for Today's Options PPO:

KEY REMOVED DRUG(S)*
TODAY'S OPTIONS PPO
Lantus
Toujeo
Pataday
Epipen 2-PAK
Fenofibric acid capsule
Fluoxetine tablet
Premarin

*This is not a comprehensive list of drug removals

What should members do if they are notified about drugs being removed from the Formulary?

- Members should share their notification letter and our 2018 Formulary with their doctor (or other prescriber). They should ask if an alternative drug is right for treating their condition.
  - If their doctor (or other prescriber) approves an alternative drug on our Formulary, they should request a new prescription immediately so they can fill the medication beginning on January 1.
  - If their doctor (or other prescriber) feels that none of the drugs listed in our Formulary is right for treating their condition, a Formulary Exception can be requested. To learn more, please see our "Coverage Decisions" section.

Under certain circumstances, we can offer members a Transition Fill, or temporary supply, when a drug is not on the Formulary. The temporary supply gives members time to talk to their providers about the change in their drug coverage. To learn more, please see our "Transition Fill" section.

Tier Changes

What is happening?

On January 1, 2018, some drugs will be changing to a new Formulary tier and may cost more for members to fill. Be aware that Low Income Subsidy (LIS) members are not affected by this change.

- Quick Reminder: Drugs on our 2018 Formulary are grouped into five tiers, each of which has a different copay or coinsurance amount. When drugs are moved from one tier to another, copay and coinsurance amounts may be affected. Note: this does not apply to TexanPlus Star (HMO SNP).

Which drugs will be affected by tier changes?

See chart that follows for tier changes that will affect the listed drugs for TexanPlus® HMO/HMO-POS in Houston/Beaumont:

2018 Tier Changes* TexanPlus HMO/HMO-POS Only	
KEY TIER CHANGE(S)	**TIER CHANGE**
Fluconazole	1 to 2
Gavilyte-G solution	1 to 2
PEG-3350 oral packet	1 to 2
Gavilyte-C solution	1 to 2
Dexilant	3 to 4
Pradaxa	3 to 4
Sensipar 30mg	3 to 5

*This is not a comprehensive list of tier changes

See chart that follows for tier changes that will affect the listed drugs for TexanPlus HMO in Dallas/Fort Worth and Today's Options PFFS:

2018 Tier Changes* TexanPlus HMO (Dallas/ Fort Worth) Today's Options PFFS	
KEY TIER CHANGE(S)	**TIER CHANGE**
Ezetimibe	3 to 4
Prochlorperazine tablet	1 to 2
Dexilant	3 to 4
Pradaxa	3 to 4
Divalproex DR tablet	2 to 3
PEG-3350 NF oral packet	2 to 3
Ammonium lactate lotion 12%	2 to 3

*This is not a comprehensive list of tier changes

See chart that follows for tier changes that will affect the listed drugs for Today's Options PPO:

2018 Tier Changes* Today's Options PPO	
KEY TIER CHANGE(S)	**TIER CHANGE**
Pradaxa	3 to 4
Prochlorperazine tablet	1 to 2
Dexilant	3 to 4
PEG-3350 NF oral packet	2 to 3
Divalproex DR tablet	2 to 3
Ammonium lactate lotion 12%	2 to 3

*This is not a comprehensive list of tier changes

What should members do if they are notified about tier changes?

- Members should share their notification letter and our 2018 Formulary with their doctor (or other prescriber). They should ask if any other medication listed in a lower tier on our Formulary is right or safer for treating their condition. Members may have lower out-of-pocket costs for drugs in a lower tier.
- If the doctor approves the member taking another drug on our Formulary, a new prescription should be requested immediately so the medication can be filled beginning on January 1.
- If the doctor (or other prescriber) feels that none of the alternative drugs are right, a Tier Exception can be requested. For more information, see our "Coverage Decisions" section.
- Transition Fills do not apply to tier increases.
- Members should ask if they qualify for a Federal assistance program. For more information, see our "General Information" section.

Utilization Requirements

What is happening?

On January 1, 2018, some drugs on our Formulary will have new coverage restrictions (such as Prior Authorizations, Quantity Limits, and/or Step Therapy). This means that the drugs will need plan approval or have other requirements next year.

What is a Prior Authorization?

Prior Authorization is requested when the member must obtain plan approval before filling a specific prescription.

Which drugs will require a Prior Authorization?

Generally, a Prior Authorization will be required for drugs that require a clinical review for plan coverage. For more information, see our "Coverage Decisions" section.

Prior Authorization Needed
Vraylar

What are Quantity Limits?

Quantity Limits are imposed when the quantity or dosage of the drug prescribed is limited because of quality, safety, or utilization reasons. Quantity Limits may affect the dosage amount or how frequently the prescription may be filled.

Quantity Limit*	
DRUG	**QUANTITY/DAY SUPPLY**
Lidocaine 4% solution	50mL/30 days
Lidocaine 2% gel	30mL/30 days
Lidocaine 5% ointment	50gm/30 days
Lidocaine/Prilocaine cream	30gm/30 days
Bystolic 2.5mg, 5mg, 10mg	30 tablets/30 days
Bystolic 20mg	60 tablets/30 days
Renvela 0.8gm packet	540 packets/30 days
Renvela 2.4gm packet	180 packets/30 days
Renvela 800mg tablet	540 tablets/30 days

*This is not a comprehensive list of quantity limit additions

What is Step Therapy?

As part of Step Therapy, members are first required to try another drug for treating their condition before they may receive the drug initially prescribed by their doctor or other prescriber.

What is a Transition Fill?

Under certain circumstances, we can offer members a Transition Fill, or temporary supply, of a drug when the drug is not on the Formulary or when it is restricted in some way. The temporary supply gives members time to talk to their providers about the change in their drug coverage. To learn more, please see our "Transition Fills" section.

What should members do if they are notified about Utilization Requirements?

Members should share their notification letter and our 2018 Formulary with their doctor (or other prescriber). If the coverage restriction change is for a Prior Authorization or Step Therapy, they should ask their doctor (or other prescriber) to review their current drug therapy for their condition. They can also ask if any other medication listed on our Formulary is right for treating their condition.

What should members do if their drugs will have a Quantity Limit?

Members should ask their doctor (or other prescriber) to review their current prescription and quantity prescribed. If a "Coverage Decision" is needed, it can be requested by the member, an authorized representative, or the doctor.

Coverage Decisions

What is a Coverage Decision (also known as "Coverage Determination")?

Coverage Decisions determine whether drugs will be covered under the plan. Coverage Decisions include the following:

- **Quantity Limit:** an exception can be requested if the quantity or dosage of the drug prescribed is being limited because of quality, safety, or utilization reasons. Quantity Limits may affect the dosage amount or how frequently the prescription may be filled.
- **Step Therapy:** an exception can be requested if members are asked to try another drug for treating their condition before they may receive the drug initially prescribed.
- **Formulary Exception:** an exception can be requested to cover a Part D drug that is not on the plan's Formulary.
- **Tier Exception:** an exception can be requested to pay a lower cost-sharing amount for a covered drug, if applicable. Note: does not apply to TexanPlus STAR (HMO SNP).
- **Prior Authorization:** Prior Authorization is requested when the member must obtain plan approval before filling a specific prescription.

How is a Coverage Decision requested?

- A Coverage Decision can be requested by the member, an authorized representative, or by the doctor. It can be started by calling, writing, or faxing the Coverage Determination Department. To initiate a Coverage Decision online (electronic submission), the member can visit the plan website.
- The member should obtain a "supporting statement" from the doctor (or other prescriber). The statement explains why the drug exception is being requested.
- The doctor (or other prescriber) can submit the statement to us by fax or mail, or electronically using the form available on our plan website. The doctor can also call us with the information, but must follow up by faxing or mailing a written statement.

How long does it take to receive a Coverage Decision?

Decisions are generally made within 72 hours of receiving the prescribing physician's supporting statement.

- Members can request an expedited exception if their health could be seriously harmed by waiting up to 72 hours for a decision. If an expedited request is granted, the member will have a decision no later than 24 hours after we receive the doctor's supporting statement.
- Members who receive a letter of denial will be provided with instructions for requesting an appeal.

Where can members go for information about the Coverage Decision process?

More information about the Coverage Decision process can be obtained on our plan website. Details are also available in the member's Evidence of Coverage (EOC) document.

What is the phone number/address for requesting a Coverage Decision?

PHONE	Call the number on the back of your member ID card (TTY users call 711) 8:00 a.m. to 8:00 p.m. in the local time zone, 7 days a week
FAX	1-855-714-6218
MAIL	P.O. Box 31397, Tampa, FL 33631-3397

Transition Fill

What is meant by "Transition Fill" or "Transition Supply"?

Under certain circumstances, we can offer members a Transition Fill, or temporary supply, of a drug when the drug is not on the Formulary or when it is restricted in some way. The temporary supply gives members time to talk to their providers about the change in their drug coverage.

Are all Transition Fills handled in the same way?

No, the process varies depending on the member's situation.

- **For members enrolled last year and not in a long-term care facility:**
  - We will cover a temporary supply of the drug one time only during the first 90 days of the calendar year.
  - This temporary supply will be for a maximum 30-day supply, or less if the prescription is written for fewer days.
  - The prescription must be filled at a network pharmacy.
- **For members new to the plan and not in a long-term care facility:**
  - We will cover a temporary supply of the drug one time only during the first 90 days of membership in the plan.
  - This temporary supply will be for a maximum 30-day supply, or less if the prescription is written for fewer days.
  - The prescription must be filled at a network pharmacy.
- **New to the plan and residing in a long-term care facility:**
  - We will cover a temporary supply of the drug during the first 90 days of membership in the plan.
  - The first supply will be for a maximum 98-day supply, or less if the prescription is written for fewer days. Note: the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.
  - If needed, we will cover additional refills during a member's first 90 days in the plan.
- **Enrolled in a plan for more than 90 days and resides in a long-term care facility; needs a Transition Fill immediately:**
  - We will cover one 34-day supply, or less if the prescription is written for fewer days.
  - This is in addition to the above long-term care Transition Fill.
- **Current Members:**
  - We will also cover a temporary Transition Fill if members have a change in their medications because of a level-of-care change. This may include:
    - Unplanned changes in treatment settings, such as being discharged from an acute care (hospital) setting, or
    - Being admitted to, or discharged from, a long-term care facility.
  - For each drug that is not in our Formulary, or if the member's ability to get their drugs is limited, we will cover a temporary 30-day supply when using a network pharmacy (up to a 34-day supply if the member is a resident of a long-term care facility).

If a transition supply is granted, the member and the member's doctor (or other prescriber) will receive notification.

Should members discuss the drug changes with their doctors?

Yes, members should ask their doctors about taking other drugs that are included on the Formulary. If there are no appropriate alternative drugs listed on the Formulary, members or their doctors can request a Formulary Exception. To learn more about Formulary Exceptions, please see our "Coverage Decisions" section.