Community Health Plan of Washington Medicare Advantage Dual Plans

2024 Notice Formulary Drug List Changes - 1 Tier Effective 08/01/2024

Community Health Plan of Washington™ may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, we will notify you of the change at least 60 days before the date that the change becomes effective. However, 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 will immediately remove the drug from our formulary. For more recent information or other questions, please contact Community Health Plan of Washington (CHPW) Medicare Advantage (MA) Dual Plans customer service:

Current Members: 1-800-942-0247
Prospective Members: 1-800-944-1247
TTY Relay: Dial 711
7 days a week, 8 a.m. to 8 p.m.
Or visit
medicare.chpw.org

The table below outlines upcoming changes to our formulary that will impact you:
The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., RISPERDAL) and generic drugs are listed in lower-case italics (e.g., *risperidone*).

Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
desogestrel 0.15 mg-ethinyl estradiol 0.03 mg tablet	08/01/2024	Formulary Addition	Tier 1	
EXKIVITY 40 MG CAPSULE	08/01/2024	New Drug	Tier 1	PA QL LA
HUMIRA(CF) PEDI CROHN'S START 80 MG/0.8 ML-40 MG/0.4 ML SUBCUT SYR KIT	08/01/2024	New Drug	Tier 1	PA QL

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
HUMIRA(CF) PEDIATRIC CROHN'S STARTER 80 MG/0.8 ML SUBCUT SYRINGE KIT	08/01/2024	New Drug	Tier 1	PA QL
KISQALI FEMARA CO-PACK 200 MG/DAY(200 MG X 1)-2.5 MG TABLET	08/01/2024	Formulary Addition	Tier 1	PA QL
KISQALI FEMARA CO-PACK 400 MG/DAY(200 MG X 2)-2.5 MG TABLET	08/01/2024	Formulary Addition	Tier 1	PA QL
KISQALI FEMARA CO-PACK 600 MG/DAY(200 MG X 3)-2.5 MG TABLET	08/01/2024	Formulary Addition	Tier 1	PA QL
PLASMA-LYTE 148 INTRAVENOUS SOLUTION	08/01/2024	Formulary Addition	Tier 1	
TAZTIA XT 120 MG CAPSULE,EXTENDED RELEASE	08/01/2024	Formulary Addition	Tier 1	
TAZTIA XT 180 MG CAPSULE,EXTENDED RELEASE	08/01/2024	Formulary Addition	Tier 1	
TAZTIA XT 240 MG CAPSULE,EXTENDED RELEASE	08/01/2024	Formulary Addition	Tier 1	

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
TAZTIA XT 300 MG CAPSULE,EXTENDED RELEASE	08/01/2024	Formulary Addition	Tier 1	
TAZTIA XT 360 MG CAPSULE,EXTENDED RELEASE	08/01/2024	Formulary Addition	Tier 1	
adalimumab-adbm 40 mg/0.4 ml subcutaneous pen kit	08/01/2024	Removed from Formulary		*Alternative
adalimumab-adbm 40 mg/0.4 ml subcutaneous syringe kit	08/01/2024	Removed from Formulary		*Alternative
ADALIMUMAB-ADBM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.4 ML SUBCUT KIT	08/01/2024	Removed from Formulary		*Alternative
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS STRT 40 MG/0.4 ML SUBCUT KIT	08/01/2024	Removed from Formulary		*Alternative
CYLTEZO(CF) 40 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT	08/01/2024	Removed from Formulary		*Alternative
CYLTEZO(CF) PEN 40 MG/0.4 ML SUBCUTANEOUS KIT	08/01/2024	Removed from Formulary		*Alternative

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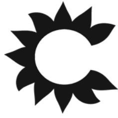

Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
CYLTEZO(CF) PEN CROHN-ULC COLITIS-HID SUP STRT 40 MG/0.4 ML SUBCUT KIT	08/01/2024	Removed from Formulary		*Alternative
CYLTEZO(CF) PEN PSORIASIS-UVEITIS STARTER 40 MG/0.4 ML SUBCUT KIT	08/01/2024	Removed from Formulary		*Alternative
LIBERVANT 10 MG BUCCAL FILM	08/01/2024	Removed from Formulary		*Alternative
LIBERVANT 12.5 MG BUCCAL FILM	08/01/2024	Removed from Formulary		*Alternative
LIBERVANT 15 MG BUCCAL FILM	08/01/2024	Removed from Formulary		*Alternative
LIBERVANT 5 MG BUCCAL FILM	08/01/2024	Removed from Formulary		*Alternative
LIBERVANT 7.5 MG BUCCAL FILM	08/01/2024	Removed from Formulary		*Alternative
OPSYNVI 10 MG-20 MG TABLET	08/01/2024	Removed from Formulary		*Alternative

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
OPSYNVI 10 MG-40 MG TABLET	08/01/2024	Removed from Formulary		*Alternative
SIMLANDI(CF) AUTOINJECTOR 40 MG/0.4 ML SUBCUTANEOUS AUTO-INJECTOR KIT	08/01/2024	Removed from Formulary		*Alternative
varenicline 1 mg tablet (56 pack)	08/01/2024	Removed from Formulary		*Alternative
WEGOVY 0.25 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	08/01/2024	Removed from Formulary		*Alternative
WEGOVY 0.5 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	08/01/2024	Removed from Formulary		*Alternative
WEGOVY 1 MG/0.5 ML SUBCUTANEOUS PEN INJECTOR	08/01/2024	Removed from Formulary		*Alternative
WEGOVY 1.7 MG/0.75 ML SUBCUTANEOUS PEN INJECTOR	08/01/2024	Removed from Formulary		*Alternative

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

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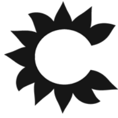

List of Abbreviations

LA: Limited Availability. This medication may only be available at certain pharmacies.

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain medications. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the medication.

QL: Quantity Limit. For certain medications, the Plan limits the amount of the medication that we will cover.

ST: Step Therapy. In some cases, the Plan requires you to try certain drugs first to treat your medical condition before we will cover another drug for that condition.

Community Health Plan of Washington is an HMO plan with a Medicare contract and a contract with the Washington State Medicaid program. Enrollment in Community Health Plan of Washington depends on contract renewal.