

# Blue MedicareRx<sup>SM</sup> Value Plus (PDP) 2023 Formulary (List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION  
ABOUT THE DRUGS WE COVER IN THIS PLAN**

This formulary was updated on 3/1/2023. For more recent information or other questions, please contact Blue MedicareRx Value Plus, at:

Connecticut	1-888-620-1747	Rhode Island	1-888-620-1748
Massachusetts	1-888-543-4917	Vermont	1-888-620-1746

or, for TTY/TDD users, 711, 24 hours a day, 7 days a week, or visit [www.RxMedicarePlans.com](http://www.RxMedicarePlans.com).

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Customer Care for more information.

**Important Message About What You Pay for Insulin** - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us," or "our," it means Blue MedicareRx<sup>SM</sup> (PDP). When it refers to "plan" or "our plan," it means Blue MedicareRx Value Plus.

This document includes a list of the drugs (formulary) for our plan which is current as of March 1, 2023. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

## What is the Blue MedicareRx Value Plus Formulary?

A formulary is a list of covered drugs selected by Blue MedicareRx Value Plus in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Blue MedicareRx Value Plus will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Blue MedicareRx Value Plus network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your *Evidence of Coverage*.

## Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but Blue MedicareRx Value Plus may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

**Changes that can affect you this year:** In the below cases, you will be affected by coverage changes during the year:

**New generic drugs.** We 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. Also, 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. If you are currently taking that brand name drug, 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.

- If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below titled “How do I request an exception to the Blue MedicareRx Value Plus Formulary?”

**Drugs removed from the market.** 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 and provide notice to members who take the drug.

**Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to the market to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must 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 30-day supply of the drug.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find the information in the section below entitled “How do I request an exception to the Blue MedicareRx Value Plus Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of March 1, 2023. To get updated information about the drugs covered by Blue MedicareRx Value Plus, please contact us. Our contact information appears on the front and back cover pages. If we have other types of mid-year non-maintenance formulary changes unrelated to the reasons stated above (e.g. remove drugs from our formulary, add prior authorization requirements, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier), we will notify you by mail. You may also access our formulary on our website at [www.RxMedicarePlans.com](http://www.RxMedicarePlans.com) to get information showing changes to, additions, and/or deletions of medications contained in our formulary.

## **How do I use the Formulary?**

There are two ways to find your drug within the formulary:

### **Medical Condition**

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular.” If you know what your drug is used for, look for the category name in the list that begins on page number 1. Then look under the category name for your drug.

### **Alphabetical Listing**

If you are not sure what category to look under, you should look for your drug in the Index that begins at the back of this document. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

## **What are generic drugs?**

Blue MedicareRx Value Plus covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

## **Are there any restrictions on my coverage?**

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

**Prior Authorization:** Blue MedicareRx Value Plus requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.

**Quantity Limits:** For certain drugs, Blue MedicareRx Value Plus limits the amount of the drug that we will cover. For example, our plan provides 2 units per prescription for FLOVENT HFA. This may be in addition to a standard one-month or three-month supply.

**Step Therapy:** In some cases, Blue MedicareRx Value Plus requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask Blue MedicareRx Value Plus to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Blue MedicareRx Value Plus formulary?" on page III for information about how to request an exception.

## **What if my drug is not on the Formulary?**

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Care and ask if your drug is covered.

If you learn that Blue MedicareRx Value Plus does not cover your drug, you have two options:

You can ask Customer Care for a list of similar drugs that are covered by Blue MedicareRx Value Plus. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.

You can ask Blue MedicareRx Value Plus to make an exception and cover your drug. See below for information about how to request an exception.

Compounds may or may not be covered by your plan benefit.

## **How do I request an exception to the Blue MedicareRx Value Plus Formulary?**

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved, this would lower the amount you must pay for your drug.

You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Blue MedicareRx Value Plus limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, Blue MedicareRx Value Plus will only approve your request for an exception if the alternative drug is included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

### **What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

If you change your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover up to a temporary 30-day supply when you go to a network pharmacy. After your first 30-day supply, you are required to use the plan's exception process.

Our transition supply will not cover drugs that Medicare does not allow Part D plans to cover or drugs that are covered under Medicare Part B.

### **For more information**

For more detailed information about your Blue MedicareRx Value Plus prescription drug coverage, please review your *Evidence of Coverage* and other plan materials.

If you have questions about Blue MedicareRx Value Plus, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY/TDD users should call 1-877-486-2048. Or, visit <https://www.medicare.gov>.

### **Blue MedicareRx Value Plus Formulary**

The formulary that begins on page 1 provides coverage information about the drugs covered by Blue MedicareRx Value Plus. If you have trouble finding your drug in the list, turn to the Index that begins at the back of this document.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ADVAIR DISKUS) and generic drugs are listed in lower-case italics (e.g., *atorvastatin*).

The information in the Requirements/Limits column tells you if Blue MedicareRx Value Plus has any special requirements for coverage of your drug. The abbreviations you may see in the drug listing include:

- **B/D** stands for drugs covered under Medicare Part B or D.
- **QL** stands for Quantity Limits.
- **PA** stands for Prior Authorization.
- **ST** stands for Step Therapy.
- **LA** stands for Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Care at the numbers that appear on the front and back cover pages, 24 hours a day, 7 days a week. TTY/TDD users should call 711.
- **NM** stands for No Mail Order. This prescription drug is not available through mail order service.





P.O. Box 30011, Pittsburgh, PA 15222-0330

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<b>Connecticut</b>	1-888-620-1747	<b>Rhode Island</b>	1-888-620-1748
<b>Massachusetts</b>	1-888-543-4917	<b>Vermont</b>	1-888-620-1746

or, for TTY/TDD users, 711, 24 hours a day, 7 days a week, or visit [www.RxMedicarePlans.com](http://www.RxMedicarePlans.com)

You can get prescription drugs shipped to your home through our network mail order delivery program which is called CVS Caremark Mail Service Pharmacy.

You also have the option to enroll your prescriptions in an automatic refill program. Under this program, we will start to process your next refill automatically when our records show that you should be close to running out of your drug. And, when your prescription is going to expire or is out of refills, we'll contact your doctor for a new one. We'll contact you by phone, text message or email (your choice) before we mail your medication.

For new prescriptions, we'll let you know before we send the first fill of your medication. There may be times when Medicare requires us to get your approval before sending your prescription to you. On every order, you'll have time to make changes or cancel, and you won't be charged until it ships. You can start or stop automatic refills at any time.

Typically, you should expect to receive your prescription drugs within 10 calendar days from the time that the mail order pharmacy receives the order. If you do not receive your prescription drug(s) within this time, please contact us at the number listed in the table above. TTY/TDD users should call 711.

Blue MedicareRx (PDP) is a Prescription Drug Plan with a Medicare Contract. Blue MedicareRx Value Plus (PDP) and Blue MedicareRx Premier (PDP) are two Medicare Prescription Drug Plans available to service residents of Connecticut, Massachusetts, Rhode Island, and Vermont.

Coverage is available to residents of the service area or members of an employer or union group and separately issued by one of the following plans: Anthem Blue Cross® and Blue Shield® of Connecticut, Blue Cross Blue Shield of Massachusetts, Blue Cross and Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont.

Anthem Insurance Companies, Inc., Blue Cross and Blue Shield of Massachusetts, Inc., Blue Cross & Blue Shield of Rhode Island, and Blue Cross and Blue Shield of Vermont are the legal entities which have contracted as a joint enterprise with the Centers for Medicare & Medicaid Services (CMS) and are the risk-bearing entities for Blue MedicareRx (PDP) plans. The joint enterprise is a Medicare-approved Part D Sponsor. Enrollment in Blue MedicareRx (PDP) depends on contract renewal.

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