

Changes to GlobalHealth's D-SNP Formulary

GlobalHealth may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking the brand name drug or original biological product, we may not tell you in advance before we make an immediate change, but we will later provide you with information about the specific change(s) we have made.

If a drug is withdrawn from sale by the manufacturer or the Food and Drug Administration (FDA) determines to be withdrawn for safety or effectiveness reasons, we may immediately remove the drug from our formulary and later provide notice to members who take the drug.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 require us to provide advance notice, we will notify affected members of the change at least thirty (30) days before the change becomes effective, or at the time the member requests a refill of the drug for which 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 can also ask us to make an exception for you. 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 1-866-494-3927 (TTY: 711), 24 hours a day, 7 days a week.

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

Changes applied to the formulary are reflected from January 2025 to April 2025

H3706_15970225_C

CY2025_04.01_1T_SNP

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Cost-Sharing Tier	Effective Date
AMOXICILLIN & K CLAVULANATE CHEW TAB 200-28.5 MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	AMOXICILLIN & K CLAVULANATE FOR SUSP 200-28.5 MG/5ML	Tier 1	01/01/2025
CORLANOR TAB	Deletion Of Drug From Formulary	Generic Available	IVABRADINE TAB	Tier 1	01/01/2025
DROXIA CAP	Deletion Of Drug From Formulary	Manufacturer Discontinuation	Consult Your Health Care Provider		03/01/2025
DUPIXENT INJ 100MG/0.67ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	DUPIXENT INJ 200MG/1.14ML	Tier 1	02/01/2025
ENDARI POW 5GM	Deletion Of Drug From Formulary	Generic Available	L-GLUTAMINE POW 5GM	Tier 1	01/01/2025
ERYTHROCIN TAB 250MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	ERYTHROMYCIN TAB 250MG BS	Tier 1	01/01/2025
FENTANYL OT LOZ	Deletion Of Drug From Formulary	Manufacturer Discontinuation	MORPHINE SULFATE TAB	Tier 1	02/01/2025
LEUKERAN TAB 2MG	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider		01/01/2025
MICROGESTIN 24 FE TAB 1-20 MG-MCG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	HAILEY 24 FE TAB 1-20 MG-MCG	Tier 1	02/01/2025
NATACYN SUS 5% OP	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider		01/01/2025
NYMYO TAB 0.25MG-35MCG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	NORGESTIMATE-ETHINYL ESTRADIOL TAB 0.25MG-35MCG	Tier 1	02/01/2025
PREHEVBRIO SUS 10MCG/ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	ENGERIX-B INJ; HEPLISAV-B INJ; RECOMBIVAX HB INJ	Tier 1	03/01/2025

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Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Cost-Sharing Tier	Effective Date
SANDIMMUNE SOL 100MG/ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	CYCLOSPORINE CAP	Tier 1	01/01/2025
SELZENTRY TAB 25MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SELZENTRY SOL 20MG/ML	Tier 1	02/01/2025
SELZENTRY TAB 75MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SELZENTRY SOL 20MG/ML	Tier 1	02/01/2025
SPRYCEL TAB	Deletion Of Drug From Formulary	Generic Available	DASATINIB TAB	Tier 1	02/01/2025
TABLOID TAB 40MG	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider		01/01/2025
TDVAX INJ 2-2 LF	Deletion Of Drug From Formulary	Manufacturer Discontinuation	TENIVAC INJ 5-2LF	Tier 1	03/01/2025
TOBRADEX ST SUS 0.3-0.05%	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	TOBRAMYCIN-DEXAMETHASONE SUS 0.3-0.1%	Tier 1	01/01/2025
VRAYLAR CAP 1.5-3MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	VRAYLAR CAP	Tier 1	02/01/2025
ZERVIAE DRO 0.24%	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	AZELASTINE DRO 0.05%	Tier 1	01/01/2025
ZYPREXA RELPREVV INJ	Deletion Of Drug From Formulary	Manufacturer Discontinuation	RISPERIDONE ER INJ	Tier 1	02/01/2025

*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.

For more information consult your Drug Formulary or call Customer Care at 1-866-494-3927, 24 hours a day, seven days a week. TTY users should call 711. www.GlobalHealth.com

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