# Changes to the Johns Hopkins Advantage MD D-SNP (HMO) Formulary

**Please retain this with your formulary.**

Changes may have occurred since the printing of the Johns Hopkins Advantage MD D-SNP (HMO) formulary. Medications added or removed from the formulary are listed below.

This is not a complete list of all formulary drugs covered by the plan. For a complete listing, or if you need additional information about the Johns Hopkins Advantage MD D-SNP (HMO) formulary, please view our website at www.hopkinsmedicare.com or call Customer Service at 1-877-293-4998 (TTY: 711), 24 hours a day, seven days a week.

If you are a current member already taking the below drug(s) before the effective date of the change, we will continue to cover the drug for the remainder of the plan year as long as the drug continues to be medically necessary for treating your condition and prescribed for you by your prescriber, and was not removed for safety reasons.

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

| Name of Affected Drug | Description of Change | Reason for Change | Alternative Drug | Alternative Drug Cost-Share 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 |
| 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 |

**PA** - Prior Authorization, **QL** - Quantity Limits, **ST** - Step Therapy, **NM** - Not available at mail order, **B/D** - Covered under Medicare B or D, **LA** - Limited Access, **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. ***** - Not available as extended days supply

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| LEUKERAN TAB 2MG | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | Consult Your Health Care Provider | | 01/01/2025 |
| NATACYN SUS 5% OP | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | Consult Your Health Care Provider | | 01/01/2025 |
| SANDIMMUNE SOL 100MG/ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | CYCLOSPORINE CAP | Tier 1 | 01/01/2025 |
| TABLOID TAB 40MG | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | Consult Your Health Care Provider | | 01/01/2025 |
| 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 |
| ZERVIATE DRO 0.24% | Deletion Of Drug From Formulary | Medicare Will No Longer Cover | AZELASTINE DRO 0.05% | Tier 1 | 01/01/2025 |
| DUPIXENT INJ 100MG/0.67ML | Deletion Of Drug From Formulary | Manufacturer Discontinuation | DUPIXENT INJ 200MG/1.14ML | Tier 1 | 02/01/2025 |
| FENTANYL OT LOZ | Deletion Of Drug From Formulary | Manufacturer Discontinuation | MORPHINE SULFATE TAB | Tier 1 | 02/01/2025 |
| 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 |
| NYMYO TAB 0.25MG-35MCG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | NORGESTIMATE-ETHINYL ESTRADIOL TAB 0.25MG-35MCG | Tier 1 | 02/01/2025 |
| SELZENTRY TAB 25MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | SELZENTRY SOL 20MG/ML | Tier 1 | 02/01/2025 |

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| 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 |
| VRAYLAR CAP 1.5-3MG | Deletion Of Drug From Formulary | Manufacturer Discontinuation | VRAYLAR CAP | Tier 1 | 02/01/2025 |
| ZYPREXA RELPREVV INJ | Deletion Of Drug From Formulary | Manufacturer Discontinuation | RISPERIDONE ER INJ | Tier 1 | 02/01/2025 |
| DROXIA CAP | Deletion Of Drug From Formulary | Manufacturer Discontinuation | Consult Your Health Care Provider | | 03/01/2025 |
| 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 |
| TDVAX INJ 2-2 LF | Deletion Of Drug From Formulary | Manufacturer Discontinuation | TENIVAC INJ 5-2LF | Tier 1 | 03/01/2025 |