MASSACHUSETTS

Notice of Formulary Changes for Your Medicare HMO Blue℠ Plan

We may add or remove drugs from our formulary during the year. If we remove drugs from our formulary; add prior authorization, quantity limits, or step therapy restrictions on a drug; or move a drug to a higher cost sharing tier, 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 and will immediately provide retrospective notice to members who take the drug.

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

Name of Drug	Description of Change	Reason for Change[1]	Alternative Drug[2]	Alternative Drug Copay	Effective Date
BRISDELLE 7.5 MG CAPSULE	Brand removed from formulary	Generic Available	PAROXETINE MESYLATE 7.5 MG CAPSULE	2	7/1/18
COPAXONE 40 MG/ML SYRINGE	Brand removed from formulary	Generic Available	GLATIRAMER ACETATE 40 MG/ML SYRINGE	5	7/1/18
EFFIENT 10 MG TABLET	Brand removed from formulary	Generic Available	PRASUGREL 10 MG TABLET	2	7/1/18
EFFIENT 5 MG TABLET	Brand removed from formulary	Generic Available	PRASUGREL 5 MG TABLET	2	7/1/18
LEXIVA 700 MG TABLET	Brand removed from formulary	Generic Available	FOSAMPRENAVIR 700 MG TABLET	5	7/1/18
LIALDA 1.2 G TABLET	Brand removed from formulary	Generic Available	MESALAMINE 1.2 G TABLET	2	7/1/18
RENVELA 800 MG TABLET	Brand removed from formulary	Generic Available	SEVELAMER CARBONATE 800 MG TABLET	2	7/1/18
SABRIL 500 MG POWDER PACKET	Brand removed from formulary	Generic Available	VIGABATRIN 500 MG POWDER PACKET	5	7/1/18
SUSTIVA 50 MG CAPSULE	Brand removed from formulary	Generic Available	EFAVIRENZ 50 MG CAPSULE	2	7/1/18
TAMIFLU 6 MG/ML ORAL SUSPENSION	Brand removed from formulary	Generic Available	OSELTAMIVIR 6 MG/ML ORAL SUSPENSION	2	7/1/18
TRANSDERM-SCOP 1 MG/3 DAY PATCH	Brand removed from formulary	Generic Available	SCOPOLAMINE 1 MG/3 DAY PATCH	2	7/1/18
VIGAMOX 0.5% DROPS	Brand removed from formulary	Generic Available	MOXIFLOXACIN 0.5% DROPS	2	7/1/18

Name of Drug	Description of Change	Reason for Change[1]	Alternative Drug[2]	Alternative Drug Copay	Effective Date
ESTRACE 0.01% CREAM	Brand removed from formulary	Generic Available	ESTRADIOL 0.01% CREAM	2	8/1/18
REYATAZ 150 MG CAPSULE	Brand removed from formulary	Generic Available	ATAZANAVIR SULFATE 150 MG CAPSULE	2	8/1/18
REYATAZ 200 MG CAPSULE	Brand removed from formulary	Generic Available	ATAZANAVIR SULFATE 200 MG CAPSULE	2	8/1/18
REYATAZ 300 MG CAPSULE	Brand removed from formulary	Generic Available	ATAZANAVIR SULFATE 300 MG CAPSULE	5	8/1/18
VIREAD 300 MG TABLET	Brand removed from formulary	Generic Available	TENOFOVIR DISOPROXIL FUMARATE 300 MG TABLET	5	8/1/18
BUPHENYL 500 MG TABLET	Brand removed from formulary	Generic Available	SODIUM PHENYLBUTYR-ATE 500 MG TABLET	5	9/1/18
SUSTIVA 200 MG CAPSULE	Brand removed from formulary	Generic Available	EFAVIRENZ 200 MG CAPSULE	5	9/1/18
SUSTIVA 600 MG TABLET	Brand removed from formulary	Generic Available	EFAVIRENZ 600 MG TABLET	5	9/1/18
SYPRINE 250 MG CAPSULE	Brand removed from formulary	Generic Available	TRIENTINE HCL 250 MG CAPSULE	5	9/1/18
ZIAGEN 20 MG/ML ORAL SOLUTION	Brand removed from formulary	Generic Available	ABACAVIR 20 MG/ML ORAL SOLUTION	2	9/1/18

1. Removal of drug from formulary; a change in its preferred or tiered cost sharing status; or a classification change such as prior authorization needed, quantity limits apply, or step therapy restrictions.
2. 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 drug is appropriate for you, given the individualized nature of the drug therapy. Please consult your physician as to whether this is an appropriate drug for you. This is not a complete list of all formulary alternatives covered by the plan.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID Card (TTY: **711**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: **711**).

ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: **711**).

Blue Cross Blue Shield of Massachusetts is an HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Y0014_1622 Accepted 05172016 186487M (06/18)