Community Health Plan of Washington (CHPW) Medicare Advantage Dual Complete and Dual Select (HMO D-SNP) Plans

COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

2026 Notice Formulary Drug List Changes - Duals Effective 07/01/2026

Community Health Plan of Washington (CHPW) Medicare Advantage Dual Complete and Dual Select (HMO D-SNP) Plans may make changes to the drugs covered on our formulary during the year. These changes may include removing a drug from the formulary, moving a drug to a higher cost-sharing tier, or adding coverage requirements such as prior authorization, quantity limits, or step therapy.

If a change to our Formulary Drug List affects you, we will notify you at least 30 days before the date that the change becomes effective or, when you request a refill, provide an approved month's supply of the drug under the same terms as previously allowed, along with written notice of the change.

CHPW may immediately remove a drug from our Formulary Drug List and send a notice to members who take the drug 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.

You or your prescriber may request a coverage determination, including an exception, if a change affects your drug coverage. This allows you to ask us to cover a drug not on our formulary or to remove coverage restrictions. The notice we send will explain how to make this request. For more information, please refer to your Evidence of Coverage.

For more recent information or other questions, please contact Community Health Plan of Washington Dual Complete and Dual Select (HMO D-SNP) Plans Customer Service:

Current Members: 1-800-942-0247
Prospective Members: 1-800-944-1247
TTY: 711
7 days a week, 8 a.m. to 8 p.m.
Or visit our website at: 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*).

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
dapagliflozin 10 mg-metformin er 500 mg tablet, ext rel 24hr	07/01/2026	Formulary Addition	Tier 6	QL
dapagliflozin 5 mg-metformin er 500 mg tablet,ext rel 24hr	07/01/2026	Formulary Addition	Tier 6	QL
exenatide 10 mcg/dose(250 mcg/ml)2.4 ml subcutaneous pen injector	07/01/2026	Formulary Addition	Tier 3	PA QL
exenatide 5 mcg/dose (250 mcg/ml)1.2 ml subcutaneous pen injector	07/01/2026	Formulary Addition	Tier 3	PA QL
IBRANCE 75 MG CAPSULE	07/01/2026	Formulary Addition	Tier 5	PA QL
TYPHIM VI 25 MCG/0.5 ML INTRAMUSCULAR SOLUTION	07/01/2026	New Drug	Tier 6	

*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.

List of Abbreviations

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

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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.