



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

### 2026 Notice Formulary Drug List Changes - Duals Effective 06/01/2026

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 CHPW Dual Complete and Dual Select Plans Customer Service at 1-800-942-0247 (TTY: 711), 7 days a week, 8 a.m. to 8 p.m., or visit [medicare.chpw.org](http://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
<i>bacitracin 500 unit/gram eye ointment</i>	06/01/2026	New Drug	Tier 3	
IBRANCE 100 MG CAPSULE	06/01/2026	New Drug	Tier 5	PA QL
IBRANCE 75 MG CAPSULE	06/01/2026	New Drug	Tier 5	PA QL
<i>insulin syringe u-100 with needle 1/2 ml 28 gauge</i>	06/01/2026	Formulary Addition	Tier 3	PA
JANTOVEN 1 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 10 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 2 MG TABLET	06/01/2026	Formulary Addition	Tier 1	



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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
JANTOVEN 2.5 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 3 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 4 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 5 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 6 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
JANTOVEN 7.5 MG TABLET	06/01/2026	Formulary Addition	Tier 1	
<i>levonorgestrel 0.15 mg-ethinyl estradiol 0.03 mg tablet</i>	06/01/2026	New Drug	Tier 2	



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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
LIDOCAINE VISCOUS 2 % MUCOSAL SOLUTION	06/01/2026	Formulary Addition	Tier 2	
NYAMYC 100,000 UNIT/GRAM TOPICAL POWDER	06/01/2026	Formulary Addition	Tier 3	QL
TRUQAP 160 MG TABLET	06/01/2026	Formulary Addition	Tier 5	PA QL
ZYDELIG 100 MG TABLET	06/01/2026	New Drug	Tier 5	PA QL
ZYDELIG 150 MG TABLET	06/01/2026	New Drug	Tier 5	PA QL

\*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.

**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.



**COMMUNITY HEALTH PLAN**  
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**MEDICARE ADVANTAGE**

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**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.