

Community Health Plan of Washington Medicare Advantage



COMMUNITY HEALTH PLAN
of Washington™
MEDICARE ADVANTAGE

2025 Notice Formulary Drug List Changes - 5 Tier Effective 04/01/2025

Community Health Plan of Washington™ may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, 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. For more recent information or other questions, please contact Community Health Plan of Washington Medicare Advantage Customer Service:

Current Members: 1-800-942-0247
Prospective Members: 1-800-944-1247
TTY Relay: Dial 711
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*).

Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
Austedo 12 mg tablet	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo 6 mg tablet	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo 9 mg tablet	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 12 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 18 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
Austedo XR 24 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 30 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 36 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 42 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 48 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR 6 mg tablet, extended release	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR Titration (Week 1-4) 12-18-24-30 mg tablet, ER 24hr dose pk	04/01/2025	Formulary Addition	Tier 5	PA QL
Austedo XR Titration Kit(Week 1-4) 6 mg-12 mg-24 mg tablet, ER dosepack	04/01/2025	Formulary Addition	Tier 5	PA QL
Lagevrio 200 mg capsule (EUA)	04/01/2025	Formulary Addition	Tier 2	QL
<i>mesna 400 mg tablet</i>	04/01/2025	New Drug	Tier 5	

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
Byetta 10 mcg/dose(250 mcg/mL)2.4 mL subcutaneous pen injector	04/01/2025	Removal		*Alternative
Byetta 5 mcg/dose (250 mcg/mL)1.2 mL subcutaneous pen injector	04/01/2025	Removal		*Alternative
Lagevrio 200 mg capsule (EUA)	04/01/2025	Removal		*Alternative
<i>norethindrone 1 mg-ethinyl estradiol 20 mcg (21)-iron 75 mg (7) tablet</i>	04/01/2025	Removal		*Alternative
Presto Pro Blood Glucose Meter	04/01/2025	Removal		*Alternative
Triderm 0.1 % topical cream	04/01/2025	Removal		*Alternative
Wavesense AMP kit	04/01/2025	Removal		*Alternative
WaveSense Presto kit	04/01/2025	Removal		*Alternative

*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.

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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.

PAnS: Prior Authorization for new starts. The plan requires you or your physician to get prior authorization for certain drugs if you are taking them for the first time. 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 drug.

QL: Quantity Limit. For certain drugs, 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. Enrollment in Community Health Plan of Washington depends on contract renewal.