

## 2024 Medicare Part D Formulary Change

We may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug (or move a drug to a higher cost-sharing tier), we will let you know of the change. 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 let you know.

The product changes noted below will be implemented on the Medicare Part D Plan formulary.

To see if your drug is on this list, scroll down or click this [\[SEARCH\]](#) button and enter the name of your drug in the pop-up task pane.

New Added Products: **Effective 3/1/2024**

Drug	Restrictions*
AKEEGA 100 MG-500 MG TABLET	PA QL LA
AKEEGA 50 MG-500 MG TABLET	PA QL LA
AUGTYRO 40 MG CAPSULE	PA QL
KALYDECO 5.8 MG ORAL GRANULES IN PACKET	PA QL
KESIMPTA PEN 20 MG/0.4 ML SUBCUTANEOUS PEN INJECTOR	PA QL
VIGPODER 500 MG ORAL POWDER PACKET	PA LA
ZENPEP 60,000-189,600-252,600 UNIT CAPSULE,DELAYED RELEASE	

New Added Products: **Effective 2/1/2024**

Drug	Restrictions*
ADALIMUMAB-ADBIM 10 MG/0.2 ML SUBCUTANEOUS SYRINGE KIT	PA QL
ADALIMUMAB-ADBIM 20 MG/0.4 ML SUBCUTANEOUS SYRINGE KIT	PA QL
ADALIMUMAB-ADBIM 40 MG/0.8 ML SUBCUTANEOUS PEN KIT	PA QL
ADALIMUMAB-ADBIM 40 MG/0.8 ML SUBCUTANEOUS SYRINGE KIT	PA QL
ADALIMUMAB-ADBIM(CF) PEN CROHN'S-UC-HS STARTER 40 MG/0.8 ML SUBCUT KIT	PA QL

Drug	Restrictions*
ADALIMUMAB-ADBM(CF) PEN PSORIASIS-UVEITIS STRT 40 MG/0.8 ML SUBCUT KIT	PA QL
BREO ELLIPTA 50 MCG-25 MCG/DOSE POWDER FOR INHALATION	QL
BREYNA 160 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER	QL
BREYNA 80 MCG-4.5 MCG/ACTUATION HFA AEROSOL INHALER	QL
BRIMONIDINE 0.1 % EYE DROPS	
CRESEMBA 74.5 MG CAPSULE	PA
FRUZAQLA 1 MG CAPSULE	PA QL
FRUZAQLA 5 MG CAPSULE	PA QL
HYRIMOZ(CF) PEDIATRIC CROHN'S STARTR 80 MG/0.8 ML SUBCUTANEOUS SYRINGE	PA QL
INPEFA 200 MG TABLET	PA QL
KOURZEQ 0.1 % DENTAL PASTE	
LAGEVRIO 200 MG CAPSULE (EUA)	QL
LITHIUM CITRATE 8 MEQ/5 ML ORAL SOLUTION	
OJJAARA 100 MG TABLET	PA QL
OJJAARA 150 MG TABLET	PA QL
OJJAARA 200 MG TABLET	PA QL
PAXLOVID 150 MG-100 MG TABLETS IN A DOSE PACK (RENAL DOSE)	QL
PAXLOVID 300 MG (150 MG X 2)-100 MG TABLETS IN A DOSE PACK	QL
PAZOPANIB 200 MG TABLET	PA QL
PITAVASTATIN CALCIUM 1 MG TABLET	QL
PITAVASTATIN CALCIUM 2 MG TABLET	QL
PITAVASTATIN CALCIUM 4 MG TABLET	QL
SAXAGLIPTIN 2.5 MG TABLET	QL
SAXAGLIPTIN 2.5 MG-METFORMIN ER 1,000 MG TABLET,EXTEND RELEASE 24HR MP	QL
SAXAGLIPTIN 5 MG TABLET	QL
SAXAGLIPTIN 5 MG-METFORMIN ER 1,000 MG TABLET,EXTEND RELEASE 24HR MP	QL
SAXAGLIPTIN 5 MG-METFORMIN ER 500 MG TABLET,EXTEND RELEASE 24HR MP	QL

Drug	Restrictions*
TESTOSTERONE 12.5 MG/1.25 GRAM PER PUMP ACTUATION (1%) TRANSDERMAL GEL	PA QL
TRUQAP 160 MG TABLET	PA QL
TRUQAP 200 MG TABLET	PA QL
TURQOZ (28) 0.3 MG-30 MCG TABLET	
VANFLYTA 17.7 MG TABLET	PA QL
VANFLYTA 26.5 MG TABLET	PA QL
XDEMVIY 0.25 % EYE DROPS	PA QL
ZURZUVAE 20 MG CAPSULE	PA
ZURZUVAE 25 MG CAPSULE	PA
ZURZUVAE 30 MG CAPSULE	PA



For more information about how these changes may affect your cost-sharing, such as copayments or coinsurance, or for more information about asking for an updated coverage determination or a formulary exception, please see the plan Evidence of Coverage.

Alternative drugs are drugs in the same therapeutic category/class as the affected drug. Only your doctor can determine alternative drugs that are appropriate for you given the individualized nature of drug therapy. Please talk to your doctor about any changes or recommendations to your medical care and prescription drug therapy. Alternative drugs and additional information about formulary changes can be found on the plan formulary,

\*Indicates a restriction of Step Therapy, Prior Authorization or Quantity Limits may exist.

[LA] = Limited Access, [PA] = Prior Authorization, [QL] = Quantity Limit, [ST] = Step Therapy

ConnectiCare, Inc. is an HMO-POS plan with a Medicare contract. ConnectiCare Insurance Company, Inc. is an HMO-POS D-SNP plan with a Medicare contract and a contract with the Connecticut Medicaid Program. Enrollment in a ConnectiCare Medicare plan depends on contract renewal.

**Note to existing members:** This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

Beneficiaries must use network pharmacies to access their premium and/or copayment/coinsurance may change on January 1, 2025.

This document includes ConnectiCare Medicare Plan's partial formulary as of March 1, 2024. For a complete, updated formulary, please visit our website at [www.connecticare.com/Medicare](http://www.connecticare.com/Medicare) or call the Member Services number below.

For alternative formats or language, please call Member Services toll free at: ConnectiCare's Member Services at 800-224-2273. From Oct. 1 through March 31: 8 a.m. to 8 p.m., seven days a week. From April 1 through Sept. 30: 8 a.m. to 8 p.m., Monday through Saturday.

TTY users should call 711.

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