2019

BlueMedicare℠ Comprehensive

Formulary

BlueMedicare Preferred (HMO) H2758-002, 004, 006

BlueMedicare Preferred POS (HMO POS) H2758-008

Florida Blue

This formulary was updated on 04/24/2019. For more recent information or other questions, please contact Florida Blue Preferred HMO Member Services at 1-844-783-5189 or, for TTY users, 1-800-955-8770. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week. Or visit **www.floridablue/medicare.**

HMO coverage is offered by BeHealthy Florida, Inc., DBA Florida Blue Preferred HMO, an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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BlueMedicare Preferred (HMO)
BlueMedicare Preferred POS (HMO POS)
2019 Formulary
(List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

Formulary ID 00019222, Version 10

This formulary was updated on 04/24/2019. For more recent information or other questions, please contact BlueMedicare Preferred HMO and BlueMedicare Preferred POS Member Services number at 1-844-783-5189. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week. Or visit www.floridablue.com/medicare.

Florida Blue Preferred HMO is an HMO plan with a Medicare contract. Enrollment in Florida Blue Preferred HMO depends on contract renewal.

If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-926-6565 (TTY: 1-800-955-8770).

Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-926- 6565 (TTY: 1-877-955-8773).

The formulary may change at any time. You will receive notice when necessary.

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.

When this drug list (formulary) refers to "we," "us", or "our," it means Florida Blue Preferred HMO. When it refers to "plan" or "our plan," it means BlueMedicare Preferred and BlueMedicare Preferred POS.

This document includes a list of the drugs (formulary) for our plan which is current as of April 24, 2019. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2020, and from time to time during the year.

What is the BlueMedicare Preferred and BlueMedicare Preferred POS Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Our plan will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a BlueMedicare Preferred and BlueMedicare Preferred POS network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Generally, if you are taking a drug on our 2019 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2019 coverage year except when a new, less expensive generic drug becomes available when new information about the safety or effectiveness of a drug is released, or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.). Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year.

Below are changes to the drug list that will affect members currently taking a drug:

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on the steps you may take to request an exception, and you can also find information in the section below entitled "How do I request an exception to the BlueMedicare Preferred and Preferred POS Formulary?"
- **Drugs removed from the market.** 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 provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a new generic drug to replace a brand name drug currently on the formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier.) We may add a generic drug that is not new to market to replace a brand name drug currently on the

formulary or add new restrictions to the brand name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines.
If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 30-day supply of the drug.

The enclosed formulary is current as of April 24, 2019. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages.

BlueMedicare Preferred and BlueMedicare Preferred POS provides monthly updates of the formulary on our website (**www.floridablue.com/medicare)** and in print as needed. The paragraphs that follow will explain how you will be notified in the event of certain changes.

BlueMedicare Preferred and BlueMedicare Preferred POS will only remove Part D drugs from its formulary, move covered Part D drugs to a less preferred tier status or add utilization management requirements 60 days after the beginning of the contract year associated with the annual election period, and only if these changes are approved by CMS.

If BlueMedicare Preferred and BlueMedicare Preferred POS should make such formulary changes, members currently taking the affected drug are exempt from the formulary change for the remainder of the contract year.

Prior to removing a covered Part D drug from its formulary, or making any change in the preferred or tiered cost-sharing status of a covered Part D drug, BlueMedicare Preferred and BlueMedicare Preferred POS
will either:

- Provide direct written notice to affected enrollees at least 60 days prior to the date the change becomes effective; or
- At the time an affected enrollee requests a refill of the Part D drug, provide such enrollee with a 30-day supply of the Part D drug under the same terms as previously allowed and written notice of the formulary change.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category, “Cardiovascular Agents.” If you know what your drug is used for, look for the category name in the list that begins on page 1. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 100. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 31 tablets per prescription for Januvia. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 1. You can also get more information about the restrictions applied to specific covered drugs by visiting our web site. We have posted online a document that explains our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask us to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the, BlueMedicare Preferred and BlueMedicare Preferred POS formulary?" on page iv for information about how to request an exception.

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Member Services and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options:

- You can ask Member Services for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered by our plan.
- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the, BlueMedicare Preferred and BlueMedicare Preferred POS Formulary?

You can ask our plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level if this drug is not on the specialty tier. If approved this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you request a formulary, tiering or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 30 day supply. If your prescription is written for fewer days. we'll allow refills to Provide up to a maximum 30 day supply of medication. After your first 30 day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Circumstances exist in which unplanned transitions for current members could arise and in which prescribed drug regimens may not be on the formulary. These circumstances usually involve level-of-care changes in which a member is changing from one treatment setting to another. For these unplanned transitions, you must use our exceptions and appeals process. Coverage determinations and redeterminations will be processed as expeditiously as your health condition requires.

When a member is admitted to or discharged from a Long Term Care (LTC) facility, he or she does not have access to the remainder of the previously dispensed prescription. We will ensure you have a refill upon admission or discharge. A one-time override of the "refill too soon" edits is provided for each medication which would be impacted due to a member being admitted to or discharged from an LTC facility. Early refill edits are not used to limit appropriate and necessary access to a member's Part D benefit, and such members are allowed to access a refill upon admission or discharge.

For more information

For more detailed information about your BlueMedicare Preferred and BlueMedicare Preferred POS prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about our plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or, visit **http://www.medicare.gov**.

Our Plan's Formulary

The formulary that begins on page 1 provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 100.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., LANTUS) and generic drugs are listed in lower-case italics (e.g., *metformin*).

The information in the Requirements/Limits column tells you if we have any special requirements for coverage of your drug.

The information in the second column of the chart tells you at what level (tier) your drug is covered.

The third column of the chart indicates whether any special requirements apply for coverage of a drug such as "Prior Authorization," "Quantity Limits" and "Step Therapy."

If Quantity Limits apply to a drug, the restriction amounts are shown in the listing beginning on page 1.

DOSAGE / FORM ABBREVIATIONS KEY			
act	Actuation	**mcg**	Microgram
ad	Adsorbed	**meq**	Milli-Equivalent
aer, aero	Aerosol	**mg**	Milligram
app	Applicator	**ml**	Milliliter
ba, breath act, breath activ	Breath Activated	**mu**	Million Units
bau	Bioequivalent Allergy Units	**nebu**	Nebules
cap, caps	Capsules	**orally disintegr tab**	Orally disintegrating tablets
cart	Cartridge	**op, ophth**	Ophthalmic
chew tab	Chewable Tablets	**osm**	osmotic
conc	Concentrate	**pf**	Preservative-Free
conj	Conjugate, conjugated	**pfu**	Plaque Forming Units
crys	Crystals	**pow, powd**	Powder
deter	Deterrent	**Pref, prefill**	Prefilled
disint	disintegrating	**pak**	pack
dr	Delayed-Release	**ptwk**	patch weekly
ec	Enteric-Coated	**pttw**	patch twice weekly
el, elu	Enzyme-Linked	**recomb**	Recombinant
er, extended, extended rel, xl, xr	Extended-Release	**sl**	Sublingual
ext	extract	**sol, soln**	Solution
gm	Gram	**sr**	Sustained-Release
gu	Genitourinary	**supp, suppos**	Suppositories
hr	Hour	**sus, susp**	Suspension
Ig	Immunie globuline	**syr**	Syringe
im	Intramuscular	**tab, tabs**	Tablets
inh, inhal	Inhalation	**td**	Transdermal
inj	Injection	**tl**	Translingual
ir	Immediate-Release	**unt**	Unit
iv	Intravenous	**vac**	Vaccine
l	Liter	**va**	vaginal

Initial Coverage Stage

The copayment/coinsurance amounts that you pay for a one-month (30-day) supply of drugs in each Drug Tier are shown below.

	Pharmacy Type	Tier 1 Preferred Generics	Tier 2 Generics	Tier 3 Preferred Brand	Tier 4 Non-Preferred Brand	Tier 5 Specialty	Tier 6 Select Care
BlueMedicare Preferred (HMO) (Manatee, Sarasota)	Preferred Retail	$0 copay	$1 copay	$35 copay	$100 copay	33% of the cost	$7 copay
	Standard Retail	$7 copay	$8 copay	$42 copay	$100 copay		
	Mail Order	$0 copay	$1 copay	$35 copay	$100 copay		
BlueMedicare Preferred (HMO) (Clay, Duval)	Preferred Retail	$0 copay	$7 copay	$35 copay	$85 copay	33% of the cost	$7 copay
	Standard Retail	$7 copay	$14 copay	$42 copay	$92 copay		
	Mail Order	$0 copay	$7 copay	$35 copay	$85 copay		
BlueMedicare Preferred (HMO)(Pinellas)	Preferred Retail	$0 copay	$1 copay	$35 copay	$100 copay	33% of the cost	$7 copay
	Standard Retail	$7 copay	$8 copay	$42 copay	$100 copay		
	Mail Order	$0 copay	$1 copay	$35 copay	$100 copay		
BlueMedicare Preferred POS (HMO POS) (Manatee, Pinellas and Sarasota)	Preferred Retail	$0 copay	$7 copay	$35 copay	$85 copay	33% of the cost	$7 copay
	Standard Retail	$7 copay	$14 copay	$42 copay	$92 copay		
	Mail Order	$0 copay	$7 copay	$35 copay	$85 copay		

Abbreviation Key

1 = Preferred Generic Drugs
2 = Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Brand Drugs
5 = Specialty Drugs
6 = Select Care
BD = Drugs that may be covered under Medicare Part B or Part D depending on the circumstance. These drugs require prior authorization to determine coverage under Part B or Part D. Information may need to be provided that describes the use or the place where the drug is received to determine coverage.
PA = Prior Authorization
QL = Quantity Limits
ST = Step Therapy
***** = Limited distribution drugs are indicated by an asterisk (*) in the drug list. These drugs may be available only at certain pharmacies. Member Services number at 1-844-783-5189. (TTY users should call 1-800-955-8770.) Hours are 8:00 a.m. – 8:00 p.m. local time, seven days a week. Or visit www.floridablue.com/medicare.
# = High-Risk Medication (HRM). Medicine that may be unsafe in patients greater than 65 years of age. Our formulary does include coverage for some of these drugs, but alternatives may be found in lower co-pay tiers. Please discuss with your doctor if there are alternatives to these medications that would be appropriate for you to use.
^ =Drugs for which additional coverage is provided in the coverage gap.

This formulary was updated on 0 /2 /2019. For more recent information or other questions, please contact Florida Blue Preferred HMO Member Services at 1-844-783-5189 or, for TTY users, 1-800-955-8770. We are open from 8:00 a.m. – 8:00 p.m. local time, seven days a week. Or visit **www.floridablue/medicare.**