Priority Health

2024 Formulary

Priority Health Medicare

List of covered drugs

Please read:
This document contains information about the drugs we cover in this plan.

Y0056_NCMS100010852407H_C 01112024

ID 24468, Version X

This formulary was approved on MM/DD/YYYY. For more recent information or other questions, please contact Priority Health Medicare toll-free at 888.389.6648 (TTY users should call 711), 8 a.m. to 8 p.m., seven days a week, or visit *prioritymedicare.com*.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if your plan has a deductible). Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if your plan has a deductible).

Important Message About What You Pay for Commercially Available Paxlovid – Our plan will cover Commercially Available Paxlovid at no cost to you, even if you haven't paid your deductible (if your plan has a deductible), when you fill at an in-network pharmacy. Call Customer Service for more information.

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 Priority Health. When it refers to “plan” or “our plan,” it means Priority Health Medicare.

This document includes a list of the drugs (formulary) for our plan which is current as of January 1, 2024. 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, 2025, and from time to time during the year.

What is the Priority Health Medicare Formulary?

A formulary is a list of covered drugs selected by Priority Health Medicare 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. Priority Health Medicare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Priority Health Medicare 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?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **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 how to request an exception, and you can also find information in the section below entitled "*How do I request an exception to the Priority Health Medicare 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 generic drug that is not new to the 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 both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, 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.
  - If we make these other changes, 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 how to request an exception, and you can also find information in the section below entitled "*How do I request an exception to the Priority Health Medicare Formulary?*"

Changes that will not affect you if you are currently taking the drug: Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of January 1, 2024. To get updated information about the drugs covered by Priority Health Medicare, please contact us. Our contact information appears on the front and back cover pages. If there are significant changes to the formulary, you may receive a letter in the mail outlining those changes.

How do I use the Formulary?

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

1. Medical Condition

The formulary begins on page 10. 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 10. Then look under the category name for your drug.

2. Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on the page following the Drug List. 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?

Priority Health Medicare 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:** Priority Health Medicare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Priority Health Medicare before you fill your prescriptions. If you don't get approval, Priority Health Medicare may not cover the drug.
- **Quantity Limits:** For certain drugs, Priority Health Medicare limits the amount of the drug that Priority Health Medicare will cover. For example, Priority Health Medicare provides 60 tablets per prescription for ENTRESTO. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Priority Health Medicare 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, Priority Health Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Priority Health Medicare 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 10. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted on line documents that explain 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 Priority Health Medicare 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 Priority Health Medicare Formulary?*" below 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 Customer Service and ask if your drug is covered.

If you learn that Priority Health Medicare does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by Priority Health Medicare. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by Priority Health Medicare.
- You can ask Priority Health Medicare 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 Priority Health Medicare Formulary?

You can ask Priority Health Medicare 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 unless the drug is 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, Priority Health Medicare limits 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, Priority Health Medicare 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 believe 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.

Priority Health Medicare provides members experiencing a level of care change with a transition supply of at least 30 days of medication unless the prescription is written for fewer days.

For more information

For more detailed information about your Priority Health Medicare prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about Priority Health Medicare, 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 *medicare.gov*.

Priority Health Medicare Formulary

The formulary that begins on page 10 provides coverage information about the drugs covered by Priority Health Medicare. If you have trouble finding your drug in the list, turn to the Index that begins on the page following the Drug List.

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

The information in the Requirements/Limits column tells you if Priority Health Medicare has any special requirements for coverage of your drug.

List of Abbreviations

B/D: Part B vs. Part D. This drug requires prior authorization and may be covered differently under Medicare Part B (medical services) or D (prescription drug coverage) depending on your circumstances. Information may need to be submitted by your doctor describing the use and setting of the drug to make the determination.

EA: Each

GM: Grams

HI: Home Infusion. This prescription drug may be covered under our medical benefit. For more information, call Customer Service at toll-free 888.389.6648 (TTY users should call 711), 8 a.m. to 8 p.m., seven days a week, or visit *prioritymedicare.com*.

LA: Limited Availability. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Customer Service at toll-free 888.389.6648 (TTY users should call 711), 8 a.m. to 8 p.m., seven days a week, or visit *prioritymedicare.com*.

ML: Milliliters

PA: Prior Authorization. Priority Health Medicare requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Priority Health Medicare before you fill your prescriptions. If you don't get approval, Priority Health Medicare may not cover the drug.

QL: Quantity Limit. For certain drugs, Priority Health Medicare limits the amount of the drug that Priority Health Medicare will cover. For example, Priority Health Medicare provides 60 tablets per 30-day prescription of ENTRESTO. This may be in addition to a standard one-month or three-month supply.

ST: Step Therapy. In some cases, Priority Health Medicare 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, Priority Health Medicare may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Priority Health Medicare will then cover Drug B.

Understanding your copayments/coinsurance

The tables below list the Priority Health Medicare drug tiers and the copayment or coinsurance amount associated with each tier during the initial coverage stage.

Drug Tiers	**Priority**Medicare Key℠ (HMO-POS)	**Priority**Medicare Value℠ (HMO-POS)	**Priority**Medicare℠ (HMO-POS)	**Priority**Medicare ONE℠ (HMO-POS)
Preferred retail pharmacy: one-month (30-day) supply				
Tier 1 Preferred generic	$4 copay	$2 copay	$1 copay	$0 copay
Tier 2 Generic	$15 copay	$10 copay	$8 copay	$10 copay
Tier 3 Preferred brand	$42 copay	After deductible of $75 is met: $42 copay	$38 copay	$42 copay
Tier 4 Non-preferred drug	45% coinsurance	After deductible of $75 is met: 50% coinsurance	45% coinsurance	45% coinsurance
Tier 5 Specialty (30-day supply only)	33% coinsurance	After deductible of $75 is met: 31% coinsurance	33% coinsurance	33% coinsurance
Preferred retail pharmacy: three-month (90-day supply)				
Tier 1 Preferred generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$45 copay	$30 copay	$24 copay	$30 copay
Tier 3 Preferred brand	$126 copay	After deductible of $75 is met: $126 copay	$114 copay	$126 copay
Tier 4 Non-preferred drug	45% coinsurance	After deductible of $75 is met: 50% coinsurance	45% coinsurance	45% coinsurance
Preferred mail order: three month (90-day) supply*				
Tier 1 Preferred generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3 Preferred brand	$105 copay	After deductible of $75 is met: $105 copay	$95 copay	$105 copay
Tier 4 Non-preferred drug	45% coinsurance	After deductible of $75 is met: 50% coinsurance	45% coinsurance	45% coinsurance

*All drugs listed on formulary are available via mail order.

Drug Tiers	**Priority** Medicare Edge℠ (PPO)	**Priority** Medicare Compass℠ (PPO)	**Priority** Medicare Vital℠ (PPO)	**Priority** Medicare Ideal℠ (PPO)	**Priority** Medicare Merit℠ (PPO)	**Priority** Medicare Select℠ (PPO)	**Priority** Medicare Thrive℠ (PPO)
Preferred retail pharmacy: one-month (30-day) supply							
Tier 1 Preferred generic	$2 copay	$4 copay	$1 copay	$4 copay	$2 copay	$1 copay	$3 copay
Tier 2 Generic	$8 copay	$15 copay	$10 copay	$13 copay	$10 copay	$7 copay	$10 copay
Tier 3 Preferred brand	$38 copay	$42 copay	After deductible of $350 is met: $42 copay	After deductible of $125 is met: $42 copay	$42 copay	$37 copay	$42 copay
Tier 4 Non-preferred drug	40% coinsurance	45% coinsurance	After deductible of $350 is met: 45% coinsurance	After deductible of $125 is met: 50% coinsurance	50% coinsurance	45% coinsurance	45% coinsurance
Tier 5 Specialty (30-day supply only)	33% coinsurance	33% coinsurance	After deductible of $350 is met: 26% coinsurance	After deductible of $125 is met: 30% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance
Preferred retail pharmacy: three-month (90-day) supply							
Tier 1 Preferred generic	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$24 copay	$45 copay	$30 copay	$39 copay	$30 copay	$21 copay	$30 copay
Tier 3 Preferred brand	$114 copay	$126 copay	After deductible of $350 is met: $126 copay	After deductible of $125 is met: $126 copay	$126 copay	$111 copay	$126 copay
Tier 4 Non-preferred drug	40% coinsurance	45% coinsurance	After deductible of $350 is met: 45% coinsurance	After deductible of $125 is met: 50% coinsurance	50% coinsurance	45% coinsurance	45% coinsurance
Preferred mail order: three month (90-day) supply*							
Tier 1 Preferred generic	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 Generic	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3 Preferred brand	$95 copay	$105 copay	After deductible of $350 is met: $105 copay	After deductible of $125 is met: $105 copay	$105 copay	$92.50 copay	$105 copay
Tier 4 Non-preferred drug	40% coinsurance	45% coinsurance	After deductible of $350 is met: 45% coinsurance	After deductible of $125 is met: 50% coinsurance	50% coinsurance	45% coinsurance	45% coinsurance

*All drugs listed on formulary are available via mail order.

Form Approved
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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-389-6648. Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-389-6648. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-389-6648。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-389-6648。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-389-6648. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-389-6648. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-389-6648 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-389-6648. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-389-6648 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-389-6648. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-888-389-6648. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-389-6648 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-389-6648. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-389-6648. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-389-6648. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-389-6648. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-389-6648 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。

This formulary was approved on MM/DD/YYYY. For more recent information or other questions, please contact Priority Health Medicare toll-free at 888.389.6648 (TTY users should call 711), 8 a.m. to 8 p.m., seven days a week, or visit *prioritymedicare.com*. The Formulary may change at any time. You will receive notice when necessary.

The pharmacy network and/or provider network may change at any time. You will receive notice when necessary. Priority Health Medicare's pharmacy network offers limited access to pharmacies with preferred cost sharing in Michigan. The lower costs advertised in our plan materials for these pharmacies may not be available at the pharmacy you use. For up-to-date information about our network pharmacies, including pharmacies with preferred cost sharing, please call 888.389.6648, TTY users should call 711, or consult the online pharmacy directory at *prioritymedicare.com*.

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