Florida Blue | MEDICARE

2020 BlueMedicare℠ Comprehensive Formulary

(List of Covered Drugs)

BlueMedicare Classic (HMO) H1035-019,020,021

BlueMedicare Choice (Regional PPO) R3332-001

DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

Formulary ID 00020563, Version 6

This formulary was updated on 12/30/2019. For more recent information or other questions, please contact Florida Blue at 1-800-926-6565 or, for TTY users, 1-800-955-8770, from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 –March 31, except for Thanksgiving and Christmas. From April 1 – September 30, we are open Monday – Friday, 8:00 a.m. –8:00 p.m. local time, except for Federal holidays. Or visit **www.floridablue.com/medicare.**

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BlueMedicare Choice (Regional PPO)
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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 Medicare or Florida Blue. When it refers to "plan" or "our plan," it means BlueMedicare Classic and BlueMedicare Choice Regional PPO.

This document includes a list of the drugs (formulary) for our plan which is current as of December 30, 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 Classic and BlueMedicare Choice 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 Classic and BlueMedicare Choice 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 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 BlueMedicare Classic and BlueMedicare Choice 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 31-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 BlueMedicare Classic and BlueMedicare Choice Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2020 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2020 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.

The enclosed formulary is current as of December 30, 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.

Our plans provide 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.

Our plan will only remove Part D drugs from our 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 Classic and BlueMedicare Choice should make such formulary changes, members currently taking the affected drug are exempt from the formulary change for the remainder of the contract year except as described above.

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, our plan will either:

- Provide direct written notice to affected enrollees at least 30 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 31-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 102. 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 30 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 website. 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 Classic and BlueMedicare Choice 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 Classic and BlueMedicare Choice 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 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum of a 31-day supply of medication. After your first 31 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 Classic and BlueMedicare Choice 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 102.

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 our plan has any special requirements for coverage of your drug.

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

All drugs included in this formulary, with the exception of limited distribution drugs, are available through our mail-order services. Limited distribution drugs are indicated in the formulary with an asterisk (*). Contact us for more details.

Initial Coverage Stage

The copayment/coinsurance amounts that you pay for a one-month (31-day) supply of drugs in each Drug Tier are shown below.

For BlueMedicare Classic

	Pharmacy Type	Tier 1 Preferred Generics	Tier 2 Generics	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drugs	Tier 5 Specialty	Tier 6 Select Care Drugs
Blue Medicare Classic (Bay, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Duval, Escambia, Lake, Lee, Manatee, Marion, Martin, Santa Rosa, Sarasota, St. Johns, St. Lucie and Sumter)	Preferred Retail	$0 copay	$10 copay	$40 copay	$93 copay	33%	$0 copay
	Standard Retail	$10 copay	$15 copay	$47 copay	$100 copay		$0 copay
	Mail-Order	$0 copay	$10 copay	$40 copay	$93 copay		$0 copay
Blue Medicare Classic (Orange, Osceola and Seminole)	Preferred Retail	$0 copay	$10 copay	$40 copay	$93 copay	33%	$0 copay
	Standard Retail	$15 copay	$20 copay	$47 copay	$100 copay		$0 copay
	Mail-Order	$0 copay	$10 copay	$40 copay	$93 copay		$0 copay
Blue Medicare Classic (Hernando, Hillsborough, Pasco and Polk)	Preferred Retail	$2 copay	$10 copay	$40 copay	$93 copay	33%	$0 copay
	Standard Retail	$14 copay	$20 copay	$47 copay	$100 copay		$0 copay
	Mail-Order	$2 copay	$10 copay	$40 copay	$93 copay		$0 copay

For BlueMedicare Choice

	Pharmacy Type	Tier 1 Preferred Generics	Tier 2 Generics	Tier 3 Preferred Brand	Tier 4 Non-Preferred Drugs	Tier 5 Specialty	Tier 6 Select Care Drugs
Blue Medicare Choice (Statewide)	Preferred Retail	$0 copay	$10 copay	$40 copay	$93 copay	28%	$0 copay
	Standard Retail	$10 copay	$20 copay	$47 copay	$100 copay		$0 copay
	Mail-Order	$0 copay	$10 copay	$40 copay	$93 copay		$0 copay
	A $250 deductible applies to Tiers 3, 4 and 5 only.						

Coverage Gap Stage

Below is information, by plan, that explains what additional coverage each plan provides when you are in the Coverage Gap Stage. For more information, please refer to your *Evidence of Coverage*.

Plan(s)	Additional Coverage when you are in the Coverage Gap Stage
• BlueMedicare Classic (Bay, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Duval, Escambia, Lake, Lee, Manatee, Marion, Martin, Santa Rosa, Sarasota, St. Johns, St. Lucie and Sumter)	Thes plan provides coverage of Tier 1: Preferred Generics and Tier 6 Select Care when you are in the Coverage Gap Stage. You pay the same cost-sharing you paid during the Initial Coverage Stage for Tier 1 and Tier 6 drugs.
• BlueMedicare Classic (Hernando, Hillsborough, Orange, Osceola, Pasco, Polk and Seminole)	This plan provides coverage of Tier 1: Preferred Generics, Tier 2 Generics and Tier 6 Select Care when you are in the Coverage Gap Stage. You pay the same cost-sharing you paid during the Initial Coverage Stage for Tier 1, Tier 2 and Tier 6 drugs.
• BlueMedicare Choice (Statewide)	This plan provides coverage of Tier 1: Preferred Generics and Tier 6 Select Care when you are in the Coverage Gap Stage. You pay the same cost-sharing you paid during the Initial Coverage Stage for Tier 1 and Tier 6 drugs.

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	**ixup, suppos**	Suppositories
hr	Hour	**sus, susp**	Suspension
Ig	Immune globulin	**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

Column 1 – Symbol Key
***** = Limited distribution drugs are indicated by an asterisk (*) in the drug list. These drugs may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call our Member Services at 1-800-926-6565 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 from October 1 – March 31, except for Thanksgiving and Christmas. From April 1 – September 30, we are open Monday – Friday 8:00 a.m. – 8:00 p.m. local time, except for Federal holidays. 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.
^ = Additional coverage of this prescription drug in the coverage gap is provided by certain plans. Please refer to the table in the "Coverage Gap Stage" section on page viii to determine if your plan provides additional coverage in the gap. You can also refer to your *Evidence of Coverage*.
Column 2 – Drug Tiers
1 = Preferred Generic Drugs
2 = Generic Drugs
3 = Preferred Brand Drugs
4 = Non-Preferred Drugs
5 = Specialty Drugs
6 = Select Care Drugs
Column 3 – Abbreviation Key
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

This formulary was updated on 12/30/2019. For more recent information or other questions, please contact Florida Blue at 1-800-926-6565 or, for TTY users, 1-800-955-8770, from 8:00 a.m. – 8:00 p.m. local time, seven days a week from October 1 – March 31, except for Thanksgiving and Christmas. From April 1 – September 30, we are open Monday – Friday, 8:00 a.m. – 8:00 p.m. local time, except for Federal holidays. Or visit **www.floridablue.com/medicare.**