

Upcoming Changes to HIP's Formulary

HIP 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 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 and notify you.

The table below outlines upcoming changes to our formulary that will impact you.

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
01/01/2010	ACTHIB VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	ADACEL VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	AFINITOR TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	APLENZIN TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	APRACLONIDINE HCL DROPS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	APTIVUS SOLUTION	Addition to Formulary: Tier 2	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	BICALUTAMIDE TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	BOOSTRIX INJECTION	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	BUPROBAN TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	CARBAMAZEPINE XR TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage

01/01/2010	COMVAX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	EFFIENT TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	ENGERIX-B SYRINGE	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	ENGERIX-B VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	EXTAVIA KIT	Addition to Formulary: Tier 4	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	GALANTAMINE HYDROBROMIDE SOLUTION	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	GARDASIL VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	HAVRIX SYRINGE	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	HAVRIX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	INFANRIX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	LAMICTAL ODT TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	LAMICTAL XR TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	MALATHION LOTION	Addition to Formulary: Tier 3	New Drug Addition t	N/A	See Evidence of Coverage
01/01/2010	MELPHALAN HCL VIAL	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	MYCOPHENOLATE MOFETIL CAPS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	MYCOPHENOLATE MOFETIL TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage

01/01/2010	NYAMYC POWDER	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	ONGLYZA TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	OXALIPLATIN VIAL	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	PEDIARIX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	PEDVAXHIB VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	RECOMBIVAX HB VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	REVELA POWDER PACKET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	RISPERIDONE 0.25 MG ODT TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	RISPERIDONE 0.5 MG ODT TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	RISPERIDONE 2 MG ODT TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	RISPERIDONE 3 MG ODT TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	RISPERIDONE 4 MG ODT TABS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	SABRIL POWDER PACKET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	SABRIL TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	SAPHRIS TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	SAVELLA TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	SIMPONI SYRINGE	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage

01/01/2010	STAVUDINE SOLUTION	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	TRIHIBIT KIT	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	TRIPEDIA VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	TWINRIX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	URSODIOL TABS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	VAQTA VIAL	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2010	VIMPAT VIAL	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2010	ZOSTAVAX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage

*Alternative drugs are drugs in the same therapeutic category/class or higher 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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