2024 Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) Formulary

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

When this drug list (formulary) refers to "we," "us", or "our," it means Johns Hopkins Advantage MD. When it refers to "plan" or "our plan," it means Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO).

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

What is the Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) 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 plan 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 titled "How do I request an exception to the Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) 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 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
    - f 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 Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) 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 1/1/2024. 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. In the event of any mid-year non-maintenance formulary changes, the formularies will be updated monthly and posted on our website.

How do I use the Formulary?

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

Medical Condition

The formulary begins on page 11. 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 - DRUGS TO TREAT HEART AND CIRCULATION CONDITIONS". If you know what your drug is used for, look for the category name in the list that begins on page 11. 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 76. 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 76 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, our plan 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 every 30 days 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, our plan 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 11. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online 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 our plan 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 Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) Formulary?" on page 5 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 our plan does not cover your drug, you have two options:

- You can ask Customer Service 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 our plan 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 Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) 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 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, our plan 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, 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, tier or utilization restriction exception. **When you request a formulary, tier 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.

If you experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary (or if your ability to get your drugs is limited), we will cover a onetime temporary supply for up to 30-days (or 31-days if you are a long-term care resident) from a network pharmacy. During this period you should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

For more information

For more detailed information about your Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) 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.

Johns Hopkins Advantage MD (PPO), Johns Hopkins Advantage MD Plus (PPO) and Johns Hopkins Advantage MD Premier (PPO) Formulary

The formulary that begins on the next page 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 76.

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

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

- PA – Prior Authorization. Our plan requires you or your provider to get prior authorization for certain drugs. This means that you will need to get approval from us before you fill your prescriptions. If you don't get approval, we may not cover the drug.

- QL – Drug has Quantity limit. For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 30 tablets per 30 days per prescription for rosuvastatin.

- ST – 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.

- NM – Not available at mail-order pharmacies

- LA – Limited Access. This prescription may be available only at certain pharmacies. For more information consult your Pharmacy Directory or call Customer Service at 1-877-293-5325, 24 hours a day, 7 days a week. TTY users should call 711.

- B/D – This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

- EX - This prescription drug is not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

- V/I - This drug's Tier Copay may not apply to you. Our plan covers most Part D vaccines at no cost to you. Our plan covered insulin is no more than $35 for a one-month supply. Call Customer Service for your estimated cost.

- * - Not available as extended days' supply. Non-extended day supply. Not available for an extended (long-term) supply.

Johns Hopkins Advantage MD (PPO) and Plus (PPO)		
Cost Sharing Tier	**Standard Retail Cost-Sharing (in-network)**	**Standard Mail Order Cost-Sharing (in-network)**
Cost-Sharing Tier 1 (Preferred Generic)	$4 copay for a 30-day supply $6 copay for a 60-day supply $8 copay for a 100-day supply	$4 copay for a 30-day supply $6 copay for a 60-day supply $8 copay for a 100-day supply
Cost-Sharing Tier 2 (Generic)	$12 copay for a 30-day supply $18 copay for a 60-day supply $24 copay for a 90-day supply	$12 copay for a 30-day supply $18 copay for a 60-day supply $24 copay for a 90-day supply
Cost-Sharing Tier 3 (Preferred Brand)	$47 copay for a 30-day supply $94 copay for a 60-day supply $141 copay for a 90-day supply	$47 copay for a 30-day supply $70.50 copay for a 60-day supply $94 copay for a 90-day supply
Cost-Sharing Tier 4 (Non-Preferred Drug)	$100 copay for a 30-day supply $200 copay for a 60-day supply $300 copay for a 90-day supply	$100 copay for a 30-day supply $150 copay for a 60-day supply $200 copay for a 90-day supply
Cost-Sharing Tier 5 (Specialty Tier)	33% coinsurance for a 30-day supply (only)	

NOTE:

- Drugs are provided in a Long-Term Care Facility up to a 31-day supply
- Drugs in Tier 5 are only available for a 30-day supply
- Mail order is available to conveniently order up to a 100-day supply of medication on Tier 1 and a 90 day supply of medication of Tier 2 through Tier 4 at two times the 30-day copay, saving you money and time. Contact us by calling the phone number listed on the front and back page.
- You can find complete cost-sharing information in your Evidence of Coverage

Johns Hopkins Advantage MD Premier (PPO)		
Cost Sharing Tier	**Standard Retail Cost-Sharing (in-network)**	**Standard Mail Order Cost-Sharing (in-network)**
Cost-Sharing Tier 1 (Preferred Generic)	$0 copay for a 30-day supply $0 copay for a 60-day supply $0 copay for a 100-day supply	$0 copay for a 30-day supply $0 copay for a 60-day supply $0 copay for a 100-day supply
Cost-Sharing Tier 2 (Generic)	$10 copay for a 30-day supply $15 copay for a 60-day supply $20 copay for a 90-day supply	$10 copay for a 30-day supply $15 copay for a 60-day supply $20 copay for a 90-day supply
Cost-Sharing Tier 3 (Preferred Brand)	$40 copay for a 30-day supply $80 copay for a 60-day supply $120 copay for a 90-day supply	$40 copay for a 30-day supply $60 copay for a 60-day supply $80 copay for a 90-day supply
Cost-Sharing Tier 4 (Non-Preferred Drug)	$90 copay for a 30-day supply $180 copay for a 60-day supply $270 copay for a 90-day supply	$90 copay for a 30-day supply $135 copay for a 60-day supply $180 copay for a 90-day supply
Cost-Sharing Tier 5 (Specialty Tier)	33% coinsurance for a 30-day supply (only)	
NOTE: - Drugs are provided in a Long-Term Care Facility up to a 31-day supply - Drugs in Tier 5 are only available for a 30-day supply - Mail order is available to conveniently order up to a 100-day supply of medication on Tier 1 and a 90 day supply of medication of Tier 2 through Tier 4 at two times the 30-day copay, saving you money and time. Contact us by calling the phone number listed on the front and back page. - You can find complete cost-sharing information in your Evidence of Coverage		