



## **Changes to the Johns Hopkins Advantage MD (HMO) Formulary**

**Please retain this with your formulary.**

Changes may have occurred since the printing of the Johns Hopkins Advantage MD (HMO) formulary. Medications added or removed from the formulary are listed below.

This is not a complete list of all formulary drugs covered by the plan. For a complete listing, or if you need additional information about the Johns Hopkins Advantage MD (HMO) formulary, please view our website at [www.hopkinsmedicare.com](http://www.hopkinsmedicare.com) or call Customer Service at 1-877-293-5325 (TTY: 711), 24 hours a day, seven days a week.

If you are a current member already taking the below drug(s) before the effective date of the change, we will continue to cover the drug for the remainder of the plan year as long as the drug continues to be medically necessary for treating your condition and prescribed for you by your prescriber, and was not removed for safety reasons.

**The table below outlines changes to our formulary that may impact you.**

<b>Name of Affected Drug</b>	<b>Description of Change</b>	<b>Reason for Change</b>	<b>Alternative Drug</b>	<b>Alternative Drug Cost-Share Tier</b>	<b>Effective Date</b>
AMOXICILLIN & K CLAVULANATE CHEW TAB 200-28.5 MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	AMOXICILLIN & K CLAVULANATE FOR SUSP 200-28.5 MG/5ML	Tier 3	01/01/2025
CORLANOR TAB	Deletion Of Drug From Formulary	Generic Available	IVABRADINE TAB	Tier 4	01/01/2025
ENDARI POW 5GM	Deletion Of Drug From Formulary	Generic Available	L-GLUTAMINE POW 5GM	Tier 5	01/01/2025
ERYTHROCIN TAB 250MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	ERYTHROMY CIN TAB 250MG BS	Tier 4	01/01/2025
LEUKERAN TAB 2MG	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider	—	01/01/2025

**PA** - Prior Authorization, **QL** - Quantity Limits, **ST** - Step Therapy, **NM** - Not available at mail order, **B/D** - Covered under Medicare B or D, **LA** - Limited Access, **GC** - We provide coverage of this prescription drug in the coverage gap. Please refer to our Evidence of Coverage for more information about this coverage. \* - Not available as extended days supply

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NATACYN SUS 5% OP	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider	–	01/01/2025
SANDIMMUNE SOL 100MG/ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	CYCLOSPORIN E CAP	Tier 4	01/01/2025
TABLOID TAB 40MG	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	Consult Your Health Care Provider	–	01/01/2025
TOBRADEX ST SUS 0.3-0.05%	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	TOBRAMYCIN - DEXAMETHAS ONE SUS 0.3- 0.1%	Tier 3	01/01/2025
ZERVIAE DRO 0.24%	Deletion Of Drug From Formulary	Medicare Will No Longer Cover	AZELASTINE DRO 0.05%	Tier 2	01/01/2025
DUPIXENT INJ 100MG/0.67ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	DUPIXENT INJ 200MG/1.14ML	Tier 5	02/01/2025
FENTANYL OT LOZ	Deletion Of Drug From Formulary	Manufacturer Discontinuation	MORPHINE SULFATE TAB	Tier 3	02/01/2025
NYMYO TAB 0.25MG-35MCG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	NORGESTIMA TE-ETHINYL ESTRADIOL TAB 0.25MG- 35MCG	Tier 2	02/01/2025
SELZENTRY TAB 25MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SELZENTRY SOL 20MG/ML	Tier 5	02/01/2025
SELZENTRY TAB 75MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	SELZENTRY SOL 20MG/ML	Tier 5	02/01/2025
SPRYCEL TAB	Deletion Of Drug From Formulary	Generic Available	DASATINIB TAB	Tier 5	02/01/2025
VRAYLAR CAP 1.5- 3MG	Deletion Of Drug From Formulary	Manufacturer Discontinuation	VRAYLAR CAP	Tier 5	02/01/2025
ZYPREXA RELPREVV INJ	Deletion Of Drug From Formulary	Manufacturer Discontinuation	RISPERIDONE ER INJ	Tier 4 / Tier 5	02/01/2025
DROXIA CAP	Deletion Of Drug From Formulary	Manufacturer Discontinuation	Consult Your Health Care Provider	–	03/01/2025

PA = Prior Authorization, QL = Quantity Limits, ST = Step Therapy, LA = Limited Access, 2  
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PREHEVBRIO SUS 10MCG/ML	Deletion Of Drug From Formulary	Manufacturer Discontinuation	ENGERIX-B INJ; HEPLISAV-B INJ; RECOMBIVAX HB INJ	Tier 1	03/01/2025
TDVAX INJ 2-2 LF	Deletion Of Drug From Formulary	Manufacturer Discontinuation	TENIVAC INJ 5-2LF	Tier 1	03/01/2025

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