2024 Addendum for MCS Classicare Prescription Drug Formulary 1

This document provides a summary of the changes suffered by the Prescription Drug Formulary 1 from January to April 2024.

MCS Classicare may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug and/or move a drug to other cost-sharing tier, we will notify the affected enrollees through the Formulary Change Letter or the Explanation of Benefits (EOB).

Below is an updated drugs list for prescription drugs that have either been included, removed or there has been a change in prior authorization, quantity limits, step therapy restrictions and/or move a drug from its tiered cost-sharing status in the Prescription Drug Formulary 1.

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Abrysvo Solution Reconstituted 120 MCG/0.5ML Intramuscular	Tier 1	CMS Approved Addition	Not Apply	01.01.2024
AmBisome Suspension Reconstituted 50 MG Intravenous	Non Formulary	CMS Approved Enhancement	amphotericin b liposome suspension reconstituted 50 mg intravenous, Tier 5 + BvD	01.01.2024
Amphotericin B Liposome Suspension Reconstituted 50 MG Intravenous	Tier 5 + BvD	CMS Approved Addition	Not Apply	01.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Arexvy Suspension Reconstituted 120 MCG/0.5ML Intramuscular	Tier 1	CMS Approved Addition	Not Apply	01.01.2024
Austedo XR Patient Titration Tablet Extended Release Therapy Pack 6 & 12 & 24 MG Oral	Tier 5 + Quantity Limit 42/28 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2024
Cosentyx UnoReady Solution Auto-Injector 300 MG/2ML Subcutaneous	Tier 5 + Quantity Limit 8/28 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2024
Daybue Solution 200 MG/ML Oral	Tier 5 + Quantity Limit 3600 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2024
Flovent Diskus Aerosol Powder Breath Activated 100 MCG/ACT Inhalation	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2024
Flovent Diskus Aerosol Powder Breath Activated 250 MCG/ACT Inhalation	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2024
Flovent Diskus Aerosol Powder Breath Activated 50 MCG/ACT Inhalation	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2024
Haloette Ring 0.12-0.015 MG/24HR Vaginal	Tier 3 + Quantity Limit 1/28	CMS Approved Addition	Not Apply	01.01.2024
Multiple Electro Type 1 pH 5.5 Solution Intravenous	Tier 2 + BvD	CMS Approved Addition	Not Apply	01.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Plasma-Lyte 148 Solution Intravenous	Non Formulary	CMS Approved Enhancement	multiple electro type 1 ph 5.5 solution intravenous, Tier 2 + BvD	01.01.2024
Spiriva HandiHaler Capsule 18 MCG Inhalation	Non Formulary	CMS Approved Enhancement	tiotropium bromide monohydrate capsule 18 mcg inhalation, Tier 2 + Quantity Limit 30	01.01.2024
Talzenna Capsule 0.1 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2024
Talzenna Capsule 0.35 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2024
Tiotropium Bromide Monohydrate Capsule 18 MCG Inhalation	Tier 2 + Quantity Limit 30	CMS Approved Addition	Not Apply	01.01.2024
Vigadrone Tablet 500 MG Oral	Tier 5 + Quantity Limit 180 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2024
Zejula Tablet 100 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2024
Zejula Tablet 200 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2024
Zejula Tablet 300 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Alphagan P Solution 0.1 % Ophthalmic	Non Formulary	CMS Approved Enhancement	brimonidine tartrate solution 0.1 % ophthalmic, Tier 3	02.01.2024
Breo Ellipta Aerosol Powder Breath Activated 50-25 MCG/INH Inhalation	Tier 3 + Quantity Limit 60	CMS Approved Addition	Not Apply	02.01.2024
Brimonidine Tartrate Solution 0.1 % Ophthalmic	Tier 3	CMS Approved Addition	Not Apply	02.01.2024
Ciprofloxacin HCl Tablet 100 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Clindamycin Phosphate Solution 300 MG/2ML Injection	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
cycloSPORINE Emulsion 0.05 % Ophthalmic	Tier 3 + Quantity Limit 60	CMS Approved Addition	Not Apply	02.01.2024
EnilloRing Ring 0.12-0.015 MG/24HR Vaginal	Tier 3 + Quantity Limit 1/28	CMS Approved Addition	Not Apply	02.01.2024
Fruzaqla Capsule 1 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Fruzaqla Capsule 5 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Fulphila Solution Prefilled Syringe 6 MG/0.6ML Subcutaneous	Tier 5 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2024
HumaLOG Tempo Pen Solution Pen-Injector 100 UNIT/ML Subcutaneous	Tier 6 + Quantity Limit 40	CMS Approved Addition	Not Apply	02.01.2024
Insulin Glargine Solostar Solution Pen-Injector 100 UNIT/ML Subcutaneous	Tier 6 + Quantity Limit 40	CMS Approved Addition	Not Apply	02.01.2024
Insulin Glargine Solution 100 UNIT/ML Subcutaneous	Tier 6 + Quantity Limit 40	CMS Approved Addition	Not Apply	02.01.2024
Lagevrio Capsule 200 MG Oral	Tier 1	CMS Approved Addition	Not Apply	02.01.2024
Lithium Solution 8 MEQ/5ML Oral	Tier 2	CMS Approved Addition	Not Apply	02.01.2024
Livalo Tablet 1 MG Oral	Non Formulary	CMS Approved Enhancement	pitavastatin calcium tablet 1 mg oral, Tier 2 + Quantity Limit 30 + Step Therapy New Starters	02.01.2024
Livalo Tablet 2 MG Oral	Non Formulary	CMS Approved Enhancement	pitavastatin calcium tablet 2 mg oral, Tier 2 + Quantity Limit 30 + Step Therapy New Starters	02.01.2024
Livalo Tablet 4 MG Oral	Non Formulary	CMS Approved Enhancement	pitavastatin calcium tablet 4 mg oral, Tier 2 + Quantity Limit 30 + Step Therapy New Starters	02.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Nevirapine ER Tablet Extended Release 24 Hour 100 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Ojjaara Tablet 100 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Ojjaara Tablet 150 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Ojjaara Tablet 200 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Olopatadine HCl Solution 0.1 % Ophthalmic	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Paxlovid (150/100) Tablet Therapy Pack 10 x 150 MG & 10 x 100MG Oral	Tier 1	CMS Approved Addition	Not Apply	02.01.2024
Paxlovid (300/100) Tablet Therapy Pack 20 x 150 MG & 10 x 100MG Oral	Tier 1	CMS Approved Addition	Not Apply	02.01.2024
Pitavastatin Calcium Tablet 1 MG Oral	Tier 2 + Quantity Limit 30 + Step Therapy New Starters	CMS Approved Addition	Not Apply	02.01.2024
Pitavastatin Calcium Tablet 2 MG Oral	Tier 2 + Quantity Limit 30 + Step Therapy New Starters	CMS Approved Addition	Not Apply	02.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Pitavastatin Calcium Tablet 4 MG Oral	Tier 2 + Quantity Limit 30 + Step Therapy New Starters	CMS Approved Addition	Not Apply	02.01.2024
Sohonos Capsule 1 MG Oral	Tier 5 + Quantity Limit 28/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2024
Sohonos Capsule 1.5 MG Oral	Tier 5 + Quantity Limit 56/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2024
Sohonos Capsule 10 MG Oral	Tier 5 + Quantity Limit 56/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2024
Sohonos Capsule 2.5 MG Oral	Tier 5 + Quantity Limit 28/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2024
Sohonos Capsule 5 MG Oral	Tier 5 + Quantity Limit 28/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2024
Synjardy XR Tablet Extended Release 24 Hour 10-1000 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Synjardy XR Tablet Extended Release 24 Hour 12.5-1000 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Synjardy XR Tablet Extended Release 24 Hour 25-1000 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Synjardy XR Tablet Extended Release 24 Hour 5-1000 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Synribo Solution Reconstituted 3.5 MG Subcutaneous	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Truqap Tablet 160 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Truqap Tablet 200 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Vanflyta Tablet 17.7 MG Oral	Tier 5 + Quantity Limit 56/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Vanflyta Tablet 26.5 MG Oral	Tier 5 + Quantity Limit 56/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Viibryd Starter Pack KIT 10 & 20 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2024
Xdemvy Solution 0.25 % Ophthalmic	4 + PA 1	CMS Approved Addition	Not Apply	02.01.2024
Zurzuvae Capsule 20 MG Oral	Tier 5 + Quantity Limit 28/14 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Zurzuvae Capsule 25 MG Oral	Tier 5 + Quantity Limit 28/14 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Zurzuvae Capsule 30 MG Oral	Tier 5 + Quantity Limit 14/14 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2024
Accutane Capsule 30 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	03.01.2024
Akeega Tablet 100-500 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2024
Akeega Tablet 50-500 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2024
Augtyro Capsule 40 MG Oral	Tier 5 + Quantity Limit 240 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2024
Kalydeco Packet 5.8 MG Oral	5 + Prior Authorization	CMS Approved Addition	Not Apply	03.01.2024
Ogsiveo Tablet 50 MG Oral	Tier 5 + Quantity Limit 180 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2024
Vigpoder Packet 500 MG Oral	Tier 5 + Quantity Limit 180 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Zenpep Capsule Delayed Release Particles 60000-189600 UNIT Oral	Tier 3	CMS Approved Addition	Not Apply	03.01.2024
Adalimumab-adbm (2 Pen) Auto-Injector Kit 40 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 10 MG/0.2ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 20 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Adalimumab-adbm (2 Syringe) Prefilled Syringe Kit 40 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Adalimumab-adbm(CD/UC/HS Strt) Auto-Injector Kit 40 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Adalimumab-adbm(Ps/UV Starter) Auto-Injector Kit 40 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 4/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Amjevita Solution Auto-Injector 40 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Amjevita Solution Auto-Injector 80 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Amjevita Solution Prefilled Syringe 40 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Amjevita-Ped 15kg to <30kg Solution Prefilled Syringe 20 MG/0.2ML Subcutaneous	Tier 5 + Quantity Limit 2/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Bosulif Capsule 100 MG Oral	Tier 5 + Quantity Limit 180 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	04.01.2024
Bosulif Capsule 50 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	04.01.2024
HumaLOG Mix 50/50 SUSPENSION (50-50) 100 UNIT/ML Subcutaneous	Non Formulary	CMS Approved Deletion	Not Apply	04.01.2024
Humira-CD/UC/HS Starter Pen-Injector Kit 40 MG/0.8ML Subcutaneous	Non Formulary	CMS Approved Deletion	Not Apply	04.01.2024
Iwilfin Tablet 192 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	04.01.2024
Mayzent Starter Pack Tablet Therapy Pack 12 x 0.25 MG Oral	Tier 5 + Quantity Limit 210 + Prior Authorization New Starters	CMS Approved Enhancement	Not Apply	04.01.2024
Na Sulfate-K Sulfate-Mg Sulf Solution 17.5-3.13-1.6 GM/177ML Oral	Tier 2	CMS Approved Addition	Not Apply	04.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Paromomycin Sulfate Capsule 250 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	04.01.2024
Penbraya Suspension Reconstituted Intramuscular	Tier 1	CMS Approved Addition	Not Apply	04.01.2024
Ramelteon Tablet 8 MG Oral	2 + Quantity Limit 30	CMS Approved Addition	Not Apply	04.01.2024
Synjardy XR Tablet Extended Release 24 Hour 10-1000 MG Oral	3 + Quantity Limit 30	CMS Approved Addition	Not Apply	04.01.2024
Synjardy XR Tablet Extended Release 24 Hour 12.5-1000 MG Oral	3 + Quantity Limit 60	CMS Approved Addition	Not Apply	04.01.2024
Synjardy XR Tablet Extended Release 24 Hour 25-1000 MG Oral	3 + Quantity Limit 30	CMS Approved Addition	Not Apply	04.01.2024
Synjardy XR Tablet Extended Release 24 Hour 5-1000 MG Oral	3 + Quantity Limit 60	CMS Approved Addition	Not Apply	04.01.2024
Temazepam Capsule 22.5 MG Oral	Tier 2 + Quantity Limit 30 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Temazepam Capsule 7.5 MG Oral	Tier 2 + Quantity Limit 30 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Xalkori Capsule Sprinkle 150 MG Oral	Tier 5 + Quantity Limit 180 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	04.01.2024
Xalkori Capsule Sprinkle 20 MG Oral	Tier 5 + Quantity Limit 240 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	04.01.2024
Xalkori Capsule Sprinkle 50 MG Oral	Tier 5 + Quantity Limit 120 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	04.01.2024
Zilbrysq Solution Prefilled Syringe 23 MG/0.574ML Subcutaneous	Tier 5 + Quantity Limit 16.072/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024
Zilbrysq Solution Prefilled Syringe 32.4 MG/0.81ML Subcutaneous	Tier 5 + Quantity Limit 22.68/28 + Prior Authorization	CMS Approved Addition	Not Apply	04.01.2024

Ahead you will find some definitions that help you to understand the changes in the Prescription Drug Formulary 1:

Prior authorization – This means your doctor must contact the plan before the plan will cover the drug. Your doctor must show that the drug is medically necessary for it to be covered.

Quantity Limits – This means there is a limit to how much medication or other dosage form you can get at a time.

Step Therapy – This means one or more similar lower cost drugs must be used before the step-therapy drug is covered.

If you have any questions regarding this notification, please contact our Customer Service Center at 787-620-2530 (metro area) or 1-866-627-8183 (toll free). Members with hearing impairment should call 1-866-627-8182 (TTY). Service hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. from October 1 to March 31. From April 1 to September 30, Monday through Friday from 8:00 a.m. to 8:00 p.m and Saturdays from 8:00 a.m. to 4:30 p.m. Remember that we have our Service Centers conveniently located throughout the Island to respond to the needs of our members. In MCS we are available to serve you.

MCS Classicare is an HMO plan subscribed by MCS Advantage, Inc.

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