

## Upcoming Changes to the Medicare Blue<sup>SM</sup> Plus Formulary

Medicare Blue Plus may add or remove drugs from the 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 a higher cost-sharing tier, we will notify you of the change at least 60 days before the date that the change becomes effective. 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, however, we will immediately remove the drug from our formulary.

This table outlines upcoming changes to our formulary that may impact you.

Name of Affected Drug	Notice # <sup>*</sup>	Description of Change	Reason for Change	Alternative Drug <sup>**</sup>	Alternative Drug Copayment/ Coinsurance	Effective Date
ARIMIDEX	2nd	Deletion of Drug from Formulary	Generic Available	ANASTROZOLE	\$9	10/01/10
ASTELIN NASAL SPRAY	2nd	Deletion of Drug from Formulary	Generic Available	AZELASTINE NASAL SPRAY 0.1%	\$9	10/01/10
AUGMENTIN XR	3rd	Deletion of Drug from Formulary	Generic Available	AMOXICILLIN/CLAVULANATE K ER	\$9	10/01/10

<sup>\*</sup> We include each drug in our notice of formulary changes for three consecutive months. This column indicates whether this is the first, second or third notice given.

<sup>\*\*</sup> Alternative drugs are drugs in the same therapeutic category/class or cost-sharing tier as the affected drug. Only your physician can determine if the alternate here is appropriate for you given the individualized nature of the drug therapy. Please consult your physician as to whether this is an appropriate drug for you.

<sup>\*\*\*</sup> This change will not affect your coverage for this drug for the remainder of the plan year if you are currently taking this drug.

H4209\_MB29201 (08/2010)

Order # 12115M (08-10)

This product is offered by BlueCross BlueShield of South Carolina,  
an independent licensee of the Blue Cross and Blue Shield Association.

CARDIZEM LA 180MG, 240MG, 300MG, 360MG, 420MG	3rd	Deletion of Drug from Formulary	Generic Available	DILTIAZEM ER TAB	\$9	10/01/10
COZAAR	3rd	Deletion of Drug from Formulary	Generic Available	LOSARTAN	\$9	10/01/10
DIFFERIN GEL 0.1%	2nd	Deletion of Drug from Formulary	Generic Available	ADAPALENE GEL 0.1%	\$9	10/01/10
HYZAAR	3rd	Deletion of Drug from Formulary	Generic Available	LOSARTAN & HYDROCHLORO THIAZIDE	\$9	10/01/10
LIPRAM, LIPRAM- PN, LIPRAM-UL	3rd	Deletion of Drug from Formulary	Medicare Will No Longer Cover	CONSULT YOUR HEALTH CARE PROVIDER	N/A	Until Supplies Run Out
PANCRELIPASE	3rd	Deletion of Drug from Formulary	Medicare Will No Longer Cover	CONSULT YOUR HEALTH CARE PROVIDER	N/A	Until Supplies Run Out
PEPCID SUSPENSION	2nd	Deletion of Drug from Formulary	Generic Available	FAMOTIDINE SUSPENSION	\$9	10/01/10
SKELAXIN	3rd	Deletion of Drug from Formulary	Generic Available	METAXALONE	\$9	10/01/10
ULTRASE & ULTRASE MT	3rd	Deletion of Drug from Formulary	Medicare Will No Longer Cover	CONSULT YOUR HEALTH CARE PROVIDER	N/A	Until Supplies Run Out
VIOKASE	3rd	Deletion of Drug from Formulary	Medicare Will No Longer Cover	CONSULT YOUR HEALTH CARE PROVIDER	N/A	Until Supplies Run Out

### What to Do if You Disagree with a Coverage Decision

If we deny your request for a drug that you haven't received, or deny your request to pay you back for a drug that you have received, we will send you a letter explaining our decision. If you disagree with our decision, you can request an appeal within 60 calendar days from the date of our first decision. You can request a "standard" or "fast" (expedited) appeal. We will automatically give you a fast appeal if your physician tells us that waiting for a standard decision may seriously jeopardize your life or health.

You can request an appeal by calling 1-800-645-6025 Monday - Friday, 8 a.m. – 8 p.m. Eastern Time (TTY/TDD users should call 1-888-645-6023).

Your doctor needs to give us a statement explaining that the drug you need is medically necessary to treat your condition if you or your doctor believe that:

- You need a drug that isn't on our list of covered drugs (formulary)
- The Plan should waive a coverage rule or limit on a drug that you need
- You can't take any of the drugs on our preferred tier for your condition, and you would like us to cover a non-preferred drug at the preferred cost-sharing amount

Your doctor can mail the statement to Medicare Advantage, P.O. Box 100191, Columbia, SC, 29202 or fax it to 1-803-264-9581.