

City of Houston

During the plan year, drugs may be added to or removed from the formulary. If we remove drugs from the formulary, 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. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe, or if the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary.

The table below outlines upcoming change(s) to our formulary that may impact you.

NAME OF AFFECTED DRUG	DESCRIPTION OF CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG ¹	ALTERNATIVE DRUG COPAY	EFFECTIVE DATE
BUPHENYL TAB 500MG	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	SODIUM PHENYLBUTYRATE TAB 500 MG	Tier 5	6/1/2018
COPAXONE INJ 40MG/ML	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	GLATIRAMER INJ 40MG/ML	Tier 5	6/1/2018
ESTRACE VAGINAL CREAM 0.01%	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	ESTRADIOL VAGINAL CREAM 0.01%	Tier 2	6/1/2018
ISTALOL OPHTH SOLN 0.5%	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	TIMOLOL MALEATE OPHTH SOLN 0.5% (ONCE-DAILY)	Tier 2	6/1/2018
RELPAK TAB	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	ELETRIPTAN TAB	Tier 2	6/1/2018
RENVELA PAK	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	SEVELAMER CARBONATE PACKET	Tier 2	6/1/2018
RENVELA TAB 800MG	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	SEVELAMER CARBONATE TAB 800 MG	Tier 2	6/1/2018

NAME OF AFFECTED DRUG	DESCRIPTION OF CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG ¹	ALTERNATIVE DRUG COPAY	EFFECTIVE DATE
REYATAZ CAP	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	ATAZANAVIR CAP	Tier 5	6/1/2018
SABRIL PACK 500MG	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	VIGABATRIN POWDER PACK 500MG	Tier 5	6/1/2018
SUSTIVA CAP 200MG	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	EFAVIRENZ CAP 200 MG	Tier 5	6/1/2018
SUSTIVA CAP 50MG	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	EFAVIRENZ CAP 50 MG	Tier 2	6/1/2018
TAMIFLU SUSP 6MG/ML	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	OSELTAMIVIR PHOSPHATE SUSP 6 MG/ML	Tier 2	6/1/2018
TRANSDERM-SC PATCH 1.5MG	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	SCOPOLAMINE PATCH	Tier 4	6/1/2018
VIGAMOX DROPS 0.5%	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	MOXIFLOXACIN HCL OPHTH SOLN 0.5%	Tier 2	6/1/2018
ZIAGEN SOLN 20MG/ML	DELETION OF DRUG FROM FORMULARY	GENERIC AVAILABLE	ABACAVIR SOLN 20MG/ML	Tier 2	6/1/2018

TexanPus® HMO is a Medicare Advantage plan with a Medicare contract. Enrollment in TexanPus® HMO depends on contract renewal.

¹Please consult with your physician as to whether this is an appropriate drug for you, as he or she must decide to prescribe it for you if appropriate. If none of the alternative drugs listed above are right for you due to your medical condition, you may request an exception to our formulary. To file a formulary exception request, you (or your physician/prescriber) must send us a supporting statement from your physician. If your physician's supporting statement demonstrated the medical necessity for a drug not on our formulary, we will grant a formulary exception. For more information, you can call us at 1-866-230-2513, 8:00 a.m. to 8:00 p.m. in your local time zone (TTY users call 711) 7 days a week.

TexanPus® HMO complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-888-736-7442 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-736-7442 (TTY: 711). Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-736-7442 (TTY: 711)。

