2025 Addendum for MCS Classicare Prescription Drug Formulary 3

This document provides a summary of the changes suffered by the Prescription Drug Formulary 3 from January 2025 to March 2025.

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 3.

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Augtyro Capsule 160 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Azithromycin Packet 1 GM Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Cobenfy Capsule 100-20 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Cobenfy Capsule 125-30 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Cobenfy Capsule 50-20 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Cobenfy Starter Pack Capsule Therapy Pack 50-20 & 100-20 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 100 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 140 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 20 MG Oral	Tier 5 + Quantity Limit 90 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 50 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 70 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 80 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Descovy Tablet 120-15 MG Oral	Tier 5	CMS Approved Enhancement	Not Apply	02.01.2025
Descovy Tablet 200-25 MG Oral	Tier 5	CMS Approved Enhancement	Not Apply	02.01.2025
Desogestrel-Ethinyl Estradiol Tablet 0.15-30 MG-MCG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Diphtheria-Tetanus Toxoids DT Suspension 25-5 LFU/0.5ML Intramuscular	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Emtricitabine-Tenofovir DF Tablet 200-300 MG Oral	Tier 2	CMS Approved Enhancement	Not Apply	02.01.2025
Ergoloid Mesylates Tablet 1 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
fentaNYL Citrate Lozenge On A Handle 1200 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
FentaNYL Citrate Lozenge On A Handle 1600 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
fentaNYL Citrate Lozenge On A Handle 200 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
fentaNYL Citrate Lozenge On A Handle 400 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
fentaNYL Citrate Lozenge On A Handle 600 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
fentaNYL Citrate Lozenge On A Handle 800 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Fintepla Solution 2.2 MG/ML Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Gallifrey Tablet 5 MG Oral	Tier 2	CMS Approved Addition	Not Apply	02.01.2025
Hadlima PushTouch Solution Auto-Injector 40 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Hadlima PushTouch Solution Auto-Injector 40 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Hadlima Solution Prefilled Syringe 40 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 6/28 Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Hadlima Solution Prefilled Syringe 40 MG/0.8ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
HYDROcodone-Acetaminophen Solution 10-325 MG/15ML Oral	Tier 2 + Quantity Limit 2700	CMS Approved Addition	Not Apply	02.01.2025
Itovebi Tablet 3 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Itovebi Tablet 9 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Lazcluze Tablet 240 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Lazcluze Tablet 80 MG Oral	Tier 5 + Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 0.31 MG/3ML Inhalation	Tier 2 + Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 0.63 MG/3ML Inhalation	Tier 2 + Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 1.25 MG/0.5ML Inhalation	Tier 2 + Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 1.25 MG/3ML Inhalation	Tier 2 + Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
levoFLOXacin Solution 0.5 % Ophthalmic	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Lumakras Tablet 240 MG Oral	Tier 5 + Quantity Limit 120 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Menest Tablet 0.3 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Menest Tablet 0.625 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Menest Tablet 1.25 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Menest Tablet 2.5 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Nicotrol Inhaler 10 MG Inhalation	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Nymyo Tablet 0.25-35 MG-MCG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
oxyCODONE HCl ER Tablet ER 12 Hour Abuse-Deterrent 10 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
oxyCODONE HCl ER Tablet ER 12 Hour Abuse-Deterrent 20 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Quadracel Suspension Intramuscular	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Quinapril-hydroCHLOROthiazide Tablet 10-12.5 MG Oral	Tier 2	CMS Approved Addition	Not Apply	02.01.2025
Quinapril-hydroCHLOROthiazide Tablet 20-12.5 MG Oral	Tier 2	CMS Approved Addition	Not Apply	02.01.2025
Quinapril-hydroCHLOROthiazide Tablet 20-25 MG Oral	Tier 2	CMS Approved Addition	Not Apply	02.01.2025
Rinvoq LQ Solution 1 MG/ML Oral	Tier 5 + Quantity Limit 360 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Rotarix Suspension Reconstituted Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Selzentry Tablet 25 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Selzentry Tablet 75 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Simlandi (2 Pen) Auto-Injector Kit 40 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Simlandi (2 Syringe) Prefilled Syringe Kit 40 MG/0.4ML Subcutaneous	Tier 5 + Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Sprycel Tablet 100 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 100 mg oral, Tier 5 + Quantity Limit 60 + Prior Authorization	02.01.2025
Sprycel Tablet 140 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 140 mg ora, Tier 5 + Quantity Limit 30 + Prior Authorization	02.01.2025
Sprycel Tablet 20 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 20 mg oral, Tier 5 + Quantity Limit 90 + Prior Authorization	02.01.2025
Sprycel Tablet 50 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 50 mg oral, Tier 5 + Quantity Limit 60 + Prior Authorization	02.01.2025
Sprycel Tablet 70 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 70 mg oral, Tier 5 + Quantity Limit 60 + Prior Authorization	02.01.2025
Sprycel Tablet 80 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 80 mg oral, Tier 5 + Quantity Limit 60 + Prior Authorization	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Tazarotene Cream 0.05 % External	Tier 2 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Tazorac Cream 0.05 % External	Non Formulary	CMS Approved Enhancement	tazarotene cream 0.05 % external, Tier 2 + Prior Authorization	02.01.2025
Thalomid Capsule 150 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Thalomid Capsule 200 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Tivicay Tablet 10 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Tivicay Tablet 25 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Tremfya Solution Auto-Injector 200 MG/2ML Subcutaneous	Tier 5 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Tremfya Solution Prefilled Syringe 200 MG/2ML Subcutaneous	Tier 5 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
TRI-NYMYO 28 DAY PACK	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Voranigo Tablet 10 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Voranigo Tablet 40 MG Oral	Tier 5 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
ZyPREXA Relprevv Suspension Reconstituted 210 MG Intramuscular	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
CARBAMAZEPIN CHW 200MG	Tier 2	Addition	Not Apply	03.01.2025
Danziten Tablet 71 MG Oral	Tier 5 + Quantity Limit 112/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
Danziten Tablet 95 MG Oral	Tier 5 + Quantity Limit 112/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
DIPHENHYDRAM INJ 50MG/ML	Tier 1	Addition	Not Apply	03.01.2025
Droxia Capsule 200 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	03.01.2025
Droxia Capsule 300 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	03.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Droxia Capsule 400 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	03.01.2025
ERZOFRI INJ 117/0.75	Tier 5 + Quantity Limit 0.75/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 156MG/ML	Tier 5 + Quantity Limit 1/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 234/1.5	Tier 5 + Quantity Limit 1.5/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 351/2.25	Tier 5 + Quantity Limit 2.25/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 39/0.25	Tier 5 + Quantity Limit 0.25/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 78/0.5ML	Tier 5 + Quantity Limit 0.5/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
Imkeldi Solution 80 MG/ML Oral	Tier 5 + Quantity Limit 280/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
MESNA TAB 400MG	Tier 2	Addition	Not Apply	03.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
OPIPZA MIS 10MG	Tier 5 + Quantity Limit 90 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
OPIPZA MIS 2MG	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
OPIPZA MIS 5MG	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
Phenytek Capsule 200 MG Oral	Tier 2	CMS Approved Addition	Not Apply	03.01.2025
Phenytek Capsule 300 MG Oral	Tier 2	CMS Approved Addition	Not Apply	03.01.2025
PreHevbrio Suspension 10 MCG/ML Intramuscular	Non Formulary	CMS Approved Deletion	Not Apply	03.01.2025
Revuforj Tablet 110 MG Oral	Tier 5 + Quantity Limit 120 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
Revuforj Tablet 160 MG Oral	Tier 5 + Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
STAVUDINE CAP 15MG	Tier 2 + Quantity Limit 60	Addition	Not Apply	03.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
STAVUDINE CAP 20MG	Tier 2 + Quantity Limit 60	Addition	Not Apply	03.01.2025
STAVUDINE CAP 30MG	Tier 2 + Quantity Limit 60	Addition	Not Apply	03.01.2025
STAVUDINE CAP 40MG	Tier 2 + Quantity Limit 60	Addition	Not Apply	03.01.2025
TOPIRAMATE CAP 50MG	Tier 2	Addition	Not Apply	03.01.2025

Ahead you will find some definitions that help you to understand the changes in the Prescription Drug Formulary 3:

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.