



# 2025 Addendum for MCS Classicare Prescription Drug Formulary 2

This document provides a summary of the changes suffered by the Prescription Drug Formulary 2 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 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 2.

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Amoxicillin-Pot Clavulanate Tablet Chewable 200-28.5 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2025
Austedo XR Patient Titration Tablet Extended Release Therapy Pack 12 & 18 & 24 & 30 MG Oral	Quantity Limit 60 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2025
Austedo XR Tablet Extended Release 24 Hour 18 MG Oral	Quantity Limit 60 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2025
Ciprofloxacin HCl Solution 0.2 % Otic	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Corlanor 5 mg tablet	Non Formulary	CMS Approved Enhancement	ivabradine hcl tablet 5 mg oral, Quantity Limit 60 + Prior Authorization	01.01.2025
Corlanor 7.5 mg tablet	Non Formulary	CMS Approved Enhancement	ivabradine hcl tablet 7.5 mg oral, Quantity Limit 60 + Prior Authorization	01.01.2025
Drizalma Sprinkle Capsule Delayed Release Sprinkle 20 MG Oral	Quantity Limit 60	CMS Approved Addition	Not Apply	01.01.2025
Drizalma Sprinkle Capsule Delayed Release Sprinkle 30 MG Oral	Quantity Limit 60	CMS Approved Addition	Not Apply	01.01.2025
Drizalma Sprinkle Capsule Delayed Release Sprinkle 40 MG Oral	Quantity Limit 30	CMS Approved Addition	Not Apply	01.01.2025
Drizalma Sprinkle Capsule Delayed Release Sprinkle 60 MG Oral	Quantity Limit 60	CMS Approved Addition	Not Apply	01.01.2025
Endari 5-gram oral powder packet	Non Formulary	CMS Approved Enhancement	l-glutamine packet 5 gm oral, Quantity Limit 180 + Prior Authorization	01.01.2025
Entresto Capsule Sprinkle 15-16 MG Oral	Quantity Limit 240	CMS Approved Addition	Not Apply	01.01.2025
Entresto Capsule Sprinkle 6-6 MG Oral	Quantity Limit 240/31	CMS Approved Addition	Not Apply	01.01.2025
GaviLyte-N with Flavor Pack Solution Reconstituted 420 GM Oral	Formulary Enhancement	CMS Approved Addition	Not Apply	01.01.2025
HumaLOG Junior KwikPen Solution Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
HumaLOG KwikPen Solution Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
HumaLOG Mix 50/50 KwikPen Suspension Pen-injector (50-50) 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
HumaLOG Mix 75/25 KwikPen Suspension Pen-injector (75-25) 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
HumaLOG Solution Cartridge 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
HumaLOG Tempo Pen Solution Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
HumuLIN 70/30 KwikPen Suspension Pen-Injector (70-30) 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
HumuLIN N KwikPen Suspension Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
Insulin Lispro (1 Unit Dial) Solution Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
Insulin Lispro Junior KwikPen Solution Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
Insulin Lispro Prot & Lispro Suspension Pen-Injector (75-25) 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
Ivabradine HCl Tablet 5 MG Oral	Quantity Limit 60 + Prior Authorization	CMS Approved Enhancement	Not Apply	01.01.2025
Ivabradine HCl Tablet 7.5 MG Oral	Quantity Limit 60 + Prior Authorization	CMS Approved Enhancement	Not Apply	01.01.2025
Lantus SoloStar Solution Pen-Injector 100 UNIT/ML Subcutaneous	Quantity Limit 45	CMS Approved Enhancement	Not Apply	01.01.2025
Leukeran Tablet 2 MG Oral	Non Formulary	CMS Required Deletion	Not Apply	01.01.2025
L-Glutamine Packet 5 GM Oral	Quantity Limit 180 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2025

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DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
MResvia Suspension Prefilled Syringe 50 MCG/0.5ML Intramuscular	Formulary Enhancement	CMS Approved Addition	Not Apply	01.01.2025
Natacyn Suspension 5 % Ophthalmic	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2025
Ojemda Tablet 100 MG Oral (16 pack)	Quantity Limit 24/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2025
Ojemda Tablet 100 MG Oral (24 pack)	Quantity Limit 24/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2025
Otezla Tablet 20 MG Oral	Quantity Limit 60 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2025
Otezla Tablet Therapy Pack 4 x 10 & 51 x20 MG Oral	Quantity Limit 55/28 + Prior Authorization	CMS Approved Addition	Not Apply	01.01.2025
Retevmo Tablet 120 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2025
Retevmo Tablet 160 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2025
Retevmo Tablet 40 MG Oral	Quantity Limit 180 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2025
Retevmo Tablet 80 MG Oral	Quantity Limit 120 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	01.01.2025
SandIMMUNE Solution 100 MG/ML Oral	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2025
Soliqua Solution Pen-injector 100-33 UNT-MCG/ML Subcutaneous	Quantity Limit 45 + Step Therapy New Starters	CMS Approved Enhancement	Not Apply	01.01.2025
Tabloid Tablet 40 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	01.01.2025
Vaxchora Suspension Reconstituted Oral	Formulary Enhancement	CMS Approved Addition	Not Apply	01.01.2025
Augtyro Capsule 160 MG Oral	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
Azithromycin Packet 1 GM Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Cobenfy Capsule 100-20 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Cobenfy Capsule 125-30 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Cobenfy Capsule 50-20 MG Oral	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	Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 100 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 140 MG Oral	Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 20 MG Oral	Quantity Limit 90 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 50 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 70 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Dasatinib Tablet 80 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Descovy Tablet 120-15 MG Oral	Formulary Enhancement	CMS Approved Enhancement	Not Apply	02.01.2025
Descovy Tablet 200-25 MG Oral	Formulary Enhancement	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

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DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Emtricitabine-Tenofovir DF Tablet 200-300 MG Oral	Formulary Enhancement	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
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
fentaNYL Citrate Tablet 800 MCG Buccal	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Fintepla Solution 2.2 MG/ML Oral	Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Gallifrey Tablet 5 MG Oral	Formulary Enhancement	CMS Approved Addition	Not Apply	02.01.2025
Hadlima PushTouch Solution Auto-Injector 40 MG/0.4ML Subcutaneous	Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Hadlima PushTouch Solution Auto-Injector 40 MG/0.8ML Subcutaneous	Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Hadlima Solution Prefilled Syringe 40 MG/0.4ML Subcutaneous	Quantity Limit 6/28 Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Hadlima Solution Prefilled Syringe 40 MG/0.8ML Subcutaneous	Quantity Limit 6/28 + Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
HYDROcodone-Acetaminophen Solution 10-325 MG/15ML Oral	Quantity Limit 2700	CMS Approved Addition	Not Apply	02.01.2025

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DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Itovebi Tablet 3 MG Oral	Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Itovebi Tablet 9 MG Oral	Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Lazcluze Tablet 240 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Lazcluze Tablet 80 MG Oral	Quantity Limit 30 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 0.31 MG/3ML Inhalation	Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 0.63 MG/3ML Inhalation	Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 1.25 MG/0.5ML Inhalation	Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
Levalbuterol HCl Nebulization Solution 1.25 MG/3ML Inhalation	Quantity Limit 540 + BvD	CMS Approved Addition	Not Apply	02.01.2025
IlevoFLOXacin Solution 0.5 % Ophthalmic	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
Lumakras Tablet 240 MG Oral	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
Naloxone HCl Liquid 4 MG/0.1ML Nasal	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



DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
oxyCODONE HCl ER Tablet ER 12 Hour Abuse-Deterrent 10 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	02.01.2025
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	Formulary Enhancement	CMS Approved Addition	Not Apply	02.01.2025
Quinapril-hydroCHLOROthiazide Tablet 20-12.5 MG Oral	Formulary Enhancement	CMS Approved Addition	Not Apply	02.01.2025
Quinapril-hydroCHLOROthiazide Tablet 20-25 MG Oral	Formulary Enhancement	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
Simlandi (2 Pen) Auto-Injector Kit 40 MG/0.4ML Subcutaneous	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	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 + Quantity Limit 60 + Prior Authorization	02.01.2025
Sprycel Tablet 140 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 140 mg ora + Quantity Limit 30 + Prior Authorization	02.01.2025
Sprycel Tablet 20 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 20 mg oral + Quantity Limit 90 + Prior Authorization	02.01.2025



DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
Sprycel Tablet 50 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 50 mg oral + Quantity Limit 60 + Prior Authorization	02.01.2025
Sprycel Tablet 70 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 70 mg oral + Quantity Limit 60 + Prior Authorization	02.01.2025
Sprycel Tablet 80 MG Oral	Non Formulary	CMS Approved Enhancement	dasatinib tablet 80 mg oral + Quantity Limit 60 + Prior Authorization	02.01.2025
Tazarotene Cream 0.05 % External	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 + 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	Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Tremfya Solution Prefilled Syringe 200 MG/2ML Subcutaneous	Prior Authorization	CMS Approved Addition	Not Apply	02.01.2025
Voranigo Tablet 10 MG Oral	Prior Authorization New Starters	CMS Approved Addition	Not Apply	02.01.2025
Voranigo Tablet 40 MG Oral	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

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DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
CARBAMAZEPIN CHW 200MG	Formulary Enhancement	Addition	Not Apply	03.01.2025
Danziten Tablet 71 MG Oral	Quantity Limit 112/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
Danziten Tablet 95 MG Oral	Quantity Limit 112/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
DIPHENHYDRAM INJ 50MG/ML	Formulary Enhancement	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
Droxia Capsule 400 MG Oral	Non Formulary	CMS Approved Deletion	Not Apply	03.01.2025
ERZOFRI INJ 117/0.75	Quantity Limit 0.75/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 156MG/ML	Quantity Limit 1/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 234/1.5	Quantity Limit 1.5/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 351/2.25	Quantity Limit 2.25/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 39/0.25	Quantity Limit 0.25/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
ERZOFRI INJ 78/0.5ML	Quantity Limit0.5/21 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
Imkeldi Solution 80 MG/ML Oral	Quantity Limit 280/28 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
MESNA TAB 400MG	Formulary Enhancement	Addition	Not Apply	03.01.2025
OPIPZA MIS 10MG	Quantity Limit 90 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
OPIPZA MIS 2MG	Quantity Limit 60 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025

DRUG NAME	TYPE OF FORMULARY CHANGE	REASON FOR CHANGE	ALTERNATIVE DRUG	EFFECTIVE DATE OF CHANGE
OPIPZA MIS 5MG	Quantity Limit 60 + Prior Authorization New Starters	Addition	Not Apply	03.01.2025
Phenytek Capsule 200 MG Oral	Formulary Enhancement	CMS Approved Addition	Not Apply	03.01.2025
Phenytek Capsule 300 MG Oral	Formulary Enhancement	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	Quantity Limit 120 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
Revuforj Tablet 160 MG Oral	Quantity Limit 60 + Prior Authorization New Starters	CMS Approved Addition	Not Apply	03.01.2025
STAVUDINE CAP 15MG	Quantity Limit 60	Addition	Not Apply	03.01.2025
STAVUDINE CAP 20MG	Quantity Limit 60	Addition	Not Apply	03.01.2025
STAVUDINE CAP 30MG	Quantity Limit 60	Addition	Not Apply	03.01.2025
STAVUDINE CAP 40MG	Quantity Limit 60	Addition	Not Apply	03.01.2025
TOPIRAMATE CAP 50MG	Formulary Enhancement	Addition	Not Apply	03.01.2025

Ahead you will find some definitions that help you to understand the changes in the Prescription Drug Formulary 2:

**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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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1.866.627.8183 (TTY: 1.866.627.8182).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.627.8183 (TTY: 1.866.627.8182).

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 1.866.627.8183 (TTY: 1.866.627.8182)。

