

Changes to Aetna Assure Premier Plus (HMO D-SNP) Formulary

The table below outlines all the changes to our formulary since the formulary list was last printed on 01/01/2025.

Name of Drug Affected	Description of Change	Reason for Change	Alternative Drug
CLENPIQ SOLUTION 10MG-3.5GM/160ML	CLENPIQ SOLUTION 10MG-3.5GM/160ML was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	CLENPIQ SOLUTION 10MG-3.5GM/175ML
DESOGESTREL/ETHI NYL/ESTRADIOL TABLET	DESOGESTREL/ETHIN YL/ESTRADIOL TABLET was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	APRI TABLET
DUPIXENT INJECTION 100MG/0.67ML	DUPIXENT INJECTION 100MG/0.67ML was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	DUPIXENT INJECTION 200MG/1.14ML
FENTANYL OT LOZENGE 1200MCG	FENTANYL OT LOZENGE 1200MCG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	FENTANYL OT LOZENGE 800MCG
FENTANYL OT LOZENGE 600MCG	FENTANYL OT LOZENGE 600MCG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	FENTANYL OT LOZENGE 800MCG
MAFENIDE ACETATE PAK 5%	MAFENIDE ACETATE PAK 5% was removed from formulary coverage as of 2/1/2025. Please	This medication is no longer Medicare Part D eligible.	SULFAMYLON CREAM 85MG/GM

	discuss next steps with your physician.		
MICROGESTIN FE 24 TABLET 1MG/20MCG	MICROGESTIN FE 24 TABLET 1MG/20MCG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	TARINA 24 FE TABLET
NYMYO TABLET 0.25MG-35MCG	NYMYO TABLET 0.25MG-35MCG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	NORGESTIMATE/ETHINYL ESTRADIOL TABLET 0.25MG/35MCG
ROTARIX SUSPENSION (RECONSTITUTED)	ROTARIX SUSPENSION (RECONSTITUTED) was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	ROTARIX SUSPENSION (NON-RECONSTITUTED)
SELZENTRY TABLET 25MG	SELZENTRY TABLET 25MG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	MARAVIROC TABLET 150MG
SELZENTRY TABLET 75MG	SELZENTRY TABLET 75MG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	MARAVIROC TABLET 150MG
SORINE TABLET 120MG	SORINE TABLET 120MG was removed from formulary coverage as of 2/1/2025. Please discuss next steps with your physician.	This medication is no longer Medicare Part D eligible.	SOTALOL HCL TABLET 120MG
SORINE TABLET 160MG	SORINE TABLET 160MG was removed from formulary coverage as of 2/1/2025. Please	This medication is no longer Medicare Part D eligible.	SOTALOL HCL TABLET 160MG

	discuss next steps with your physician.		
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- The first column lists the drug name.
- The second column describes what change occurred to the coverage of the drug in the first column and includes any special requirements.
- The third column explains why we made the change. If we remove a drug from the formulary then we will provide you information on the name of the alternative drug covered on the formulary (see the fourth column).
- The fourth column includes possible formulary alternatives that you could consider with your doctor. Alternative drugs are drugs in the same therapeutic category/class as the affected drug. Only your doctor can determine alternative drugs that are appropriate for you given the individualized nature of the drug therapy. Please talk to your doctor about any changes or recommendations to your medical care and prescription drug therapy. Alternative drugs and additional information about formulary changes can be found on the plan formulary.

What if you disagree with these changes?

A coverage decision is a decision we make about your benefits and coverage. We are making a coverage decision for you whenever we decide what is covered for you. If you disagree with our decision to remove a drug, you may file a grievance with us. If you disagree with any of the coverage decisions we have made, you can make an appeal. If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.”

An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision. To make an exception, your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception.

Please refer to the Chapter 8 of your Evidence of Coverage, titled *What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information on how to request a coverage decision, exception, grievance, or to appeal any of the changes we have made to the formulary.

If you have any questions or would like assistance in requesting a coverage decision, exception, grievance, or appeal, please call Member Services at **1-844-362-0934 (TTY: 711)**, from October 1 – March 31; 8 AM to 8 PM, seven days a week, Monday - Friday, from April 1 - September 30. You may also send coverage decision, grievance, and appeal requests to 4500 E. Cotton Center Blvd., Phoenix, AZ, 85040.

Note: This is not a complete list of drugs covered by our plan. See the List of Coverage Drugs (Formulary).

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Aetna Assure Premier Plus (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Aetna Assure Premier Plus depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations, and conditions of coverage.

If you speak a language other than English, free language assistance services are available. Visit our website at [AetnaBetterHealth.com/New-Jersey-hmosnp](https://www.aetna.com/betterhealth/new-jersey-hmosnp) or call 1-844-362-0934 (TTY: 711), 8 a.m. to 8 p.m., 7 days a week.

ESPAÑOL (SPANISH): Si habla un idioma que no sea el inglés, los servicios gratuitos de asistencia en idiomas están disponibles. Visite nuestro sitio web en [AetnaBetterHealth.com/New-Jersey-hmosnp](https://www.aetna.com/betterhealth/new-jersey-hmosnp) o llame al 1-844-362-0934 (TTY: 711), de 8 a.m. a 8 p.m., los 7 días de la semana.

(CHINESE) 傳統漢語(中文)如果您講英語以外的語言,則提供免費語言援助服務。請造訪我們的網站[AetnaBetterHealth.com/New-Jersey-hmosnp](https://www.aetna.com/betterhealth/new-jersey-hmosnp)或致電, 1-844-362-0934(TTY:711),上午8時至下午8時,每週7天

You can get this document for free in other formats, such as large print, braille, or audio. Call Member Services at 1-844-362-0934 (TTY: 711), 8 AM to 8 PM, 7 days a week. The call is free.

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