



VANTAGE MEDICARE
ADVANTAGE

Changes in Formulary Drugs effective August 1, 2011

The list of prescription drugs below identifies those drugs which had a change applied from July 2011 to August 2011. There are several different types of changes identified in the list.

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization (PA):** Vantage Medicare Advantage requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from Vantage Medicare Advantage before you fill your prescriptions. If you do not get approval, Vantage Medicare Advantage may not cover the drug.
- **Quantity Limits (QL):** For certain drugs, Vantage Medicare Advantage limits the amount of the drug that Vantage Medicare Advantage will cover. This may be in addition to a standard one month or three-month supply.
- **Step Therapy (ST):** In some cases, Vantage Medicare Advantage requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Vantage Medicare Advantage may not cover drug B unless you try Drug A first. If Drug A does not work for you, Vantage Medicare Advantage will then cover Drug B. If a drug is prescribed to a member who has never been prescribed that drug before, the ST requirement may apply to "new starts" only.

If you have any questions, please contact Vantage Health Plan at (318) 361-0900 or toll-free at (888) 823-1910. For the hearing impaired, please call TTY (318) 361-2131 or toll-free TTY (866) 524-5144. Member Services is available Monday through Friday from 8:00 am – 8:00 pm to assist you. You may also visit the Vantage Medicare Advantage website, www.vhp-medicare.com.

Drugs Added to the Formulary

Label Name	Tier
ANDROGEL GEL 1.62%	2
BROMDAY SOL 0.09%	3
BROMFENAC SOL 0.09%	1
CYCLOBENZAPR CAP 15MG ER	1
CYCLOBENZAPR CAP 30MG ER	1
DOCETAXEL INJ 80MG/8ML	1
EDURANT TAB 25MG	2
EPINASTINE DRO 0.05%	1
FRAGMIN INJ 12500UNT	3
FRAGMIN INJ 15000UNT	3
FRAGMIN INJ 18000UNT	3
HORIZANT TAB 600MG	3
LETROZOLE TAB 2.5MG	1
MATZIM LA TAB 180MG/24	1
MATZIM LA TAB 240MG/24	1
MATZIM LA TAB 300MG/24	1
MATZIM LA TAB 360MG/24	1
MATZIM LA TAB 420MG/24	1
NITROFURANTN SUS 25MG/5ML	1
OXYCOD/ASA TAB	1
PAROXETIN ER TAB 37.5MG	1

Label Name	Tier
PROLASTIN-C INJ 1000MG	4
VIIBRYD TAB 10MG	3
VIIBRYD TAB 20MG	3
VIIBRYD TAB 40MG	3
VIRAMUNE XR TAB	2
ZEOSA CHW	1
ZYTIGA TAB 250MG	4

Deletions from the Formulary:

Label Name	Tier
XIBROM SOL 0.09%	2
MATZIM LA TAB 180MG/24	1
MATZIM LA TAB 240MG/24	1
MATZIM LA TAB 300MG/24	1
MATZIM LA TAB 360MG/24	1
MATZIM LA TAB 420MG/24	1
TRANDO/VERAP TAB 1-240 CR	1
TRANDO/VERAP TAB 2-180 CR	1
TRANDO/VERAP TAB 2-240 CR	1

TRANDO/VERAP TAB 4-240 CR	1
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Drugs that have Quantity Limits Added

Label Name	Quantity Limit
HORIZANT TAB 600MG	Quantity Limit Added
VIIBRYD TAB 10MG	Quantity Limit Added
VIIBRYD TAB 20MG	Quantity Limit Added
VIIBRYD TAB 40MG	Quantity Limit Added

Drugs that have Prior Authorizations Added :

Label Name	PA Added
ZYTIGA TAB 250MG	PA applies to new starts only
ANDROGEL GEL 1.62%	PA Applies

Drugs with Step Therapy Added: none

Label Name	ST Added