Upcoming Changes to CareSource Advantage® Zero Premium (HMO)/CareSource Advantage® (HMO)/ CareSource Advantage Plus® (HMO)'s Formulary

CareSource Advantage Zero Premium/CareSource Advantage/CareSource Advantage Plus may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Or, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. We may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made. Also, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we may immediately remove the drug from our formulary and provide notice to members who take the drug.

Before we make other changes during the year to our Drug List that affect members currently taking a drug and that require us to provide advance notice, we will notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

If you are affected by a change in drug coverage or restriction, you or your prescriber can ask us to make an exception and continue to cover the drug in the way you would like. The notice we provide you will also include information on the steps to request an exception. To learn more about coverage decisions and how to ask for an exception, see your *Evidence of Coverage*, or call Customer Care at **1-844-607-2827 (TTY: 1-800-750-0750 or 711)**. We are open 8 a.m. to 8 p.m. seven days a week from October 1 to March 31, and Monday through Friday the rest of the year.

The table below outlines upcoming changes to our formulary that may impact you.

Name of Affected Drug	Description for Change	Reason for Change	Alternative Drug	Alternative Drug Copay*	Effective Date
AURYXIA TAB 210MG	PRIOR AUTHORIZATION ADDED	PA ADDED TO ENSURE USE IS FOR A PART D COVERED INDICATION	CONSULT YOUR HEALTH CARE PROVIDER		1/1/2019
POLYETHYLENE GLYCOL 3350 ORAL POWDER	DELETION OF DRUG FROM FORMULARY	MANUFACTURER DISCONTINUATION	LACTULOSE SOLUTION 10 GM/15ML	Tier 2	1/1/2019

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your physician can determine if one of the alternatives listed here is appropriate for you given the individualized nature of drug therapy. Please consult your physician to confirm if this is an appropriate drug for you.