Upcoming Changes to HIP's Formulary

HIP may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, [or] add prior authorizations, quantity limits and/or step therapy restrictions on a drug [or move a drug to a higher cost-sharing tier], we will notify you of the change at least 60 days before the date that the change becomes effective. However, 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 will immediately remove the drug from our formulary and notify you.

The table below outlines upcoming changes to our formulary that will impact you:

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
03/01/2009	ACETASOL HC EAR DROPS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	ADVAIR	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	AMITIZA CAPSULES	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	APRISO CAPSULE ER	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	ASTEPRO NASAL SPRAY	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	AVANDIA TABLET	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	BANZEL TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	CARBIDOPA-LEVO ODT	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	DORZOLAMIDE HCL 2% EYE DROPS	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	DUREZOL 0.05% EYE DROPS	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
03/01/2009	EPIDUO GEL	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	EPLERENONE TABLET	Tier Status Change: From Tier 3 to Tier 1	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	GALANTAMINE TABLET	Tier Status Change: From Tier 3 to Tier 1	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	GALANTAMINE ER CAPSULE	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	HALFLYTELY-BISACODYL BOWEL KIT	Addition to Formulary: Tier 2	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	KEPPRA XR TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	MILLIPRED SOLUTION	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	MORPHINE SULF SOLN	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	MOXATAG ER TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	OXYBUTYNIN SYRUP	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	OXYCODONE HCL ER TABLET	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	PRANDIMET TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	PROMACTA TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	PROTRIPTYLINE HCL TABLET	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	RELISTOR	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
03/01/2009	RENVELA TABLET	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	REPREXAIN TABLET	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	SANCUSO PATCH	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	STAVUDINE CAPSULE	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	TOBRAMYCIN-DEXAMETH OPTH SUSP	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	TRILIPIX CAPSULE DR	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	VALTREX CAPLET	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	VENLAFAXINE HCL TAB ER	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	VERAMYST NASAL SPRAY	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
03/01/2009	VERIPRED SOLN	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
03/01/2009	XENAZINE TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	ADAGEN VIAL	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	ALVESCO INHALER	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	AMINOSYN IV SOLUTION	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	AMINOSYN II IV SOLUTION	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
01/01/2009	AMINOSYN M IV SOLUTION	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	AMINOSYN HBC IV SOLUTION	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	AMINOSYN HF IV SOLUTION	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	AMINOSYN PF IV SOLUTION	Remove Clinical Prior Approval Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	ANAFRANIL CAPSULE	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	APIDRA VIAL	Addition to Tier 5 for HIP VIP Care Improvement Members	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	AVANDIA TABLET	Addition to Tier 5 for HIP VIP Care Improvement Members	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	BUDEPRION XL 150MG TABLET	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	CELEBREX 400MG CAPSULE	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	CIMZIA	Remove Limited Distribution Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	DIVALPROEX SOD TAB EC	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	DOXYCYCLINE 25MG/5ML SUSP	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	EPLERENONE TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	GALANTAMINE TABLET	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	KADIAN CAPSULE SR	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
01/01/2009	LEVAQUIN ORAL SOLUTION	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	LEVAQUIN TABLETS	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	LEVEMIR VIAL	Addition to Tier 5 for HIP VIP Care Improvement Members	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	LEVEMIR FLEXPEN	Addition to Tier 5 for HIP VIP Care Improvement Members	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	NEUMEGA	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	NISOLDIPINE TABLET ER	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	NORPRAMIN TABLET	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	OMEPRAZOLE CAPSULE DR	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	PAMELOR SOLUTION	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	PAMELOR CAPSULE	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	PANTOPRAZOLE SOD TAB EC	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	POTASSIUM CL 8MEQ CAP SA	Addition to Formulary: Tier 1	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	ROTATEQ VACCINE	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	SIMCOR TABLETS	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	STAVZOR CAPSULE SA	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage

Effective Date of Change	Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug*	Alternative Drug Co-payment/Coinsurance
01/01/2009	SURMONTIL CAPSULE	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	TOFRANIL TABLET	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	TOFRANIL PM CAPSULE	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	VENTOLIN HFA INHALER	Tier Status Change: From Tier 3 to Tier 2	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	VIVACTIL TABLET	Remove Step Protocol Requirement	Formulary Enhancement	N/A	See Evidence of Coverage
01/01/2009	ZAMICET SOLUTION	Addition to Formulary: Tier 3	New Drug Addition	N/A	See Evidence of Coverage
01/01/2009	ZENAPAX VIAL	Remove Clinical Prior Authorization Requirement	Formulary Enhancement	N/A	See Evidence of Coverage

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

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