

Independence Blue Cross (IBX)

2027 Excluded Covered Drug List

(List of Excluded Covered Drugs)

PLEASE READ:

**THIS DOCUMENT CONTAINS INFORMATION ABOUT THE EXCLUDED DRUGS WE COVER
IN THIS PLAN**

Some plans cover certain excluded drugs under enhanced drug coverage. This document contains a listing of these drugs, as well as certain criteria to consider when filling prescriptions for these drugs. These prescription drugs are not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for this drug does not count towards your total drug costs (that is, the amount you pay does not help you qualify for catastrophic coverage or apply toward meeting your Part D deductible if you have one). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for this drug.

Some of the drugs on this excluded covered drug list may be available over the counter. If you want these drugs covered by the plan, you will need a valid prescription. Otherwise you will need to pay for them out of pocket.

For more information or other questions, please contact our Member Help Team at the number on the back of your member ID card (TTY users should call **711**), seven days a week, 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. You can find this listing online at **ibxmedicare.com/formulary**.

The information in the Requirements/Limits column of the drug chart tells you if your plan has any special requirements for coverage of the drug.

- **Quantity Limits (QL):** For certain drugs, the plan limits the amount of the drug that we will cover.

The first column of the chart lists the drug name. Brand-name drugs are capitalized and generic drugs are listed in lower-case italics. The second column of the chart lists the drug tier. The drug tier is the level of cost-sharing for which you are responsible. Tier 2 is the generic drug tier, and Tier 3 is the brand-name drug tier.

Drug Name	Drug Tier	Requirements/Limits
Diagnostic drugs, Diluents		
STERILE WATER FOR INJECTION SOLUTION INJECTIONS	3	
<i>tropicamide solution 1 % ophthalmic</i>	2	
Drugs for anorexia, weight loss, or weight gain		
<i>lomaira tablet 8 mg oral</i>	2	QL (3 EA per 1 day)
<i>phentermine hcl tablet 37.5 mg oral</i>	2	QL (1 EA per 1 day)
<i>phentermine hcl tablet 8 mg oral</i>	2	QL (3 EA per 1 day)
Drugs used for cold or cough symptoms		
<i>benzonatate capsule 100 mg oral</i>	2	
<i>benzonatate capsule 200 mg oral</i>	2	
<i>guaifenesin ac syrup 100-10 mg/5ml oral</i>	2	QL (480 MG/ML per 30 days)
HYDROCOD POLI-CHLORPHE POLI ER SUSPENSION EXTENDED RELEASE 10-8 MG/5ML ORAL	3	QL (300 MG/ML per 30 days)
<i>hydrocodone bit-homatrop mbr solution 5-1.5 mg/5ml oral</i>	2	QL (480 MG/ML per 30 days)
<i>promethazine-codeine solution 6.25-10 mg/5ml oral</i>	2	QL (480 MG/ML per 30 days)
<i>promethazine-dm syrup 6.25-15 mg/5ml oral</i>	2	
<i>pseudoeph-bromphen-dm syrup 30-2-10 mg/5ml oral</i>	2	
Drugs used for cosmetic purposes or hair growth treatment		
<i>bimatoprost solution 0.03 % external</i>	2	QL (3 ML per 28 days)
<i>finasteride tablet 1 mg oral</i>	2	QL (1 EA per 1 day)
HYDROQUINONE CREAM 4% EXTERNAL	3	QL (30 GRAMS per 28 days)
LATISSE SOLUTION 0.03% EXTERNAL	3	QL (3 ML per 28 days)
Drugs used to treat erectile dysfunction		
<i>avanafil tablet 200 mg oral</i>	2	QL (6 EA per 30 days)
CIALIS TABLET 10 MG ORAL	3	QL (6 EA per 30 days)
<i>sildenafil citrate tablet 100 mg oral</i>	2	QL (6 EA per 30 days)
<i>sildenafil citrate tablet 25 mg oral</i>	2	QL (6 EA per 30 days)
<i>sildenafil citrate tablet 50 mg oral</i>	2	QL (6 EA per 30 days)
<i>tadalafil tablet 10 mg oral</i>	2	QL (6 EA per 30 days)
<i>tadalafil tablet 20 mg oral</i>	2	QL (6 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>varденаfil hcl tablet 10 mg oral</i>	2	QL (6 EA per 30 days)
<i>varденаfil hcl tablet 20 mg oral</i>	2	QL (6 EA per 30 days)
VIAGRA TABLET 100 MG ORAL	3	QL (6 EA per 30 days)
Local Corticosteroid		
HYDROCORTISONE ACETATE SUPPOSITORY 25 MG RECTAL	3	
HYDROCORT-PRAMOXINE (PERIANAL) CREAM 2.5-1% EXTERNAL	3	
Smoking Cessation		
<i>nicotine mini lozenge 4 mg mouth/throat</i>	2	
NICOTINE PATCH 24 HOUR 14 MG/24HR TRANSDERMAL	3	QL (30 EA per 30 days)
NICOTINE PATCH 24 HOUR 21 MG/24HR TRANSDERMAL	3	QL (30 EA per 30 days)
<i>nicotine polacrilex lozenge 4 mg mouth/throat</i>	2	
Vitamins and Dietary Supplements		
<i>cyanocobalamin solution 1000 mcg/ml injection</i>	2	
<i>folic acid tablet 1 mg oral</i>	2	
FOLTANX RF CAPSULE 3-90.314-2-35 MG ORAL	3	
<i>phytonadione tablet 5 mg oral</i>	2	
RENAL CAPSULE 1MG ORAL	3	
<i>vitamin d (ergocalciferol) capsule 1.25 mg (50000 ut) oral</i>	2	

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Independence Blue Cross offers products through its subsidiaries and affiliates including Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

