Upcoming CareFirst Medicare Formulary Updates

CareFirst BlueCross BlueShield Group Medicare Rx (PDP) strives to provide affordable, accessible care to our members. We review our formularies regularly and make changes to encourage member utilization of safe, clinically appropriate, and cost-effective medications.

Below are some of the key formulary changes that will be effective January 1, 2026. It is not inclusive of all formulary changes. To view a complete list of covered drugs and utilization management programs, visit our website: Postal Employees Prescription Drug Plan Management | CareFirst BlueCross BlueShield Medicare

Formulary Drug Removals

Below are some of the medications that will not be covered in 2026 and the covered alternatives you should review with your doctor. If you need a non-formulary drug to be covered for medical necessity reasons, you or your provider may submit a coverage determination request (more information below).

Product	Drug Class	Covered Alternative(s)*
CYMBALTA CAP 20MG	Mental Health	duloxetine cap 60mg dr (generic of CYMBALTA)
insulin aspart	Diabetes	NOVOLOG
insulin degludec	Diabetes	LANTUS SOLOSTAR INJ, TOUJEO SOLOSTAR INJ, TOUJEO MAX SOLOSTAR INJ
LOTREL CAP	Hypertension	amlodipine/benazepril cap (generic of LOTREL)
SOAANZ	Diuretics	torsemide tab, furosemide tab, bumetanide tab

Formulary Drug Tier Changes

Below is a list of commonly prescribed medications that will move to a higher tier, along with covered drug alternatives. If you need a drug covered at a lower cost-share tier, you or your provider may submit a coverage determination request (more information below).

Product	Drug Class	Covered Alternative(s) at Lower Tiers*
AVEED	Testosterone replacement therapy	DEPO-TESTOST INJ, XYOSTED INJ, UNDECATREX CAP, TLANDO CAP, AZMIRO INJ, Testosterone CYP INJ, VOGELXO GEL, TESTIM GEL 1, Testosterone gel 1
BRILINTA	Heart/Stroke	ticagrelor tabs
TRESIBA FLEX PEN 100U/ML	Diabetes	LANTUS SOLOSTAR INJ, LANTUS INJ, TOUJEO SOLOSTAR INJ, TOUJEO MAX SOLOSTAR INJ

Utilization Management Changes

Below is a list of medications that will require utilization management strategies, such as prior authorization before the drug is covered.

Product	Drug Class	Note
CLINDAMYCIN GEL 1%	Acne	Prior Authorization
Dicyclomine tab/cap	Irritable bowel syndrome	Prior Authorization
GLP-1 (such as MOUNJARO, OZEMPIC)	Diabetes	Prior Authorization
SANTYL	Wound Care	Prior Authorization
VOQUEZNA	Heart Burn	Prior Authorization

Brand names are CAPITALIZED.

Frequently Asked Questions:

- **Where can you find information on drug coverage?**
  - On our website: Postal Employees Prescription Drug Plan Management | CareFirst BlueCross BlueShield Medicare

- **What is a Coverage Determination?**
  Coverage Determination is a decision CareFirst makes about your coverage and benefit, including the amount you will pay. These decisions are being made to ensure patient safety and to keep your overall drug costs down. If a drug is not covered or there are restrictions or limits on a drug, you or your prescriber may request a coverage determination. To ensure you receive your prescription drug when you need it, a standard review will be completed in 72 hours or less, and an expedited review will be completed in 24 hours or less.

- **How to Request a Coverage Determination?**
  The member, prescriber or member's appointed representative may request a coverage decision and/or exception any of the following ways:

  - **Phone:** Our customer service team is available 24/7/365 at 833-840-7962.
  - **Fax:** 855-633-7673
  - **Online:** Coverage Determination Form English | Spanish
  - **Mail:** CVS Caremark Coverage Determinations/Exceptions
    P.O. Box 52000
    MC109
    Phoenix, AZ 85072-2000