

Pharmacy Benefit Dimensions®

An Independent Health  company

Pharmacy Benefit Dimensions PDP 3 Tier Formulary Changes

Brand Drug Name	Category/Class	Type of Change	Alternative	Reason	Effective
CIPRO HC SUS 0.2-1% OT	Otic Agents	Formulary Deletion	CIPROFLOX/HC SUS 0.2-1%OT	Generic Alternative on T1	4/1/2026
FYCOMPA SUS 0.5MG/ML	Anticonvulsants / Anticonvulsants, Other	Formulary Deletion	PERAMPANEL SUS 0.5MG/ML	Generic Alternative on T1	4/1/2026

How do I request coverage determination, including an exception?

To request a coverage determination, including an exception, you may contact us in any of the following ways:

- Mail your coverage determination request to: Independent Health's Pharmacy Department, 511 Farber Lakes Drive, Buffalo, NY 14221
- Fax: (716) 631-9636 or 1-800-273-7397
- Phone: (716) 631-2934 or 1-800-247-1466, we are available Monday through Friday from 8 a.m. to 5 p.m.

Requests for coverage of a non-formulary drug, or an exception to a coverage rule, require a supporting statement. For non-formulary drug requests, your statement must show that the requested drug is medically necessary for treatment, because all other drugs on our formulary would be less effective or would have adverse effects for the patient. For prior authorization or other coverage rule requests, your statement must show that the coverage rule wouldn't be appropriate given your patient's condition or would have adverse effects for your patient.

For expedited requests, we must notify you of our decision no later than 24 hours from when we receive your request. For standard requests, we must notify you of our decision no later than 72 hours from when we receive your request.

For exceptions, the time frame begins when we obtain your statement. We will expedite your request if we determine, or you tell us, that your patient's life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.