Pharmacy Benefit Dimensions®
An Independent Health company

Pharmacy Benefit Dimensions PDP 3 Tier Formulary Changes				
Brand Drug Name	**Type of Change**	**Generic Alternative**	**Reason**	**Effective**
Alphagan-P 0.1% ophthalmic solution	Formulary Deletion	brimonidine 0.1% ophthalmic solution	Generic Alternative on T1	2/1/2024
Balcoltra tablet	Formulary Deletion	Joyeaux tablet	Generic Alternative on T1	2/1/2024
Livalo 1 mg tablet	Formulary Deletion	pitavastatin 1 mg tablet	Generic Alternative on T1	2/1/2024
Livalo 2 mg tablet	Formulary Deletion	pitavastatin 2 mg tablet	Generic Alternative on T1	2/1/2024
Livalo 4 mg tablet	Formulary Deletion	pitavastatin 4 mg tablet	Generic Alternative on T1	2/1/2024
Vyvanse 10 mg capsule	Formulary Deletion	lisdexamfetamine 10 mg capsule	Generic Alternative on T1	2/1/2024
Vyvanse 20 mg capsule	Formulary Deletion	lisdexamfetamine 20 mg capsule	Generic Alternative on T1	2/1/2024
Vyvanse 30 mg capsule	Formulary Deletion	lisdexamfetamine 30 mg capsule	Generic Alternative on T1	2/1/2024
Vyvanse 40 mg capsule	Formulary Deletion	lisdexamfetamine 40 mg capsule	Generic Alternative on T1	2/1/2024
Vyvanse 50 mg capsule	Formulary Deletion	lisdexamfetamine 50 mg capsule	Generic Alternative on T1	2/1/2024
Vyvanse 60 mg capsule	Formulary Deletion	lisdexamfetamine 60 mg capsule	Generic Alternative on T1	2/1/2024
Vyvanse 70 mg capsule	Formulary Deletion	lisdexamfetamine 70 mg capsule	Generic Alternative on T1	2/1/2024
Votrient 200mg tablets	Formulary Deletion	pazopanib 200mg tablets	Generic Alternative on T1	2/1/2024

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) 250-7105 or 1-800-806-8083, 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.