



DualChoice

Changes to 2026 IEHP DualChoice (HMO D-SNP) Formulary Updated 03/01/2026

IEHP DualChoice (HMO D-SNP) may change the formulary (add or remove drugs on the approved drug list) during the year based on new clinical data and the number of products on the market. All the changes are reviewed and approved by a group of Doctors and Pharmacists who are in practice.

If IEHP DualChoice removes a Covered Part D drug or makes any changes to the drug list, we will post the changes on our website. We will also let our affected Members know at least thirty (30) calendar days before the effective date of change. But, if the Food and Drug Administration (FDA) deems a drug on our list to be unsafe, or if the drug's manufacturer removes the drug from the market, then we will remove the drug from our drug list right away. You should know, a generic drug works the same as a brand-name drug and often costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic.

This table outlines upcoming change to our formulary that may impact you.

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Ensacove 100 mg capsule	03/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members

Affected Drugs BRAND Drug Name Generic Drug Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Ensacove 25 mg capsule	03/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Koselugo 5 mg sprinkle capsule	03/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Koselugo 7.5 mg sprinkle capsule	03/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Prezcobix 675 mg-150 mg tablet	03/01/2026	Addition	--	--	All Medicare Members
Selarsdi 45 mg/0.5 mL subcutaneous solution	03/01/2026	Addition Add PA	--	--	All Medicare Members
Subvenite 10 mg/mL oral suspension	03/01/2026	Addition Add PA (New Starts Only)	--	--	All Medicare Members
metoprolol tartrate 37.5 mg tablet	03/01/2026	Addition	--	--	All Medicare Members

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
metoprolol tartrate 75 mg tablet	03/01/2026	Addition	--	--	All Medicare Members
ustekinumab-aaaz 45 mg/0.5 mL subcutaneous syringe	03/01/2026	Addition Add PA	--	--	All Medicare Members
ustekinumab-aaaz 90 mg/mL subcutaneous syringe	03/01/2026	Addition Add PA	--	--	All Medicare Members
ustekinumab 45 mg/0.5 mL subcutaneous solution	03/01/2026	Brand Deletion	Biosimilar Available	Use Biosimilar formulation or other products in the same therapeutic category on the formulary	All Medicare Members

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Stelara 45 mg/0.5 mL subcutaneous solution	03/01/2026	Brand Deletion	Biosimilar Available	Use Biosimilar formulation or other products in the same therapeutic category on the formulary	All Medicare Members
Stelara 45 mg/0.5 mL subcutaneous syringe	03/01/2026	Brand Deletion	Biosimilar Available	Use Biosimilar formulation or other products in the same therapeutic category on the formulary	All Medicare Members

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Stelara 90 mg/mL subcutaneous syringe	03/01/2026	Brand Deletion	Biosimilar Available	Use Biosimilar formulation or other products in the same therapeutic category on the formulary	All Medicare Members
ustekinumab 45 mg/0.5 mL subcutaneous syringe	03/01/2026	Brand Deletion	Biosimilar Available	Use Biosimilar formulation or other products in the same therapeutic category on the formulary	All Medicare Members

Affected Drugs BRAND Drug Name Generic Drug Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
ustekinumab 90 mg/mL subcutaneous syringe	03/01/2026	Brand Deletion	Biosimilar Available	Use Biosimilar formulation or other products in the same therapeutic category on the formulary	All Medicare Members
Brukinsa 160 mg tablet	02/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Cimzia Starter Kit 400 mg/2 mL (200 mg/mL x2) subcutaneous syringe kit	02/01/2026	Addition Add PA	--	--	All Medicare Members
conjugated estrogens 0.3 mg tablet	02/01/2026	Addition	--	--	All Medicare Members
conjugated estrogens 0.45 mg tablet	02/01/2026	Addition	--	--	All Medicare Members
conjugated estrogens 0.625 mg tablet	02/01/2026	Addition	--	--	All Medicare Members

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
conjugated estrogens 0.9 mg tablet	02/01/2026	Addition	--	--	All Medicare Members
conjugated estrogens 1.25 mg tablet	02/01/2026	Addition	--	--	All Medicare Members
Exxua 18.2 mg tablet,extended release	02/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Exxua 36.3 mg tablet,extended release	02/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Exxua 54.5 mg tablet,extended release	02/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
Exxua 72.6 mg tablet,extended release	02/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members

Affected Drugs BRAND Drug Name Generic Drug Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
fidaxomicin 200 mg tablet	02/01/2026	Addition Add Quantity Limit	--	--	All Medicare Members
Inluriyo 200 mg tablet	02/01/2026	Addition Add Quantity Limit Add PA (New Starts Only)	--	--	All Medicare Members
lomustine 10 mg capsule	02/01/2026	Addition	--	--	All Medicare Members
lomustine 100 mg capsule	02/01/2026	Addition	--	--	All Medicare Members
lomustine 40 mg capsule	02/01/2026	Addition	--	--	All Medicare Members
Luizza 1 mg-20 mcg tablet	02/01/2026	Addition	--	--	All Medicare Members
Luizza 1.5 mg-30 mcg tablet	02/01/2026	Addition	--	--	All Medicare Members
Otezla XR 75 mg tablet,extended release	02/01/2026	Addition Add PA	--	--	All Medicare Members

Affected Drugs BRAND Drug Name Generic Drug Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Otezla XR Initiation 10 mg-20 mg-30 mg tablet and 75 mg tablet,ER pack	02/01/2026	Addition Add PA	--	--	All Medicare Members
Valtya 1 mg-35 mcg tablet	02/01/2026	Addition	--	--	All Medicare Members
Tridacaine II 5 % topical patch	02/01/2026	Addition Add Quantity Limit Add PA	--	--	All Medicare Members
DIFICID 200 MG TABLET	02/01/2026	Brand Deletion	Generic Drug Available	Use Generic formulation or other products in the same therapeutic category on the formulary	All Medicare Members
Gleostine 10 mg capsule	02/01/2026	Brand Deletion	Generic Drug Available	Use Generic formulation or other products in the same therapeutic category on the formulary	All Medicare Members

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
<p style="text-align: center;">Gleostine 100 mg capsule</p>	<p style="text-align: center;">02/01/2026</p>	<p style="text-align: center;">Brand Deletion</p>	<p style="text-align: center;">Generic Drug Available</p>	<p style="text-align: center;">Use Generic formulation or other products in the same therapeutic category on the formulary</p>	<p style="text-align: center;">All Medicare Members</p>
<p style="text-align: center;">Gleostine 40 mg capsule</p>	<p style="text-align: center;">02/01/2026</p>	<p style="text-align: center;">Brand Deletion</p>	<p style="text-align: center;">Generic Drug Available</p>	<p style="text-align: center;">Use Generic formulation or other products in the same therapeutic category on the formulary</p>	<p style="text-align: center;">All Medicare Members</p>
<p style="text-align: center;">Premarin 0.3 mg tablet</p>	<p style="text-align: center;">02/01/2026</p>	<p style="text-align: center;">Brand Deletion</p>	<p style="text-align: center;">Generic Drug Available</p>	<p style="text-align: center;">Use Generic formulation or other products in the same therapeutic category on the formulary</p>	<p style="text-align: center;">All Medicare Members</p>

Affected Drugs BRAND Drug Name <i>Generic Drug</i> Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Premarin 0.45 mg tablet	02/01/2026	Brand Deletion	Generic Drug Available	Use Generic formulation or other products in the same therapeutic category on the formulary	All Medicare Members
Premarin 0.625 mg tablet	02/01/2026	Brand Deletion	Generic Drug Available	Use Generic formulation or other products in the same therapeutic category on the formulary	All Medicare Members
Premarin 0.9 mg tablet	02/01/2026	Brand Deletion	Generic Drug Available	Use Generic formulation or other products in the same therapeutic category on the formulary	All Medicare Members

Affected Drugs BRAND Drug Name Generic Drug Dosage/Requirements/Limits	Effective Date of Change	Type of Change	Reason for Change	Alternative Drug *	Applies to
Premarin 1.25 mg tablet	02/01/2026	Brand Deletion	Generic Drug Available	Use Generic formulation or other products in the same therapeutic category on the formulary	All Medicare Members

*Alternative drugs are drugs in the same therapeutic category/class or cost-sharing tier as non-approved drugs. Only your Doctor can decide if the alternate here is right for you, given how the drug works. Please ask your Doctor if the drug is right for you. This is not a full list of alternative drugs covered by IEHP DualChoice for the drug you selected.

In most cases, IEHP DualChoice will only allow you to use a non-approved drug if the alternative drug, or the lower-tiered drug, would be worse at treating your condition. Or, if it would cause you to have adverse medical effects or cause you harm.

If you think you should be able to use a drug that is not on our list or is restricted, you can contact us and ask for an appeal. **When you ask for an appeal, you should have a statement from your Doctor that supports your ask.** We must then decide whether you can use the drug or not use it, within 72 hours of getting your Doctor’s or prescriber’s statement. You can ask for an expedited (fast) appeal if you or your Doctor thinks your health could be harmed by waiting. If your expedited (fast) appeal is granted, we must decide no later than 24 hours after we get your Doctor’s or prescriber’s statement.

If you have any questions or need to contact us, you can call IEHP DualChoice Member Services at **1-877-273-IEHP (4347)**, 8am-8pm (PST), 7 days a week, including holidays. TTY users should call **1-800-718-4347**.

IEHP DualChoice (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.