

Notice of Formulary Changes

(The purpose of this notice is for web use only, your print copy of the EOB (Explanation of Benefits), and NOC (Notice of Formulary Changes - for effected members only) notification letter, should be sent to you within the required time period.

Sterling may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, move a drug on our formulary to a higher cost-sharing tier, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, we will notify you of the change at least 60 days before the date that the change becomes effective. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market we will immediately remove the drug from our formulary. If these changes affect you and you would like to obtain an updated coverage determination or an exception to a coverage determination, call:

Sterling Option IISM	Sterling Option IVSM		1-866-454-7141
Sterling Partners® - Montana			1-866-467-8545
Sterling RxSM	Sterling RxSM Plus		1-866-364-8012
24 hours a day, 7 days a week.	TTY/TDD		1-800-899-2114

The table below outlines upcoming changes to our formulary that will impact you:

*Alternative drugs are drugs in the same therapeutic category/class or cost-sharing tier as the affected drug. Only your physician can determine if the alternate listed here is appropriate for you given the individualized nature of drug therapy. Please consult with your physician as to whether this is an appropriate drug for you.

*Consult your Medical provider for changes or recommendations to your medical care and prescription therapy.

**Please consult the plan benefit design for copay/coinsurance amounts.
Therapy, Prior Authorization or Quantity Level Limits may exist.

***Indicates a restriction of Step

Required CMS items disclosure					
Name of Affected Drug	1. Drug removal / or 2. Change in: Preferred Status /or 3.Change in Tiered cost-sharing status	1. Reason for Drug removal / or 2. Reason for changing preferred cost sharing status	*Alternative Drug	Alternative Drug Expected cost sharing Co-payment/Co-insurance.	Updated Coverage Determination / or exceptions, see phone numbers listed above for your plan.
	(Indicate 1, 2, 3)	(Indicate 1, 2)			

New added Products: Effective 10/01/2008 (Informational only drug removal not required).

Drug	Not applicable - N/A	Reason	Not applicable - N/A	Cost Sharing**	See your Plan phone number listed ^
BUDEPRION XL 150 MG TABLET [QLL]	N/A	New Drug	N/A	Generic Tier	^
CIMZIA KIT [PAR]	N/A	New Drug	N/A	Specialty Tier	^
DIVALPROEX SOD 125, 250, 500 MG TAB EC	N/A	New Drug	N/A	Generic Tier	^
DORIBAX 500 MG VIAL	N/A	New Drug	N/A	Specialty Tier	^
DOXYCYCLINE MONO 25 MG/5 ML SUSP	N/A	New Drug	N/A	Generic Tier	^
DRONABINOL 2.5, 5, 10 MG CAPSULE[PAR]	N/A	New Drug	N/A	Specialty Tier	^
EPLERENONE 25, 50 MG TABLET	N/A	New Drug	N/A	Generic Tier	^
HUMIRA CROHN'S STARTER PACK[PAR] [QLL]	N/A	New Drug	N/A	Specialty Tier	^
LAMOTRIGINE 25,100, 150, 200 MG TABLET	N/A	New Drug	N/A	Generic Tier	^
LIQUADD 5 MG/5 ML SOLUTION	N/A	New Drug	N/A	Non-Preferred Brand Tier	^
NISOLDIPINE 20, 30, 40 MG TABLET ER	N/A	New Drug	N/A	Generic Tier	^
STAVZOR 125, 250, 500 MG CAPSULE SA	N/A	New Drug	N/A	Non-Preferred Brand Tier	^

Removed Products: Effective 11/01/2008

Drug	Change	Reason	Alternative*	Cost Sharing**	
APLISOL 5T UNITS/0.1 ML VIAL	1	CMS Removal of Drug Coverage	MEDICARE EXCLUDE	N/A - Drug not Covered	
TRICHOPHYTON SKIN TEST 1:200, 1:500	1	CMS Removal of Drug Coverage	MEDICARE EXCLUDE	N/A - Drug not Covered	
TUBERSOL 5T UNITS/0.1 ML VIAL	1	CMS Removal of Drug Coverage	MEDICARE EXCLUDE	N/A - Drug not Covered	^

Removed Products: Effective 12/01/2008

Drug	Change	Reason	Alternative*	Cost Sharing**	
GUAIFENESIN All prescription dosage forms	1	CMS Removal of Drug Coverage	MEDICARE EXCLUDE	N/A - Drug not Covered	^

Cost Sharing Changes: Effective 10/01/2008

Drug	Change	Reason	Alternative*	New Cost Sharing**	^
ACTIVELLA 1.0-0.5 MG TABLET	3	Generic Alternative on Market	Estradiol/Norethindrone Tablet	Non-Preferred Brand Tier	^
ALTACE 1.25 MG CAPSULE [ST]	3	Generic Alternative on Market	Ramipril	Non-Preferred Brand Tier	
DOVONEX 0.005% SOLUTION	3	Generic Alternative on Market	Calcipotriene Solution	Non-Preferred Brand Tier	
EFUDEX 5% CREAM	3	Generic Alternative on Market	Fluorouracil Cream	Non-Preferred Brand Tier	^