Blue Cross Blue Shield of Rhode Island
www.bcbsri.com

BCBSRI Pharmacy Program
April 1, 2018 Formulary Changes

The information below is effective as of April 1, 2018 and applies to all commercial BCBSRI products, including all Large Group, Small Group and Exchange (Individual) markets. These changes do not apply to the Blue CHiP for Medicare programs. Any changes to this list are the result of a comprehensive review of relevant clinical information by the BCBSRI Pharmacy and Therapeutics Committee.

Large Group and Small Group Markets Formulary

Brand Name Drugs (Excluded from coverage)

For application across all commercial formularies the following Brand-name drugs are now **available with generic equivalents**, as a result the Brand name will be **excluded** from coverage effective April 1, 2018. The generic equivalent will continue to be covered.

BUPHENYL	**ISTALOL**	**TESTIM**
COREG CR	**LEXIVA**	**TRANSDERM-SCOP**
EFFIENT	**LIALDA**	**VIREAD**
ESTRACE	**REYATAZ**	**ZIAGEN**
FLUOXETINE HCL	**SUSTIVA**	**EPIDUO GEL**
FOSRENOL	**TAMIFLU**	**VIAGRA***

* **When covered by Rider**

For the Traditional Formulary, these brand products will continue to be covered with non-preferred co-pay.

Brand Name and generic Drugs (Excluded from coverage - with medical necessity supported)

The following Brand-name drugs and products will be **excluded** from coverage effective April 1, 2018. Request for coverage will require documented medical necessity.

CLOBETASOL PROPIONATE EMUL FOAM	**HUMALOG KWIK INJ 200/ML**	**MINOCYCLINE HCL TAB**
CLOBETASOL PROPIONATE AEROSOL	**HUMALOG MIX INJ 50/50**	**MINOCYCLINE HCL ER 24HR**
CLOBETASOL PROPIONATE SPRAY	**HUMALOG MIX INJ 50/50KWP**	**OLYSIO**
DAKLINZA	**HUMALOG MIX INJ 75/25KWP**	**OMEPRAZOLE-BICARBONATE**
DOXEPIN HCL CREAM 5%	**HUMALOG MIX SUS 75/25**	**OMNIPOD MIS**
DOXYCYCLINE DELAY REL 40 MG	**HUMULIN INJ 70/30**	**PRUDOXIN CREAM 5%***
DOXYCYCLINE HYCLATE TAB 50MG	**HUMULIN INJ 70/30KWP**	**RIOMET**
FENOPROFEN CAP 200MG	**HUMULIN N INJ U-100**	**SYNERA**
FLUOCINONIDE CRE 0.1%	**HUMULIN N INJ U-100KWP**	**TECHNIVIE**
HUMALOG INJ 100/ML	**HUMULIN R INJ U-100**	**VIEKIRA**
HUMALOG INJ 100/ML	**LIDORX**	**ZEPATIER**
HUMALOG JR INJ 100/ML	**MILLIPRED**	**ZONALON CREAM 5%**
HUMALOG KWIK INJ 100/ML		

* **For Small Group Formulary will remain covered at Non Preferred Brand Tier**

Brand Name and generic Drugs – Prior Authorization now required

The following Brand-name and *generic* drugs will require Prior Authorization for coverage effective April 1, 2018.

DOXEPIN CREAM 5%	**MINOCYCLINE 50MG**
DOXYCYCLINE 40MG	**PRUDOXIN**
DOXYCYCLINE HYCLATE 50MG	**ZONALON**

Tier changes

The following select Brand name and *generic* drugs have been moved to a **higher** co-pay tier.

ACITRETIN CAP	**LIDOCAINE OINT 5%**	**TAZAROTENE CREAM 0.1%**
AUSTEDO	**PENTASA**	**TOBI PODHALER**
BETHKIS	**PLEGRIDY**	**ZAVESCA**
KITABIS PAK	**SYRINE**	

The following select Brand name and *generic* drugs have been moved to a **lower** co-pay tier.

AMANTADINE TAB	**MODAFINIL TAB**
DESVENLAFAXINE TAB ER	**MOXIFLOXACIN OPTH SOL 0.5%**
GENTAMICIN CREAM 0.1%	**ZOLMITRIPTAN TAB**

Individual Market (Direct Pay and Direct Pay Exchange) Formulary

Brand Name Drugs (Excluded from coverage)

For application across all commercial formularies the following Brand-name drugs are now **available with generic equivalents**, as a result the Brand name will be **excluded** from coverage effective April 1, 2018. The generic equivalent will continue to be covered.

AGGRENOX	**EMEND TRIPAC**	**LURIDE DROP**	**SABRIL POW**
ALKERAN	**EPIDUO GEL**	**METFORMIN ER**	**STRATTERA**
AXIRON SOL	**EPZICOM**	**MINASTRIN 24 FE**	**TAMIFLU**
BEYAZ	**ERYPED SUSP**	**MYFORTIC**	**TAZORAC CREAM**
BUPHENYL	**FOSRENOL CHEW**	**PENTASA CR**	**TRANSDERM-SCOP**
CAFERGOT	**KALETRA**	**PRISTIQ**	**VIGAMOX DROP**
CELLCEPT	**LAMICTAL KIT**	**QUARTETTE**	**VIRAZOLE INH**
E.E.S. GRAN SUSP	**LEXIVA**	**RENVELA**	**ZIAGEN SOL**
EFFIENT	**LIALDA**	**ROZEREM**	**ZYFLO CR**
EMEND			

Brand Name and generic Drugs – Quantity Limit

The following product will have a Quantity Limit on coverage effective April 1, 2018

PHENTERMINE CAP

Brand Name and generic Drugs – Prior Authorization now required

The following Brand-name and *generic* drugs will require Prior Authorization for coverage effective April 1, 2018.

DOXEPIN CREAM 5%
DOXYCYCLINE 40MG
DOXYCYCLINE HYCLATE 50MG
MINOCYCLINE 50MG
PRUDOXIN
ZONALON

Tier Changes

The following select generic drugs have been moved to a higher co-pay tier, effective April 1, 2018

AMPICILLIN CAP
BROMFENAC OPTH SOL
CLARITHROMYCIN SUSP
FLURBIPROFEN OPTH SOL
PENICILLIN VK SOL