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

BCBSRI Pharmacy Program
April 1, 2019 Formulary Changes

The information below is effective as of April 1, 2019 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 available with generic equivalents (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, 2019. The generic equivalent will continue to be covered.

ADCIRCA
ALBENZA
AMICAR
AMPYRA
ANDROGEL
ANDROGEL PUMP
ASACOL HD
BUTRANS
CANASA
COSOPT PF
CYCLOPHOSPHAMIDE
DEXPAK 10 DAY
DEXPAK 13 DAY
DEXPAK 6 DAY
ELIDEL
EURAX
FINACEA
FORTESTA
KADIAN
KRISTALOSE
MEPHYTON
MINIVELLE
PREVIDENT RINSE
RAPAFLO
SPORANOX
TOPICORT
UCERIS
VIRAMUNE
ZYTIGA

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

Brand Name and generic Drugs with available alternatives (Excluded from coverage)

The following Brand-name and generic drugs with preferred alternatives will be **excluded** from coverage effective April 1, 2019. Request for coverage will require documented medical necessity.

ARANESP ALBUMIN FREE
CETROTIDE
COLCHICINE
COLCRYS
CRINONE
EPOGEN
GLATOPA
GRANIX
MIRCERA
NEULASTA
NEULASTA ONPRO KIT
NEUPOGEN
OVIDREL
PROCRIT
SAVAYSA**

**** Existing patients will be grandfathered**

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

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Tier changes **– Traditional Formulary only**

The following **Brand** drugs have been moved to a **higher** co-pay tier effective April 1, 2019.

COLCHICINE **ELIDEL** **ANDROGEL**

****

Individual Market (Direct Pay/Direct Pay Exchange) Formulary

Brand Name Drugs (Excluded from coverage)

The following Brand-name drugs are now **available with generic equivalents**, as a result the Brand name will be **excluded** from coverage effective October 1, 2018. The generic equivalent will continue to be covered.

ADCIRCA
ASACOL HD
CRINONE GEL VAG
EURAX LOT
MIGRANAL SPRAY
MUPIROCIN CREAM
OVIDREL INJ
PREDNISOLONE TAB ODT
VIRAMUNE SUSP
WELCHOL PAK

Tier Changes

The following **Brand** drugs have been moved to a **higher** co-pay tier effective April 1, 2019.

NORTRIPTYLINE HCL **PREVYMIS**

Prior Authorization

The following drugs will now require prior authorization for coverage effective April 1, 2019.

ADVATE
ADYNOVATE
AFSTYLA
ALPHANINE SD
ALPROLIX
BEBULIN
BENEFIX
ELOCTATE
HELIXATE FS
HEMOFIL M
IDELVION
IXINITY
KOATE
KOATE-DVI
KOGENATE FS
KOGENATE FS BIO-SET
KOVALTRY
MONOCLATE-P
MONONINE
NOVOEIGHT
NUWIQ
PROFILNINE SD
PROFILNINE
REBINYN
RECOMBINATE
RIXUBIS
XYNTHA
XYNTHA SOLOFUSE

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

Step Therapy

The following drugs will be subject to step therapy, coverage is subject to use of preferred products first, before allowed to be eligible for coverage, effective April 1, 2019.

FETZIMA	**MAPROTILINE HCL**	**VIIBRYD STARTER PACK**
FETZIMA TITRATION PACK	**TRINTELLIX**	**VIIBRYD**
FLUOXETINE DR		

Quantity Limits

The following products will be subject to quantity limits on dispensing per prescription effective April 1, 2019.

ALORA	**ESTRADIOL**	**FEMRING**
CLIMARA PRO	**ESTRING**	**MENOSTAR**
DIVIGEL	**ESTROGEL**	**MINIVELLE**
ELESTRIN	**EVAMIST**	**ZYKADIA**

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.