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

BCBSRI Pharmacy Program
April 1, 2021 Formulary Changes

The information below is effective as of April 1, 2021 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, 2021. The generic equivalent will continue to be covered.

ALINIA	HYCODAN	SAPHRIS
ATRIPLA	JADENU SPRINKLE	SKLICE
BETHKIS	KERYDIN	SYMFI
CIPRODEX	K-TAB	SYMFI LO
DEMSER	KUVAN	TACLONEX
EMTRIVA	MONUROL	TECFIDERA
FERRIPROX	MOVIPREP	TYKERB

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

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

The following generic and Brand-name drugs with preferred alternatives will be **excluded** from coverage, effective April 1, 2021. Request for coverage will require documented medical necessity.

ALKINDI SPRINKLE	MYNATAL PLUS	PRENA1 PEARL
ALOGLIPTIN	MYNATAL-Z	PRENATE
ALOGLIPTIN/METFORMIN HCL	NATACHEW	QTERN
ALOGLIPTIN/PIOGLITAZONE	NEEVO DHA	SEGLUROMET
CITRANATAL (all formulations)	NESINA	SELECT-OB+DHA
DUET DHA 400	NESTABS DHA	STEGLATRO
DUET DHA BALANCED	NESTABS ONE	STEGLUJAN
INVOKAMET	OB COMPLETE (all formulations)	TRADJENTA
INVOKAMET XR	ONGENTYS	TRI-TABS DHA
INVOKANA	ONGLYZA	VINATE DHA RF
JENTADUETO	OSENI	VITAFOL (all formulations)
JENTADUETO XR	PNV OB+DHA	VITAMEDMD (all formulations)
KAZANO	PRENA1 CHEW	VITAPEARL
KOMBIGLYZE XR		

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

Tier changes

The following product has been moved to a **higher** co-pay tier, effective April 1, 2021.

CONCERTA

Prior Authorization

The following drug will now require prior authorization for coverage, effective April 1, 2021.

SUPPRELIN LA*

Drugs that will be designated for coverage under Medical *

The following drugs will be covered under the medical benefit, effective April 1, 2021.

ACTEMRA	LUPRON DEPOT (3-MONTH)	RUXIENCE
ACTEMRA ACTPEN	LUPRON DEPOT (4-MONTH)	SIMPONI ARIA
BOTOX	LUPRON DEPOT (6-MONTH)	TRELSTAR MIXJECT
DYSPORT	LUPRON DEPOT-PED (1-MONTH)	TYSABRI
ELIGARD	LUPRON DEPOT-PED (3-MONTH)	XEOMIN
EYLEA	PROLIA	XGEVA
LUCENTIS	RITUXAN	ZOLADEX
LUPRON DEPOT (1-MONTH)		

*specialty drug

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 April 1, 2021. The generic equivalent will continue to be covered.

CIPRODEX	MOVIPREP	SYMFI LO
CONCERTA	SYMFI	TIMOPTIC-XE
EMTRIVA		

Drugs (Excluded from coverage)

The following drugs are **available with alternatives** as a result, they will be **excluded** from coverage effective April 1, 2021.

BUTALBITAL/ACETAMINOPHEN/CAFFEINE	PRENATAL 19
CONDYLOX	RANITIDINE HCL
PHRENILIN FORTE	RANITIDINE HYDROCHLORIDE

Tier Changes

The following Brand drugs have been moved to a **higher** co-pay tier effective April 1, 2021.

NIZATIDINE	ISONIAZID

Prior Authorization

The following drug will now require prior authorization for coverage, effective April 1, 2021.

FLUOROURACIL CRE 5%	TARGRETIN GEL 1%