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

BCBSRI Pharmacy Program
October 1, 2020 Formulary Changes

The information below is effective as of October 1, 2020 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 October 1, 2020. The generic equivalent will continue to be covered.

BUTRANS DIS 7.5/HR	DYMISTA SPR 137-50	MOXEZA SOL 0.5%	PROVENTIL AER HFA
DARAPRIM TAB 25MG	GEODON INJ 20MG	PROAIR HFA AER	SAMSCA TAB 30MG
DESONATE GEL 0.05%	JADENU TAB 180MG	PROGLYCEM SUS 50MG/ML	

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 October 1, 2020. Request for coverage will require documented medical necessity.

AFINITOR TAB 10MG*	METHYLPHENID TAB 18MG ER	NAPROXEN SUS 125/5ML	SAVELLA TAB 12.5MG
CHLORZOXAZON TAB 250MG	METHYLPHENID TAB 27MG ER	ORFADIN CAP 20MG	SAVELLA TAB 25MG
DESONATE GEL 0.05%	METHYLPHENID TAB 36MG ER	PROAIR RESPI AER	SAVELLA TAB 50MG
KETOPROFEN CAP 25MG	METHYLPHENID TAB 54MG ER	SAVELLA TAB 100MG	ULESFIA LOT 5%

* Specialty

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

Excluded from coverage per Certificate of Coverage – FDA Withdrawal from Market

The following products have been withdrawn from the market per FDA regulation and as a result do not meet requirements for coverage under the certificate of coverage.

RANITIDINE CAP 150MG	RANITIDINE CAP 300MG	RANITIDINE TAB 150MG	RANITIDINE TAB 300MG

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Tier changes

The following products have been moved to a **higher** co-pay tier effective October 1, 2020. These changes generally involve a change to the next higher co-pay tier. There are some products which will have a change of more than one higher tier change related to formulary design, these products are designated with an asterisk*.

ACEBUTOLOL CAP 200MG	COMPRO SUP 25MG	HYDROXYZ HCL SYP 10MG/5ML	OXAPROZIN TAB 600MG
ACEBUTOLOL CAP 400MG	DESLORATADIN TAB 5MG	IMIPRAM PAM CAP 75MG	OXAZEPAM CAP 10MG
ACETAZOLAMID TAB 125MG	DICLOFENAC SOL 0.1% OP	IRBESAR/HCTZ TAB 150-12.5	PAROMOMYCIN CAP 250MG
ALBUTEROL TAB 2MG *	DICYCLOMINE CAP 10MG	IRBESAR/HCTZ TAB 300-12.5	PEG-3350 SOL ELECTROL
AMANTADINE SYP 50MG/5ML	DICYCLOMINE TAB 20MG	KLOR-CON M20 TAB 20MEQ ER	PHENYTOIN CHW 50MG
AMINOCAPROIC SOL 0.25/ML	DILTIAZEM CAP 120MG ER	LACTULOSE SOL 10GM/15	PHENYTOIN SUS 125/5ML
AMOX/K CLAV SUS 200/5ML	DILTIAZEM ER TAB 240MG	LAMIVUDINE TAB 300MG *	PILOCARPINE SOL 1% OP
AZITHROMYCIN SUS 200/5ML	DORZOL/TIMOL SOL 22.3-6.8	LAMOTRIGINE CHW 5MG	POT CHLORIDE TAB 20MEQ ER
BENAZEP/HCTZ TAB 5-6.25	DOXEPIN HCL CAP 25MG	LEVO/LIOTHYR TAB 15MG	POT CL MICRO TAB 20MEQ ER
BETAXOLOL SOL 0.5% OP	DOXYCYC MONO CAP 50MG	LEVO/LIOTHYR TAB 60MG	PREDNISOLONE SOL 20MG/5ML *
BETAXOLOL TAB 10MG	DOXYCYC MONO TAB 75MG	LIDO/PRILOCN CRE 2.5-2.5%	PREVALITE POW 4GM
BETHANECHOL TAB 25MG	DOXYCYCLINE TAB 75MG	MATZIM LA TAB 240MG/24	PRIMIDONE TAB 50MG
BICALUTAMIDE TAB 50MG	ECONAZOLE CRE 1%	METADATE TAB 20MG ER	PROBEN/COLCH TAB 500-0.5
BISOPRL/HCTZ TAB 10/6.25	ENALAPRIL TAB 2.5MG	METHAMPHETAM TAB 5MG	PROCHLORPER SUP 25MG
BISOPRL/HCTZ TAB 2.5/6.25	ENULOSE SOL 10GM/15	METHOTREXATE INJ 25MG/ML	QNAPRIL/HCTZ TAB 10-12.5
BISOPRL/HCTZ TAB 5-6.25MG	ESCITALOP OX SOL 10/10ML	METHOTREXATE INJ 50MG/2ML	RAMELTEON TAB 8MG
BROMFENAC SOL 0.09% OP	ESCITALOPRAM SOL 5MG/5ML	METHSCOPOLAM TAB 2.5MG	RANITIDINE TAB 150MG
CAFFEINE CIT SOL 20MG/ML *	FAMCICLOVIR TAB 125MG	METOCLOPRAM SOL 10/10ML	RANITIDINE TAB 300MG
CAFFEINE CIT SOL 60MG/3ML **	FAMOTIDINE SUS 40MG/5ML	METOCLOPRAM SOL 5MG/5ML	RISPERIDONE TAB 2MG ODT
CALC ACETATE TAB 667MG	FLAVOXATE TAB 100MG	MISOPROSTOL TAB 100MCG	RISPERIDONE TAB 3MG ODT
CANDESA/HCTZ TAB 32-12.5	FLUCONAZOLE SUS 10MG/ML	MISOPROSTOL TAB 200MCG	RIVASTIGMINE CAP 3MG
CARBINOXAMIN TAB 4MG	FLUCONAZOLE TAB 50MG	MOMETASONE CRE 0.1%	SULINDAC TAB 150MG
CARTIA XT CAP 120/24HR	FLUOCINONIDE GEL 0.05%	MOMETASONE SOL 0.1%	TOLTERODINE TAB 1MG
CAZIANT PAK	FLUOXETINE SOL 20MG/5ML	MONDOXYNE NL CAP 50MG	TRIAMCINOLON OIN 0.05%
CHLOROQUINE TAB 500MG	GAVILYTE-G SOL	MORPHINE SUL TAB 100MG ER	TRIANEX OIN 0.05%
CHLORPROMAZ TAB 10MG	GENERLAC SOL 10GM/15	MOXIFLOXACIN TAB 400MG	VALPROIC ACD SOL 250/5ML
CHOLESTYRAM POW 4GM LITE	GLYCOPYRROL TAB 1MG	NIMODIPINE CAP 30MG *	VALSARTAN TAB 160MG
CILOSTAZOL TAB 100MG	GRISEOFULVIN TAB ULTR 125	NP THYROID TAB 15MG	VALSARTAN TAB 40MG
CIPROFLOXACN SUS 500MG/5 *	GUANFACINE TAB 1MG	NP THYROID TAB 60MG	VALSARTAN TAB 80MG
CITALOPRAM SOL 10MG/5ML	GUANFACINE TAB 2MG	OCTREOTIDE INJ 1000/5ML	VELIVET PAK
CLARITHROMYC TAB 250MG	HC BUTYRATE OIN 0.1%	OCTREOTIDE INJ 200MCG	VERAPAMIL TAB 40MG
CLARITHROMYC TAB 500MG	HC/ACET ACID SOL OTIC	OLANZAPINE TAB 10MG ODT	VORICONAZOLE SUS 40MG/ML *
CLOBETASOL GEL 0.05%	HYDROCORT TAB 10MG	OLANZAPINE TAB 5MG ODT	ZEJULA CAP 100MG **
COLESTIPOL GRA 5GM *	HYDROCORT TAB 5MG	ORPHENADRINE TAB 100MG ER	

** Specialty * Tier change of more than one tier higher

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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, 2020. The generic equivalent will continue to be covered.

AFINITOR TAB 2.5MG
AFINITOR TAB 5MG
AFINITOR TAB 7.5MG
APRISO CAP 0.375GM
DEPEN TITRA TAB 250MG
ISORDIL TAB 40MG
K-TAB TAB 20MEQ
NEBUPENT INH 300MG
OCTREOTIDE INJ 1000MCG
OCTREOTIDE INJ 200MCG
ORFADIN CAP 10MG
ORFADIN CAP 2MG
ORFADIN CAP 5MG
PROVENTIL HFA
SILENOR TAB 3MG
SILENOR TAB 6MG
TRAVATAN Z DRO 0.004%

Drugs (Excluded from coverage)

The following drugs are **available with alternatives** as a result, they will be **excluded** from coverage effective October 1, 2020.

BRIMONIDINE SOL 0.15%
BUSPIRONE TAB 7.5MG
DOXYCYC MONO CAP 150MG
DOXYCYC MONO CAP 75MG
DOXYCYC MONO CAP 75MG
FENOFIBRATE CAP 130MG
FENOFIBRIC CAP 135MG DR
FLUOXETINE TAB 10MG
FLUOXETINE TAB 20MG
KETOPROFEN CAP 25MG
MEFENAM ACID CAP 250MG
MONDOXYNE NL CAP 75MG
NAPROXEN SUS 125/5ML
OKEBO CAP 75MG
OXYCODONE TAB 10MG ER
OXYCODONE TAB 15MG ER
OXYCODONE TAB 20MG ER
OXYCODONE TAB 30MG ER
OXYCODONE TAB 40MG ER
OXYCODONE TAB 60MG ER
OXYCODONE TAB 80MG ER
PROAIR HFA AER
PROAIR RESPI AER
TIMOLOL GEL SOL OPTH

Tier Changes

The following **Brand and generic** drugs have been moved to a **higher** co-pay tier effective October 1, 2020.

CARBINOXAMIN SOL 4MG/5ML *
CLOZAPINE TAB 12.5/ODT *
CROTAN LOT 10% *
DIDANOSINE CAP 200MG *
DIDANOSINE CAP 400MG *
DILT-XR CAP 180MG *
DILT-XR CAP 240MG *
ERY PAD 2% *
GAVILYTE-C SOL *
HETLIOZ CAP 20MG
LEVOBUNOLOL SOL 0.5% OP *
LIDOCAINE GEL 2% JELLY *
NEVIRAPINE TAB 100MG *
NITISINONE CAP 10MG * ^^
NITISINONE CAP 2MG * ^^
NITISINONE CAP 5MG * ^^
NITRO-TIME CAP 2.5MG CR *
ONDANSETRON TAB 24MG *
PAROMOMYCIN CAP 250MG
PROMETHEGAN SUP 50MG *
RIMANTADINE TAB 100MG *
TESTOST ENAN INJ 200MG/ML *
THEOPHYLLINE TAB 300MG ER *
VERAPAMIL CAP 200MG ER *

* Tier change of more than one tier higher ^^ Generic

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