BCBSRI Pharmacy Program
April 1, 2020 Formulary Changes

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

AFINITOR*
AMICAR
APRISO
CARAFATE
DELZICOL
DEPEN TITRATABS
DYRENIUM
FAZACLO
HALOG
JADENU
MORPHINE SULFATE (brand versions)
NEBUPENT
OCTREOTIDE ACETATE
ORFADIN
ROZEREM
SILENOR
TRAVATAN Z

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

ADZENYS ER
ADZENYS XR-ODT
AMITIZA
ANDRODERM
BETIMOL
DYANAVEL XR
FIRDAPSE*
INNOPRAN XL
KETOCONAZOLE
KETODAN
LINZESS
LIVALO
METHITEST
MOVANTIK
NISOLDIPINE ER
OXYMORPHONE HYDROCHLORIDE ER
PEXEVA
RELISTOR
SELZENTRY
SIMPONI *
STRIANT
TEKTURNA
TEKTURNA HCT
TEMIXYS
TREXALL
UTIBRON NEOHALER
ZYCLARA
ZYCLARA PUMP
ZYTIGA 500MG *

* Specialty

Growth Hormones* – Preferred product is Norditropin

GENOTROPIN
HUMATROPE
NUTROPIN AQ NUSPIN 10
OMNITROPE
SAIZEN
SEROSTIM
ZOMACTON
ZORBTIVE

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

The following products have been moved to a **higher** co-pay tier effective April 1, 2020.

APRISO
BETIMOL
CARAFATE
DEPEN TITRATABS
KETOCONAZOLE
KETODAN
LINZESS
METHITEST
MORPHINE SULFATE
NEBUPENT
NISOLDIPINE ER
OCTREOTIDE ACETATE
RAPAMUNE SOL 1MG/ML
TEMIXYS
TRAVATAN Z

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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 April 1, 2020. The generic equivalent will continue to be covered.

DYRENIUM CAP 50MG
FIRAZYR INJ
LYRICA CAP
LYRICA SOL L
MORPHINE SUL TAB
NOXAFIL TAB
ROZEREM TAB
TRANSDERM SC DISC

Drugs (Excluded from coverage)

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

BUPRENORPHIN DISC
BUTRANS DISC
DESOXIMETASONE GEL
TRIAMCINOLON AERO SPRAY

Tier Changes

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

ALENDRONATE SODIUM
ARIKAYCE
CHLOROTHIAZIDE
NITRO-TIME
ORFADIN
OXAZEPAM
OXYCODONE/ASPIRIN
SELEGILINE HCL
THEOCHRON
THEOPHYLLINE ER

Quantity Limits

The following products will be subject to quantity limits on dispensing per prescription effective April 1, 2020.

CABLIVI
COMBIPATCH
XELJANZ

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