

BCBSRI Pharmacy Program October 1, 2021 Formulary Changes

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

AZOPT	LOTEMAX	PERFOROMIST NEB
BEPREVE	MIACALCIN	THIOLA
BROVANA NEB	NAFTIFINE CREAM 2%	TRUVADA
INTELENCE	NORTHERA	VELETRI
KALETRA		

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, 2021. Request for coverage will require documented medical necessity.

ADDYI TAB	FOSAMAX PLUS D	RESTASIS MULTIDOSE
ALLZITAL	FULPHILA	SEEBRI NEOHALER
ALVESCO	KEVEYIS	SUBSYS
BASAGLAR KWIKPEN	LEVALBUTEROL TARTRATE HFA	TEMAZEPAM
BINOSTO	MITIGARE CAP	TENCON TAB
CLENPIQ	MOMETASONE FUROATE	TRETINOIN GEL
CLINDAMYCIN PHOSPHATE FOAM	NIVESTYM	TRETINOIN MICROSPHERE GEL
CLINDAMYCIN PHOSPHATE/TRETINOIN GEL	NYVEPRIA	TRETINOIN MICROSPHERE PUMP
DOXEPIN HCL 3MG/6MG	OSMOPREP	TUDORZA PRESSAIR
DULOXETINE HCL 40MG	PANCREAZE	TWIRLA
EMVERM	PERTZYE	VISTOGARD
EPINEPHRINE INJ (AVKARE/AMNEAL)	PREPOPIK	VTOL LQ
ESTRADIOL VAG TAB	QUAZEPAM	XOPENEX HFA
FEMRING VAG RING	QUILLICHEW ER	XURIDEN
FLUNISOLIDE	QUILLIVANT XR	YUVAFEM
FORFIVO XL	RESTASIS OPTH	ZIEXTENZO

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

Prior Authorization

The following drugs will now require prior authorization for coverage, effective October 1, 2021.

AUBAGIO * #
GILENYA * #

KESIMPTA * #
RINVOQ *

SUPPRELIN LA *
ZEPOSIA * #

*specialty drug # Step Therapy for New starts only

Drugs that will be designated for coverage under Medical *

The following drug will be covered under the medical benefit, effective October 1, 2021.

MYOBLOC *

*specialty drug

Tier changes

The following products will be moved to a **higher** co-pay tier, effective October 1, 2021.

ABACAV/LAMIV TAB /ZIDOVUD	DONEPEZIL TAB ODT 10MG *	METAXALONE TAB 800MG
ADDERALL XR CAP 10MG	DONEPEZIL TAB 10MG *	METFORMIN TAB 500MG ER
ADDERALL XR CAP 15MG	DONEPEZIL TAB 10MG ODT *	METFORMIN TAB 750MG ER
ADDERALL XR CAP 20MG	DONEPEZIL TAB 5MG *	METHOTREXATE TAB 2.5MG *
ADDERALL XR CAP 25MG	DONEPEZIL TAB 5MG ODT *	METHYLPRED TAB 32MG *
ADDERALL XR CAP 30MG	DONEPEZIL TAB ODT 5MG *	METRONIDAZOL GEL 0.75%
ADDERALL XR CAP 5MG	DOXEPIN HCL CON 10MG/ML *	MIRTAZAPINE TAB 15MG *
ALBUTEROL NEB 0.083% *	DOXYCYC MONO CAP 100MG	MIRTAZAPINE TAB 30MG *
ALENDRONATE SOL 70/75ML	DOXYCYC MONO CAP 50MG	MIRTAZAPINE TAB 45MG *
ALPRAZOLAM TAB 0.5MG ER *	DOXYCYCL HYC TAB 100MG *	MONDOXYNE NL CAP 100MG
ALPRAZOLAM TAB 0.5MG XR *	EC-NAPROXEN TAB 375MG *	MORPHINE SUL TAB 15MG ER *
ALPRAZOLAM TAB 3MG ER *	EMTRICITABIN CAP 200MG	MUPIROCIN CRE 2%
ALPRAZOLAM TAB 3MG XR *	ENDOCET TAB 5-325MG *	NAPROXEN DR TAB 375MG *
AMIODARONE TAB 200MG *	ESTRAD VAL INJ 200MG/5	NIFEDIPINE TAB 30MG ER *
AMITRIPTYLIN TAB 10MG *	ESTRAD VAL INJ 40MG/ML	NIZATIDINE CAP 150MG *
AMITRIPTYLIN TAB 25MG *	ETHOSUXIMIDE CAP 250MG	NIZATIDINE CAP 300MG *
AMITRIPTYLIN TAB 50MG *	ETODOLAC ER TAB 400MG	OLM MED/AMLO TAB /HCTZ
AMOX/K CLAV TAB 500-125 *	ETODOLAC ER TAB 500MG	OLM MED/HCTZ TAB 20-12.5 *
AMOX/K CLAV TAB 875-125 *	ETODOLAC ER TAB 600MG *	OLM MED/HCTZ TAB 40-12.5 *
ANAGRELIDE CAP 0.5MG	FELBAMATE TAB 600MG	OLM MED/HCTZ TAB 40-25MG *
APREPITANT CAP 40MG	FENOFIBRATE TAB 145MG	OXANDROLONE TAB 2.5MG
ATOVAQ/PROGU TAB 62.5-25	FENOFIBRATE TAB 160MG	OXCARBAZEPIN SUS 300MG/5M
AVITA CRE 0.025%	FENOFIBRATE TAB 48MG	OXCARBAZEPIN TAB 150MG *
AVITA GEL 0.025%	FENOFIBRATE TAB 54MG	OXYCOD/APAP TAB 5-325MG *
BACLOFEN TAB 10MG *	FENTANYL DIS 12MCG/HR	OXYCODONE TAB 5MG *
BENZONATATE CAP 100MG *	FENTANYL DIS 25MCG/HR	PACERONE TAB 200MG *
BENZONATATE CAP 200MG *	FENTANYL DIS 50MCG/HR	PHENOBARB TAB 100MG *
BRIMONIDINE SOL 0.2% OP *	FENTANYL DIS 62.5MCG *	PHENOBARB TAB 30MG *
BUPREN/NALOX SUB 2-0.5MG	FENTANYL DIS 75MCG/HR	PHRENILIN CAP FORTE
BUPRENORPHIN DIS 7.5/HR	FENTANYL DIS 87.5MCG *	PILOCARPINE SOL 1% OP

BUPROPION TAB 150MG SR *	FLUCONAZOLE TAB 150MG *	PREDNISOLONE SOL 15MG/5ML *
BUSPIRONE TAB 10MG *	FLUPHENAZINE TAB 10MG *	PREDNISOLONE TAB 10MG ODT
BUSPIRONE TAB 15MG *	FLUPHENAZINE TAB 1MG	PREDNISOLONE TAB 15MG ODT
BUSPIRONE TAB 5MG *	FLUPHENAZINE TAB 2.5MG	PREGABALIN SOL 20MG/ML
BUT/APAP/CAF CAP	FONDAPARINUX INJ 2.5/0.5	PROCENTRA SOL 5MG/5ML
BUT/APAP/CAF CAP CODEINE	GABAPENTIN TAB 600MG *	PROCHLORPER SUP 25MG *
BUTAL/APAP TAB 50-325MG	GENGRAF CAP 25MG	PROCHLORPER TAB 10MG *
CARBAMAZEPIN CAP 100MG ER	HALOPERIDOL TAB 0.5MG *	PROCHLORPER TAB 5MG *
CARBAMAZEPIN CAP 200MG ER	HALOPERIDOL TAB 1MG *	PROMETHAZINE SOL 6.25/5ML *
CARBAMAZEPIN CAP 300MG ER	HC BUTYRATE CRE 0.1%	PROMETHAZINE SUP 50MG *
CARBAMAZEPIN TAB 100MG ER	HC/ACET ACID SOL OTIC *	PROMETHAZINE SYP 6.25/5ML *
CARBAMAZEPIN TAB 200MG ER	HEPARIN SOD INJ 1000/ML *	PROMETHAZINE TAB 12.5MG *
CARBAMAZEPIN TAB 400MG ER	HEPARIN SOD INJ 10000/ML	PROMETHAZINE TAB 25MG *
CEPHALEXIN CAP 250MG *	HEPARIN SOD INJ 5000/0.5	PROMETHAZINE TAB 50MG *
CEPHALEXIN CAP 500MG *	HEPARIN SOD INJ 5000/ML	PROPRANOLOL TAB 10MG *
CHLORPROMAZ TAB 10MG	HYDROCO/APAP TAB 5-325MG *	RISPERIDONE TAB 0.5MG OD
CHLORZOXAZON TAB 500MG	HYDROCOD/IBU TAB 5-200MG	RISPERIDONE TAB 1MG ODT
CHLORZOXAZON TAB 750MG	HYDROCOD/IBU TAB 7.5-200	RISPERIDONE TAB 2MG ODT
CIMETIDINE TAB 200MG *	HYDROMORPHON TAB 12MG ER	RISPERIDONE TAB 3MG ODT
CIMETIDINE TAB 300MG *	HYDROMORPHON TAB 2MG *	ROSADAN GEL 0.75%
CIPROFLOXACN SOL 0.3% OP *	HYDROMORPHON TAB 4MG *	ROWEEPPRA TAB 500MG *
CLINDAMYCIN CAP 150MG *	IMIQUIMOD CRE 3.75%	SIROLIMUS SOL 1MG/ML
CLINDAMYCIN CAP 300MG *	IMIQUIMOD CRE 3.75%PMP	SUBVENITE KIT START 49
CLINDAMYCIN SOL 75MG/5ML	IMIQUIMOD CRE 5%	TACROLIMUS CAP 0.5MG
CLORAZ DIPOT TAB 15MG	LAMIVUDINE TAB 100MG	TACROLIMUS CAP 1MG
CLORAZ DIPOT TAB 3.75MG	LAMOTRIG ODT TAB 100MG	TEMAZEPAM CAP 30MG *
CLORAZ DIPOT TAB 7.5MG	LAMOTRIGINE KIT START 49	TIAGABINE TAB 12MG
CLOTTRIM/BETA LOT DIPROP	LAMOTRIGINE TAB 100MG	TIAGABINE TAB 16MG *
CLOZAPINE TAB 100MG	LAMOTRIGINE TAB 100MG ER	TIAGABINE TAB 2MG *
CLOZAPINE TAB 25MG	LAMOTRIGINE TAB 200MG	TIAGABINE TAB 4MG *
CLOZAPINE TAB 50MG	LAMOTRIGINE TAB 200MG ER	TIMOLOL GEL SOL 0.25% OP
COMPRO SUP 25MG *	LAMOTRIGINE TAB 250MG ER	TIMOLOL GEL SOL 0.5% OP
CROMOLYN SOD SOL 4% OP *	LAMOTRIGINE TAB 25MG ER	TIMOLOL MAL SOL 0.25% OP *
CYCLOBENZAPR TAB 10MG *	LAMOTRIGINE TAB 25MG ODT *	TIMOLOL MAL SOL 0.5% OP *
CYCLOBENZAPR TAB 5MG *	LAMOTRIGINE TAB 300MG ER	TRAZODONE TAB 100MG *
CYCLOPENTOL SOL 1% OP *	LAMOTRIGINE TAB 50MG ER	TRAZODONE TAB 150MG *
CYCLOPHOSPH CAP 25MG	LAMOTRIGINE TAB 50MG ODT	TRAZODONE TAB 50MG *
CYCLOPHOSPH CAP 50MG	LANSOPRAZOLE CAP 30MG DR *	TRETINOIN CRE 0.025%
CYCLOSPORINE CAP 25MG MOD	LEUCOVOR CA TAB 10MG	TRETINOIN GEL 0.025%
CYCLOSPORINE CAP 50MG MOD	LEUCOVOR CA TAB 15MG	TRIAMCINOLON OIN 0.025%
DESMOPRESSIN SPR 0.01%	LEUCOVOR CA TAB 25MG	TRIAMCINOLON OIN 0.1%
DESOXIMETAS CRE 0.25%	LEUCOVOR CA TAB 5MG	TRIAMCINOLON OIN 0.5%
DEXTROAMPHET CAP 5MG ER	LEVETIRACETA TAB 250MG *	TRIAMTERENE CAP 100MG
DEXTROAMPHET SOL 5MG/5ML	LEVETIRACETA TAB 500MG *	TRIAMTERENE CAP 50MG *

DICLOFENAC SOL 1.5%	LEVORPHANOL TAB 2MG	VALSART/HCTZ TAB 160-12.5 *
DICLOFENAC TAB 50MG DR *	LIDOCAINE PAD 5%	VALSART/HCTZ TAB 160-25MG *
DICLOFENAC TAB 75MG DR *	LORCET TAB 5-325MG *	VALSART/HCTZ TAB 80-12.5 *
DILTIAZEM TAB 30MG *	LORZONE TAB 750MG	VERAPAMIL TAB 120MG ER *
DILTIAZEM TAB 60MG *	LORZONE TAB 375MG *	VERAPAMIL TAB 180MG ER *
DILTIAZEM TAB 90MG *	MEPROBAMATE TAB 200MG	VERAPAMIL TAB 240MG ER *
DIPHENHYDRAM INJ 50MG/ML *	METAXALL TAB 800MG	XULANE DIS 150-35
DISOPYRAMIDE CAP 100MG	METAXALONE TAB 400MG	ZONISAMIDE CAP 50MG *

* 5 Tier Generic Formulary only

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

GLUCAGON KIT 1MG	SAPHRIS SUB	VELTIN GEL
LOTEMAX GEL 0.5%	TRUVADA TAB	ZYTIGA TAB
NAFTIFINE CRE HCL 2%		

Drugs (Excluded from coverage)

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

APAP-CAFFEIN CAP DIHYDROCODEINE	FENOFIBRATE CAP	NAPROXEN DR TAB
EC-NAPROXEN TAB	FENOFIBRIC CAP	TRAZODONE TAB
FEMRING	LIDOCAINE SOL 4%	TREZIX CAP

Tier Changes

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

CEFACTOR CAP	CYCLOSERINE CAP	VCF VAGINAL GEL
CEFADROXIL TAB	SODIUM POLYSTYRENE SULFONATE ORAL SUSP	

Prior Authorization

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

CODEINE	SEVENFACT	TYLENOL w/ CODEINE
FIORINAL w/ CODEINE	TRAMADOL	ULTRACET
NOVOSEVEN RT	TREZIX	ULTRAM
QDOLO		