

BCBSRI Pharmacy Program October 1, 2022, Formulary Changes

The information below is effective as of October 1, 2022 and applies to the Individual Markets/Exchange programs. 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.

Individual Market (Direct Pay/Direct Pay Exchange) Formulary

Brand Name Drugs available with generic equivalents (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, 2022. The generic equivalent will continue to be covered.

BIDIL	NORPACE	STALEVO 200
COMBIGAN	REVLIMID	STALEVO 50
ESBRIET	SAMSCA	STALEVO 75
FERRIPROX	STALEVO 100	TARGRETIN
K-PHOS	STALEVO 125	VIMPAT
LANOXIN	STALEVO 150	

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

The following drugs are **available with alternatives** as a result, they will be **excluded** from coverage effective October 1, 2022.

ADAPALENE	FOSAMAX PLUS D	NUVESSA
ADAPALENE/BENZOYL PEROXIDE	FRAGMIN	OCALIVA
ADDYI	HUMALOG	OLANZAPINE ODT
AKTEN	HUMALOG JUNIOR KWIKPEN	OLMESARTAN/AMLODIPINE/HCTZ
ALDACTAZIDE	HUMALOG KWIKPEN	OMNITROPE PEN 10 INJECTION DEVICE
ALENDRONATE SODIUM	HUMALOG MIX 50/50	OMNITROPE PEN 5 INJECTION DEVICE
ALPRAZOLAM ODT	HUMALOG MIX 50/50 KWIKPEN	ONDANSETRON HCL
AMIODARONE HCL	HUMALOG MIX 75/25	ORKAMBI
ANZEMET	HUMALOG MIX 75/25 KWIKPEN	OXERVATE
APO-VARENICLINE	HUMULIN 70/30	PACERONE
ARCAPTA NEOHALER	HUMULIN 70/30 KWIKPEN	PANRETIN
ARIPIRAZOLE ODT	HUMULIN R	PREDNICARBATE
AUGMENTED BETAMETHASONE DIPRO	HYDROMORPHONE HCL ER	PYRIDOSTIGMINE BROMIDE ER
AURYXIA	INGREZZA	RIDAURA
AVITA	INSULIN LISPRO	RISEDRONATE SODIUM DR
AZASAN	INSULIN LISPRO JUNIOR KWIKPEN	RISPERIDONE ODT
AZATHIOPRINE	INSULIN LISPRO KWIKPEN	RYTARY
BELSOMRA	INSULIN LISPRO PRO/INSULIN LISPRO KWIK	SECUADO
BEXAROTENE	INTRAROSA	SIKLOS

CALCITONIN SALMON	ISOTRETINOIN	STALEVO 100
CETRALAX	ISTURISA	STALEVO 125
CLINDACIN ETZ PLEDGETS	JUXTAPID	STALEVO 150
CLINDACIN-P	JYNARQUE	STALEVO 200
CLINDAMYCIN PHOSPHATE	KORLYM	STALEVO 50
CLOBETASOL PROPIONATE EMOLLIENT	LAMICTAL XR	STALEVO 75
CLONAZEPAM ODT	LAMOTRIGINE STARTER KIT/BLUE	SUBVENITE STARTER KIT/BLUE
CLOPIDOGREL	LAMOTRIGINE STARTER KIT/GREEN	SUBVENITE STARTER KIT/GREEN
CLOZAPINE ODT	LAMOTRIGINE STARTER KIT/ORANGE	SUBVENITE STARTER KIT/ORANGE
CORTIFOAM	LEVOTHYROXINE SODIUM	TELMISARTAN/AMLODIPINE
DDAVP	LUCEMYRA	TELMISARTAN/HCTZ
DESMOPRESSIN ACETATE	LUPANETA PACK	TENCON
DILATRATE SR	MATZIM LA	TIMOLOL MALEATE
DILTIAZEM HCL CD	METOCLOPRAMIDE ODT	TIROSINT
DILTIAZEM HCL ER	METRONIDAZOLE	TIROSINT-SOL
DONEPEZIL HCL	MIGLITOL	TOPIRAMATE ER
DONEPEZIL HYDROCHLORIDE ODT	MIRTAZAPINE ODT	TRAMADOL HCL ER
DUOPA	NAPROXEN SODIUM	TRETINOIN
EDARBI	NEBIVOLOL	TROKENDI XR
EDARBYCLOR	NEBIVOLOL HYDROCHLORIDE	VERAPAMIL HCL ER
EMEND	NEO-SYNALAR	VEREGEN
EMSAM	NISOLDIPINE ER	VERELAN PM
ERGOMAR	NITRO-DUR	VERSACLOZ
ERYTHROMYCIN/BENZOYL PEROXIDE	NITROGLYCERIN LINGUAL	VIEKIRA PAK
ETODOLAC ER	NITROMIST	ZOLMITRIPTAN ODT
FLUOCINOLONE ACETONIDE	NIVESTYM	

Prior Authorization

The following drug will now require prior authorization for coverage, effective October 1, 2022.

DIHYDROERGOTAMINE MESYLATE	ERGOTAMINE TARTRATE/CAFFEINE	DABIGATRAN ETEXILATE
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Tier Changes

The following Brand drugs will be moved to a **higher** co-pay tier effective October 1, 2022.

Tier 1 to Tier 4

DEXAMETHASONE TAB 0.5MG	DEXAMETHASONE TAB 0.75MG
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Tier 2 to Tier 4

MORPHINE SUL SOL 20MG/5ML	QUINIDINE SUL TAB 300MG	TRIHEXYPHEN SOL 0.4MG/ML
MORPHINE SUL CAP ER (all strengths)	SULFADIAZINE TAB 500MG	VANDAOLE GEL 0.75%
QUINIDINE SUL TAB 200MG	TRAMADOL HCL TAB 100MG ER	