

BCBSRI Pharmacy Program April 1, 2018 Formulary Changes

The information below is effective as of April 1, 2018 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 (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, 2018. The generic equivalent will continue to be covered.

BUPHENYL	ISTALOL	TESTIM
COREG CR	LEXIVA	TRANSDERM-SCOP
EFFIENT	LIALDA	VIREAD
ESTRACE	REYATAZ	ZIAGEN
FLUOXETINE HCL	SUSTIVA	EPIDUO GEL
FOSRENOL	TAMIFLU	VIAGRA*

* When covered by Rider

Brand Name and generic Drugs (Excluded from coverage - with medical necessity supported)

The following Brand-name drugs and products will be **excluded** from coverage effective April 1, 2018. Request for coverage will require documented medical necessity.

CLOBETASOL PROPIONATE EMUL FOAM	HUMALOG KWIK INJ 200/ML	MINOCYCLINE HCL TAB
CLOBETASOL PROPIONATE AEROSOL	HUMALOG MIX INJ 50/50	MINOCYCLINE HCL ER 24HR
CLOBETASOL PROPIONATE SPRAY	HUMALOG MIX INJ 50/50KWP	OLYSIO
DAKLINZA	HUMALOG MIX INJ 75/25KWP	OMEPRazole-BICARBONATE
DOXEPIN HCL CREAM 5%	HUMALOG MIX SUS 75/25	OMNIPOD MIS
DOXYCYCLINE DELAY REL 40 MG	HUMULIN INJ 70/30	PRUDOXIN CREAM 5%*
DOXYCYCLINE HYCLATE TAB 50MG	HUMULIN INJ 70/30KWP	RIOMET
FENOPROFEN CAP 200MG	HUMULIN N INJ U-100	SYNERA
FLUOCINONIDE CRE 0.1%	HUMULIN N INJ U-100KWP	TECHNIVIE
HUMALOG INJ 100/ML	HUMULIN R INJ U-100	VIEKIRA
HUMALOG INJ 100/ML	LIDORX	ZEPATIER
HUMALOG JR INJ 100/ML	MILLIPRED	ZONALON CREAM 5%
HUMALOG KWIK INJ 100/ML		

* For Small Group Formulary will remain covered at Non Preferred Brand Tier

Brand Name and generic Drugs – Prior Authorization now required

The following Brand-name and *generic* drugs will require Prior Authorization for coverage effective April 1, 2018.

DOXEPIN CREAM 5%	MINOCYCLINE 50MG
DOXYCYCLINE 40MG	PRUDOXIN
DOXYCYCLINE HYCLATE 50MG	ZONALON

Tier changes

The following select Brand name and *generic* drugs have been moved to a **higher** co-pay tier.

ACITRETIN CAP	LIDOCAINE OINT 5%	TAZAROTENE CREAM 0.1%
AUSTEDO	PENTASA	TOBI PODHALER
BETHKIS	PLEGRIDY	ZAVESCA
KITABIS PAK	SYRINE	

The following select Brand name and *generic* drugs have been moved to a **lower** co-pay tier.

AMANTADINE TAB	MODAFINIL TAB
DESVENLAFAXINE TAB ER	MOXIFLOXACIN OPTH SOL 0.5%
GENTAMICIN CREAM 0.1%	ZOLMITRIPTAN TAB

Individual Market (Direct Pay and Direct Pay Exchange) Formulary

Brand Name Drugs (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, 2018. The generic equivalent will continue to be covered.

AGGRENOX	EMEND TRIPAC	LURIDE DROP	SABRIL POW
ALKERAN	EPIDUO GEL	METFORMIN ER	STRATTERA
AXIRON SOL	EPZICOM	MINASTRIN 24 FE	TAMIFLU
BEYAZ	ERYPED SUSP	MYFORTIC	TAZORAC CREAM
BUPHENYL	FOSRENOL CHEW	PENTASA CR	TRANSDERM-SCOP
CAFERGOT	KALETRA	PRISTIQ	VIGAMOX DROP
CELLCEPT	LAMICTAL KIT	QUARTETTE	VIRAZOLE INH
E.E.S. GRAN SUSP	LEXIVA	REVELA	ZIAGEN SOL
EFFIENT	LIALDA	ROZEREM	ZYFLO CR
EMEND			

Brand Name and generic Drugs – Quantity Limit

The following product will have a Quantity Limit on coverage effective April 1, 2018

PHENTERMINE CAP

Brand Name and generic Drugs – Prior Authorization now required

The following Brand-name and *generic* drugs will require Prior Authorization for coverage effective April 1, 2018.

DOXEPIN CREAM 5%

MINOCYCLINE 50MG

DOXYCYCLINE 40MG

PRUDOXIN

DOXYCYCLINE HYCLATE 50MG

ZONALON

Tier Changes

The following select generic drugs have been moved to a higher co-pay tier, effective April 1, 2018

AMPICILLIN CAP

FLURBIPROFEN OPTH SOL

BROMFENAC OPTH SOL

PENICILLIN VK SOL

CLARITHROMYCIN SUSP