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

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.

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Prior Authorization

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

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

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DICLOFENAC SOL 1.5%
DICLOFENAC TAB 50MG DR *
DICLOFENAC TAB 75MG DR *
DILTIAZEM TAB 30MG *
DILTIAZEM TAB 60MG *
DILTIAZEM TAB 90MG *
DIPHENHYDRAM INJ 50MG/ML *
DISOPYRAMIDE CAP 100MG
LEVORPHANOL TAB 2MG
LIDOCAINE PAD 5%
LORCET TAB 5-325MG *
LORZONE TAB 750MG
LORZONE TAB 375MG *
MEPROBAMATE TAB 200MG
METAXALL TAB 800MG
METAXALONE TAB 400MG
VALSART/HCTZ TAB 160-12.5 *
VALSART/HCTZ TAB 160-25MG *
VALSART/HCTZ TAB 80-12.5 *
VERAPAMIL TAB 120MG ER *
VERAPAMIL TAB 180MG ER *
VERAPAMIL TAB 240MG ER *
XULANE DIS 150-35
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
LOTEMAX GEL 0.5%
NAFTIFINE CRE HCL 2%
SAPHRIS SUB
TRUVADA TAB
VELTIN GEL
ZYTIGA TAB

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

Tier Changes

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

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

Prior Authorization

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

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

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