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

BCBSRI Pharmacy Program
April 1, 2023 Formulary Changes

The information below is effective as of April 1, 2023 and applies to all commercial BCBSRI products, including all Large Group and Small Group plan designs and Direct Pay or Exchange (Individual) markets. These changes do not apply to the Blue CHiP for Medicare programs. Any changes to the Large Group and Small Group 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, 2023. The generic equivalent will continue to be covered.

DALIRESP TAB 250MCG	DIVIGEL GEL 0.75MG	PRADAXA CAP 150MG
DALIRESP TAB 500MCG	DIVIGEL GEL 1.25MG	SUPREP BOWEL SOL PREP KIT
DENAVIR CRE 1%	DIVIGEL GEL 1MG/GM	TAZORAC GEL 0.05%
DEXILANT CAP 60MG DR	GILENYA CAP 0.5MG	TAZORAC GEL 0.1%
DIVIGEL GEL 0.25MG	HETLIOZ CAP 20MG	TRIMETHOPRIM TAB 100MG
DIVIGEL GEL 0.5MG	MIRVASO GEL 0.33%	ZIOPTAN DRO 0.0015%

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 are **available with preferred alternatives** will be **excluded** from coverage, effective April 1, 2023. Request for coverage will require documented medical necessity.

AUTOJECT 2 MISC INJ DEVICE	INPEN 100EL MIS - HUM INJ DEVICE	PENICILLAMIN CAP 250MG
AUTOPEN MIS 1-21UNIT INJ DEVICE	INPEN 100NN MIS - NOV INJ DEVICE	PICATO GEL 0.015%
AUTOPEN MIS 2-42UNIT INJ DEVICE	J-TIP KIT VIAL KIT ADAPTERS	PICATO GEL 0.05%
BD PEN MIS INJ DEVICE	LEUCOVORIN CALCIUM TAB 10MG	PREDNISONE CONC 5MG/ML
BD PEN MINI MIS INJ DEVICE	MATZIM LA TAB 180MG/24	PREVALITE POW 4GM PACKETS
CHOLESTYRAMINE POWD 4GM LITE PACK	MATZIM LA TAB 240MG/24	SUMATRIPTAN INJ 4MG/0.5 CART REF
CHOLESTYRAMINE POWD 4GM PACK	MEGESTROL SUS 625MG/5M	SUMATRIPTAN INJ 6MG/0.5 CART REF
CICLOPIROX SUS 0.77%	NORDIPEN DEL MIS SYSTEM	VORTEX HOLDING CHAMBER/MASK/CHILDS/FROG
DILTIAZEM ER TAB 180MG	OMNITROPE PEN 10 INJECTION DEVICE	ZOLMITRIPTAN TAB 2.5 MG ODT
DILTIAZEM ER TAB 240MG	OMNITROPE PEN 5 INJECTION DEVICE	ZOLMITRIPTAN TAB 5MG ODT
INJECT-EASE MIS AUTO INJ DEVICE	OXYCODONE CAP 5MG	

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 April 1, 2023.

DEXCOM G7 MIS RECEIVER
DEXCOM G7 MIS SENSOR
FYLNETRA INJ 6MG/0.6
KRAZATI TAB 200MG
OZEMPIC INJ 2MG/3ML
RELYVRIO POWD PAK 3-1GM
REZLIDHIA CAP 150MG
SKYRIZI INJ 180/1.2 CARTRIDGE

Tier changes

The following product will be moved to a **higher** co-pay tier, effective April 1, 2023. This product will move from a Preferred Brand Tier to a Non-Preferred Brand Tier.

VICTOZA INJ 18MG/3ML

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Individual Markets (Direct Pay and Direct Pay Exchange) Formulary

Any changes to this list are the result of a comprehensive review of relevant clinical information by the Prime Therapeutics National Pharmacy and Therapeutics Committee which oversees the Net Results 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 April 1, 2023. The generic equivalent will continue to be covered.

DALIRESP TAB 250MCG
DALIRESP TAB 500MCG
GILENYA CAP 0.5MG
PRADAXA CAP 150MG
TRIMETHOPRIM TAB 100MG
VASCEPA CAP 0.5GM
VASCEPA CAP 1GM

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

The following generic and Brand-name drugs are **available with preferred alternatives** will be **excluded** from coverage, effective April 1, 2023. Request for coverage will require documented medical necessity.

ADULT MASK MIS - RESP THERAPY
AEROBIKA MIS - RESP THERAPY
AUTOJECT 2 MIS - RESP THERAPY
AUTOPEN MIS 2-42 UNIT RESP THERAPY
IN-CHECK INSPIRATORY FLOWMETER/ORAL- RESP THERAPY
INPEN 100/BLUE/LILLY/HUMALOG
INPEN 100/PINK/NOVOLOG/FIASP
J-TIP KIT W/VIAL ADAPTERS

AUTOPEN MIS 1-21 UNIT RESP THERAPY
BD PEN MIS
BD PEN MINI MIS
BREATHERITE VALVED MDI CHAMBER/RIGID- RESP
CEQUR SIMPL KIT PATCH 2U
CEQUR SIMPLICITY INSERTER
CHOLESTYRAMINE POWD 4GM LITE PACKETS
CHOLESTYRAMINE POWD 4GM PACKETS
CICLOPIROX SUSP 0.77%
CO MONITOR MIS- RESP THERAPY
DILTIAZEM ER TAB 180MG
DILTIAZEM ER TAB 240MG
IN-CHECK DIAL INSPIRATORYFLOW TRAINER- RESP THERAPY
IN-CHECK INSPIRATORY FLOWMETER/NASAL WITH MASK- RESP
LEUCOVORIN CALCIUM TAB 10MG
MATZIM LA TAB 180MG/24H
MATZIM LA TAB 240MG/24H
MEGESTROL SUSP 625MG/5ML
NEBULIZER CUP/TUBING- RESP THERAPY
NORDIPEN DELIVERY SYSTEM
NYVEPRIA INJ 6/0.6ML
OMNITROPE PEN 5 INJECTION DEVICE
OXYCODONE CAP HCL 5MG
PREDNISONE CONC 5MG/ML
PREVALITE POWD 4GM PK
SUMATRIPTAN INJ 4MG/0.5 CART REFILL
SUMATRIPTAN INJ 6MG/0.5 CART REFILL
ZOLMITRIPTAN TAB 2.5 MG ODT

Prior Authorization

The following drugs will now require prior authorization for coverage, effective April 1, 2023.

OZEMPIC INJ 2MG/3ML
SKYRIZI INJ 180/1.2
RADICAVA ORAL SUSP 105/5ML
RADICAVA INJ 30MG

Tier changes

The following product will be moved to a **higher** co-pay tier, effective April 1, 2023. These products will move to a Non-Preferred Brand Tier.

VELIVET
ISOSORBIDE MONONITRATE
LANSOPRAZOLE/AMOXICILLIN/CLARITHROMYCIN
PHENELZINE SULFATE
VICTOZA