

**BLUE SHIELD OF CALIFORNIA
FIRST QUARTER 2013 FORMULARY AND MEDICATION POLICY UPDATES**

EFFECTIVE MARCH 21, 2013

The Blue Shield of California (BSC) Pharmacy and Therapeutics (P&T) Committee, consisting of network physicians and pharmacists, regularly evaluates drugs for formulary inclusion and medication policy coverage criteria. The First Quarter 2013 P&T Committee decisions on formulary changes, which apply to all members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please consult the Blue Shield of California Drug Database and Formulary search tool for the following information (available at blueshieldca.com → select “pharmacy” hyperlink):

- *Quantity limits, if applicable, for specific drugs*
- *Formulary status of newly available strengths of existing drugs. Note: The formulary status of newly available strengths of existing drugs will have the same formulary status as the existing strengths unless otherwise noted.*
- *Non-formulary drugs and generic drugs that do not require prior authorization or step-edit*
- *Brand-name medications that are now non-formulary because these medications have newly available generic equivalents covered on the formulary*

For Medicare beneficiaries who are enrolled in an employer group Medicare Part D plan, the commercial formulary status applies unless otherwise stated.

Note:

*Medicare “**Statutory exclusion**” = drugs excluded for Medicare Part D under the Social Security Act section 1927(d)(2); those that have not been approved by the FDA; and those that do not meet the definition of a Part D drug as described by the Social Security Act section 1927(k).*

DRUGS REMOVED FROM FORMULARY

The following drug(s) were **REMOVED from** the Formulary, effective 06/06/2013 for commercial plans

- *These drugs are available at the non-formulary brand copayment except for members with a closed formulary benefit, or where prior authorization is required for coverage.*

Drug	Coverage Restriction	Medicare status (if differs)	Rationale for Decision	Formulary Alternatives
Diovan	Step therapy required	(effective 2014)	More cost effective alternatives available	ACE-Inhibitors, losartan, candesartan*, irbesartan*, Edarbi*

* Step therapy required

DRUGS NOT ADDED to FORMULARY

The following drugs were **NOT added to the Formulary as they do not have a clear advantage over formulary products. These drugs may have additional coverage restrictions as noted.**

- *Refer to member benefit summary for applicable member share of cost*

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Ilevro	pain/inflammation post cataract surgery			bromefenac, diclofenac, ketoralac, Lotemax ophthalmic drops

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Kazano	Type 2 diabetes	Step therapy required		Januvia*, Janumet*
Nesina	Type 2 diabetes	Step therapy required		Januvia*, Janumet*
Oseni	Type 2 diabetes	Step therapy required		Januvia*, Janumet*
Oxtellar XR	Partial seizures	Prior authorization required		oxcarbazepine
Uceris	Ulcerative colitis			balsalazide, budesonide (generic Entocort EC), Apriso, Asacol, Asacol HD
Vascepa	Hypertriglyceridemia	Prior authorization required		fenofibrate, fenofibric acid, gemfibrozil, Trilipix

*Step therapy required

GENERIC DRUGS WITH RESTRICTIONS

The following drugs are newly available **GENERIC** drugs that were **ADDED to the Formulary with coverage restrictions** (generic drugs are otherwise covered on formulary):

Newly available generic	Coverage Restriction	Medicare status (if differs)
acetaminophen-codeine, unit dose cup	Prior authorization required	Non Formulary
candesartan/hydrochlorothiazide (brand name: Atacand HCT)	Step therapy required	
desloratadine (brand name: Clarinex Reditabs)	Step therapy required	
lamotrigine (brand name: Lamictal XR)	Step therapy required	Formulary
lithium citrate, unit dose cup	Prior authorization required	Non Formulary
megestrol acetate suspension, unit dose cup	Prior authorization required	Non Formulary
pioglitazone/glimepiride (brand name: Duetact)	Step therapy required	
tranexamic acid (brand name: Lysteda)	Prior authorization required	

DRUGS ADDED TO THE BLUE SHIELD SPECIALTY TIER

The following drugs were **ADDED** to the Blue Shield Specialty Tier

- Refer to member benefit summary for applicable member share of cost.
- These drugs are obtained through the BSC specialty pharmacy network (excluding Medicare plans).

Specialty Drug	Coverage Restriction	Medicare status
Cometriq	Prior authorization required	Prior authorization required

Specialty Drug	Coverage Restriction	Medicare status
Iclusig	Prior authorization required	Prior authorization required
Juxtapid	Prior authorization required	Prior authorization required
Kynamro	Prior authorization required	Prior authorization required
Pomalyst	Prior authorization required	Prior authorization required
Xeljanz	Prior authorization required	Prior authorization required

DRUGS ADDED TO FORMULARY

The following drugs were **ADDED** to the Formulary:

Drug	Coverage Restriction	Medicare status (if differs)
Auvi-Q		
Edarbi/ Edarbyclor	Step therapy required	
Eliquis	Prior authorization required	
Lotemax 0.5% ophthalmic gel		

OFFICE-ADMINISTERED MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **March 21, 2013** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → For Providers → Authorizations → Clinical Policies and Guidelines → Medication Policy → Medication Policy List" .

Refer to medication policy for complete details. For description of change, refer to top of medication policy.

- *Abraxane - Updated*
- *Gattex - New*
- *Jetrea - New*
- *Kynamro - New*
- *Neumega - Updated*
- *N Plate - Updated*
- *Rituxan - Updated*
- *Signifor - New*
- *Synribo - Updated*

The following medication coverage policies were sunseted:

- ganciclovir

For additional information, please call 1-800-535-9481

**BLUE SHIELD OF CALIFORNIA
SECOND QUARTER 2013 FORMULARY AND MEDICATION POLICY UPDATES**

EFFECTIVE JUNE 20, 2013

The Blue Shield of California (BSC) Pharmacy and Therapeutics (P&T) Committee, consisting of network physicians and pharmacists, regularly evaluates drugs for formulary inclusion and medication policy coverage criteria. The Second Quarter 2013 P&T Committee decisions on formulary changes, which apply to all members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please consult the Blue Shield of California Drug Database and Formulary search tool for the following information (available at blueshieldca.com → select “pharmacy” hyperlink):

- *Quantity limits, if applicable, for specific drugs*
- *Formulary status of newly available strengths of existing drugs. Note: The formulary status of newly available strengths of existing drugs will have the same formulary status as the existing strengths unless otherwise noted.*
- *Non-formulary drugs and generic drugs that do not require prior authorization or step-edit*
- *Brand-name medications that are now non-formulary because these medications have newly available generic equivalents covered on the formulary*

For Medicare beneficiaries who are enrolled in an employer group Medicare Part D plan, the commercial formulary status applies unless otherwise stated.

Note:

*Medicare “**Statutory exclusion**” = drugs excluded for Medicare Part D under the Social Security Act section 1927(d)(2); those that have not been approved by the FDA; and those that do not meet the definition of a Part D drug as described by the Social Security Act section 1927(k).*

DRUGS REMOVED FROM FORMULARY

The following drug(s) were **REMOVED from the Formulary**, effective 09/05/2013 for commercial plans

- *These drugs are available at the non-formulary brand copayment except for members with a closed formulary benefit, or where prior authorization is required for coverage.*

Drug	Coverage Restriction	Medicare status (if differs)	Rationale for Decision	Formulary Alternatives
Asacol HD	Step therapy required	(effective 2014)	More cost effective alternatives available	Apriso, Lialda

DRUGS NOT ADDED to FORMULARY

The following drugs were **NOT added to the Formulary as they do not have a clear advantage over formulary products. These drugs may have additional coverage restrictions as noted.**

- *Refer to member benefit summary for applicable member share of cost*

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Delzicol	Ulcerative colitis	Step therapy required		Apriso, Lialda
desvenlafaxine ER	Depression	Step therapy required		Pristiq*
Diclegis	Nausea/vomiting of pregnancy	Prior authorization required	Statutory exclusion	

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Fulyzaq	Non infectious diarrhea in those with HIV/AIDs on antiretroviral therapy	Prior authorization required		diphenoxylate/atropine
Invokana	Type 2 diabetes	Step therapy required		metformin, sulfonylureas, pioglitazone*, Januvia*, Janumet*
Liptruzet	Hyperlipidemia	Step therapy required		atorvastatin
Osphena	Dyspareunia	Prior authorization required	Statutory exclusion	Estrace vaginal cream, Premarin vaginal cream, Vagifem, Estring
Prolensa	Ocular inflammation and pain post cataract surgery			Ophthalmic NSAIDs (e.g. bromfenac, diclofenac, ketorolac drops); Lotemax ophth drops and gel
Simbrinza	Glaucoma			Azopt, brimonidine, dorzolamide, Alphagan P, apraclonidine ophth drops
Topicort Spray	Plaque Psoriasis	Prior authorization required		desoximetasone oint, crm, gel; betamethasone dipropionate crm, oint; diflorasone crm, oint; fluocinonide crm, gel, oint, solu

*Step therapy required

GENERIC DRUGS WITH RESTRICTIONS

The following drugs are newly available **GENERIC** drugs that were **ADDED to the Formulary with coverage restrictions** (generic drugs are otherwise covered on formulary):

Newly available generic	Coverage Restriction	Medicare status (if differs)
fluvoxamine maleate (brand name: Luvox CR)	Step therapy required	
clobetasol propionate emollient (brand name: Olux-E)	Prior authorization required	
tretinoin gel, tretinoin pump (brand name: Retin-A Micro)	Restricted to age ≤ 40 and Step therapy required	
buprenorphine/naloxone tablet (brand name: Suboxone)	Prior authorization required	

DRUGS ADDED TO THE BLUE SHIELD SPECIALTY TIER

The following drugs were **ADDED** to the Blue Shield Specialty Tier

- Refer to member benefit summary for applicable member share of cost.
- These drugs are obtained through the BSC specialty pharmacy network (excluding Medicare plans).

Specialty Drug	Coverage Restriction	Medicare status
Cystaran Ophthalmic Drops	Prior authorization required	Prior authorization required
Ravicti	Prior authorization required	Statutory exclusion
Signifor	Prior authorization required	Prior authorization required
Sirturo	Prior authorization required	Prior authorization required
Tecfidera	Prior authorization required	Prior authorization required
Tobi Podhaler	Prior authorization required	Prior authorization required

DRUGS ADDED TO FORMULARY

The following drugs were **ADDED** to the Formulary:

Drug	Coverage Restriction	Medicare status (if differs)
Brilinta		
Effient		
Lialda		

DRUGS WITH NEW RESTRICTIONS

The following brand and generic drugs **remain at their current Formulary status but have NEW coverage restrictions as noted:**

Drug	Current Formulary Status	New Restriction	Medicare status (if differs)
Androgel	Formulary	Prior authorization required	(effective 2014)
Android	Formulary	Prior authorization required	Non Formulary with Prior authorization required
Anadrol-50	Non Formulary	Prior authorization required	Non Formulary with Prior authorization required
Beconase AQ	Non Formulary	Step therapy required	(effective 2014)
fluoymesterone (brand name: Androxy)	Generic	Prior authorization required	(effective 2014)
Methitest	Formulary	Prior authorization required	Non Formulary with Prior authorization required
oxandrolone (brand name: Oxandrin)	Generic	Prior authorization required	
Testred	Formulary	Prior authorization required	Non Formulary with Prior authorization required
tramadol ER tablet (brand name: Ultram ER)	Generic	Step therapy required	

OFFICE-ADMINISTERED MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **June 20, 2013** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → For Providers → Authorizations → Clinical Policies and Guidelines → Medication Policy → Medication Policy List.

Refer to medication policy for complete details. For description of change, refer to top of medication policy.

- *Abraxane - Updated*
- *Actemra - Updated*
- *Alimta - Updated*
- *Avastin - Updated*
- *Benlysta - Updated*
- *Botox - Updated*
- *Cimzia - Updated*
- *Enbrel - Updated*
- *Gattex - Updated*
- *Humira - Updated*
- *Ilaris - Updated*
- *IVIg - Updated*
- *Kadcyla - New*
- *Kineret - Updated*
- *Kynamro - Updated*
- *Kyprolis - Updated*
- *Orencia - Updated*
- *Proleukin - Updated*
- *Remicade - Updated*
- *Rituxan - Updated*
- *Simponi - Updated*
- *Sumatriptan Injection - Updated*
- *Torisel - Updated*
- *Treanda - Updated*
- *Xolair - Updated*

For additional information, please call 1-800-535-9481

**BLUE SHIELD OF CALIFORNIA
THIRD QUARTER 2013 FORMULARY AND MEDICATION POLICY UPDATES**

EFFECTIVE SEPTEMBER 26, 2013

The Blue Shield of California (BSC) Pharmacy and Therapeutics (P&T) Committee, consisting of network physicians and pharmacists, regularly evaluates drugs for formulary inclusion and medication policy coverage criteria. The Third Quarter 2013 P&T Committee decisions on formulary changes, which apply to all members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please consult the Blue Shield of California Drug Database and Formulary search tool for the following information (available at blueshieldca.com → select “pharmacy” hyperlink):

- *Quantity limits, if applicable, for specific drugs*
- *Formulary status of newly available strengths of existing drugs. Note: The formulary status of newly available strengths of existing drugs will have the same formulary status as the existing strengths unless otherwise noted.*
- *Non-formulary drugs and generic drugs that do not require prior authorization or step-edit*
- *Brand-name medications that are now non-formulary because these medications have newly available generic equivalents covered on the formulary*

For Medicare beneficiaries who are enrolled in an employer group Medicare Part D plan, the commercial formulary status applies unless otherwise stated.

Note:

*Medicare “**Statutory exclusion**” = drugs excluded for Medicare Part D under the Social Security Act section 1927(d)(2); those that have not been approved by the FDA; and those that do not meet the definition of a Part D drug as described by the Social Security Act section 1927(k).*

DRUGS NOT ADDED to FORMULARY

The following drugs were **NOT added to the Formulary as they do not have a clear advantage over formulary products. These drugs may have additional coverage restrictions as noted.**

- *Refer to member benefit summary for applicable member share of cost*

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Astagraf XL	Immunosuppressant			tacrolimus
Belviq	Obesity/weight loss	Prior authorization required	Statutory exclusion	
Breo Ellipta	COPD			Advair, Symbicort
Brisdelle	Menopausal vasomotor symptoms			
Epaned	Hypertension			enalapril
Esomeprazole strontium	GERD	Step therapy required		omeprazole, lansoprazole, pantoprazole, Dexilant
Fabior	Acne	Restricted to age ≤ 40 and Step therapy required		tretinoin, tretinoin microsphere

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Nymalize	Subarachnoid hemorrhage			nimodipine
Onfi Suspension	Seizures	Prior authorization required		clonazepam, felbamate, lamotrigine, topiramate, Banzel
Quartette	Contraception			Velivent, Caziant
Trokendi XR	Seizures	Prior authorization required		topiramate
Zenzedi	Narcolepsy, ADHD			dextroamphetamine, Adderall XR, amphetamine/d-amphetamine
Zubsolv	Opioid dependence	Prior authorization required	Statutory exclusion	buprenorphine/naloxone

GENERIC DRUGS WITH RESTRICTIONS

The following drugs are newly available **GENERIC** drugs that were **ADDED to the Formulary with coverage restrictions** (generic drugs are otherwise covered on formulary):

Newly available generic	Coverage Restriction	Medicare status (if differs)
donepezil 23mg (brand name: Aricept)	Step therapy required	
candesartan (brand name: Atacand)	Step therapy required	

DRUGS ADDED TO THE BLUE SHIELD SPECIALTY TIER

The following drugs were **ADDED** to the Blue Shield Specialty Tier

- Refer to member benefit summary for applicable member share of cost.
- These drugs are obtained through the BSC specialty pharmacy network (excluding Medicare plans).

Specialty Drug	Coverage Restriction	Medicare status
Cystagon	Prior authorization required	Prior authorization required
Gilotrif	Prior authorization required	Prior authorization required
Mekinist	Prior authorization required	Prior authorization required
Procysbi	Prior authorization required	Prior authorization required
Stelara SC	Prior authorization required	Prior authorization required
Tafinlar	Prior authorization required	Prior authorization required
temozolomide (brand name: Temodar)		

DRUGS ADDED TO FORMULARY

The following drugs were **ADDED** to the Formulary:

Drug	Coverage Restriction	Medicare status (if differs)
Suprep Bowel Prep Kit		
Tivicay		

OFFICE-ADMINISTERED MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **September 26, 2013** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → For Providers → Authorizations → Clinical Policies and Guidelines → Medication Policy → Medication Policy List.

Refer to medication policy for complete details. For description of change, refer to top of medication policy.

- Abilify Maintena - *New*
- Acthar - *Updated*
- Actemra - *Updated*
- Adcetris - *Updated*
- Avastin - *Updated*
- Cimzia - *Updated*
- Enbrel - *Updated*
- Flolan - *Updated*
- Growth Hormone - *Updated*
(Genotropin, Humatrope, Nutropin/Nutropin AQ, Norditropin, Saizen, Tev-Tropin, Omnitrope)
- Halaven - *Updated*
- Humira - *Updated*
- IVIG - *Updated*
- Kineret - *Updated*
- Marqibo - *New*
- Mycamine - *Updated*
- Naglazyme - *Updated*
- Octreotide/Sandostatin LAR - *Updated*
- Orencia - *Updated*
- Revatio - *Updated*
- Remicade - *Updated*
- Remodulin - *Updated*
- Rituxan - *Updated*
- Simponi - *Updated*
- Stelara - *Updated*
- Tysabri - *Updated*
- Tyvaso - *Updated*
- Ventavis - *Updated*
- Xgeva - *Updated*
- Veletri - *Updated*

The following medical policy was sunseted:

- Ceredase

For additional information, please call 1-800-535-9481

BLUE SHIELD OF CALIFORNIA
FOURTH QUARTER 2013 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE DECEMBER 17, 2013

The Blue Shield of California (BSC) Pharmacy and Therapeutics (P&T) Committee, consisting of network physicians and pharmacists, regularly evaluates drugs for formulary inclusion and medication policy coverage criteria. The Fourth Quarter 2013 P&T Committee decisions on formulary changes, which apply to all members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please consult the Blue Shield of California Drug Database and Formulary search tool for the following information (available at blueshieldca.com → go to the Pharmacy tab, select Plus Drug Formulary):

- *Quantity limits, if applicable, for specific drugs*
- *Formulary status of newly available strengths of existing drugs. Note: The formulary status of newly available strengths of existing drugs will have the same formulary status as the existing strengths unless otherwise noted.*
- *Non-formulary drugs and generic drugs that do not require prior authorization or step-edit*
- *Brand-name medications that are now non-formulary because these medications have newly available generic equivalents covered on the formulary*

For Medicare beneficiaries who are enrolled in an employer group Medicare Part D plan, the commercial formulary status applies unless otherwise stated.

Note:

Medicare "Statutory exclusion" = drugs excluded for Medicare Part D under the Social Security Act section 1927(d)(2); those that have not been approved by the FDA; and those that do not meet the definition of a Part D drug as described by the Social Security Act section 1927(k).

DRUGS NOT ADDED to FORMULARY

The following drugs were **NOT added to the Formulary as they do not have a clear advantage over formulary products. These drugs may have additional coverage restrictions as noted.**

- *Refer to member benefit summary for applicable member share of cost*

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Aciphex Sprinkle	GERD	Step therapy required		omeprazole, lansoprazole, pantoprazole, Dexilant
Brintellix	Depression	Step therapy required	Non-preferred brand Step therapy required	bupropion, generic SSRI's, venlafaxine IR/ER, Cymbalta, Pristiq*
Fetzima	Depression	Prior Authorization Required	Non-preferred brand Prior Authorization Required	bupropion, generic SSRI's, venlafaxine IR/ER, Cymbalta, Pristiq*
Glycate	Peptic ulcer	Step therapy required		glycopyrrolate
Khedeza	Depression	Step therapy required	Non-preferred brand Step therapy required	Pristiq*
Mirvaso	Erythema from Acne rosacea		Non-preferred brand	metronidazole topical, sulfacetamide sod/sulfur topicals

*Requires PA

Drug	Indication	Coverage Restriction	Medicare status (if differs)	Formulary Alternatives
Versacloz	Schizophrenia		Specialty Tier	clozapine, clozapine odt
Zorvolex	Pain (NSAID)	Step therapy required		generic prescription NSAIDs, (including diclofenac)

GENERIC DRUGS WITH RESTRICTIONS

The following drugs are newly available **GENERIC** drugs that were **ADDED to the Formulary with coverage restrictions** (generic drugs are otherwise covered on formulary):

Newly available generic	Coverage Restriction	Medicare status (if differs)
clonidine ER (brand name: Kapvay)	Prior authorization required	
voriconazole (brand name: Vfend)	Prior authorization required	

DRUGS ADDED TO THE BLUE SHIELD SPECIALTY TIER

The following drugs were **ADDED** to the Blue Shield Specialty Tier

- Refer to member benefit summary for applicable member share of cost.
- These drugs are obtained through the BSC specialty pharmacy network (excluding Medicare plans).

Specialty Drug	Coverage Restriction	Medicare status
Actemra SC	Prior authorization required	Prior authorization required
Adempas	Prior authorization required	Prior authorization required
Bethkis	Prior authorization required	Prior authorization required, and Part B vs. D review
Imbruvica	Prior authorization required	Prior authorization required
Opsumit	Prior authorization required	Prior authorization required
Valchlor	Prior authorization required	Prior authorization required

DRUGS ADDED TO FORMULARY

The following drugs were **ADDED** to the Formulary:

Drug	Coverage Restriction	Medicare status (if differs)
Breo Ellipta		

DRUGS WITH NEW RESTRICTIONS

The following brand and generic drugs **remain at their current Formulary status but have NEW coverage restrictions as noted:**

Drug	Current Formulary Status	New Restriction	Medicare status (if differs)
Oxytrol	Non Formulary Step therapy required	Coverage excluded for females due to availability of "Oxytrol for Women [®] " over the counter	Non Formulary Step therapy required

OFFICE-ADMINISTERED MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **December 17, 2013** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → For Providers → Authorizations → Clinical Policies and Guidelines → Medication Policy → Medication Policy List.

Refer to medication policy for complete details. For description of change, refer to top of medication policy.

- *Abraxane – Updated*
- *Actemra – Updated*
- *Arcalyst – Updated*
- *Cimzia – Updated*
- *Erbix – Updated*
- *Folotyn – Updated*
- *Gazyva – New*
- *Granix – New*
- *Growth Hormones – Updated* (*Genotropin, Humatrope, Nutropin/Nutropin AQ, Norditropin, Saizen, Tev-Tropin, Omnitrope*)
- *Hizentra – Updated*
- *Humira – Updated*
- *Ilaris – Updated*
- *Increlex – Updated*
- *Neupogen – Updated*
- *Perjeta – Updated*
- *Stelara – Updated*
- *Treanda – Updated*
- *Vectibix – Updated*

The following medical policies were discontinued:

- *Natrecor*
- *Temodar intravenous*

For additional information, please call 1-800-535-9481