BLUE SHIELD OF CALIFORNIA
FIRST QUARTER 2016 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE MARCH 17, 2016

for Large Group, Small Group, and Individual & Family Plans

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 2016 P&T Committee decisions on formulary changes, which apply to Commercial members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information available at blueshieldca.com → drop down "Members", select "Pharmacy" under Public Links, and select the appropriate drug formulary – Standard Drug Formulary, or 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 or non-preferred and generic drugs that do not require prior authorization or step therapy*
- *Brand-name medications that are now non-formulary or non-preferred because these medications have newly available generic equivalents covered on the formulary*

Summary of changes to the Medicare formularies are available at blueshieldca.com → drop down "Members", select "Pharmacy" under Public Links, select "Medicare Drug Formulary", select the appropriate plan, and select the "Summary of Changes" PDF.

DRUGS MOVED to NON-FORMULARY

The following drug(s) were moved to the non-formulary brand tier for Plus and removed from the Standard Formulary as noted.

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

Drug	Coverage Restriction	Standard Formulary (if differs)	Rationale for Decision	Plus Formulary Alternatives
Azilect		(effective 2017)	Cost effective alternatives available	selegiline (generic Eldepryl)
Bydureon, Bydureon pen, Byetta	Step therapy required	(effective 2017)	Cost effective alternatives available	metformin, glipizide, glyburide, or TZD; Tanzeum (requires step therapy with 1st line antidiabetic agent)
Capex shampoo	Prior authorization required	Non formulary	Cost effective alternatives available	Try 2 preferred medium potency topical steroids
Kazano, Nesina, Oseni	Step therapy required	(effective 2017)	Cost effective alternatives available	Januvia, Janumet/ Janumet XR (requires step with 1st line antidiabetic agent)
Levemir	Step therapy required	(effective 2017)	Cost effective alternatives available	Lantus, Toujeo

Drug	Coverage Restriction	Standard Formulary (if differs)	Rationale for Decision	Plus Formulary Alternatives
Nasonex	Step therapy required	(effective 2017)	Cost effective alternatives available	fluticasone nasal spray (generic Flonase)
Nuvigil	Prior authorization required	(effective 2017)	Cost effective alternatives available	modafinil

DRUGS NOT ADDED to FORMULARY

The following drugs were NOT added to the Plus or Standard Drug 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	Standard Formulary (if differs)	Plus Formulary Alternatives
Allzital	Headache	Prior authorization required		bupap 50/300mg, butalbital/APAP 50/325mg
Belbuca	Severe Pain/Narcotic analgesic	Prior authorization required		morphine sulfate er
Dyanavel XR suspension	ADHD	Step therapy required		2 preferred amphetamines: Adderall XR, amphetamine salt combo, dextroamphetamine, dextroamphetamine – amphetamine
Enstilar foam	Psoriasis	Prior authorization required		betamethasone/ calcipotriene (generic Taclonex)
Quillichew ER	ADHD	Prior authorization required		metadate er, methyl-phenidate extended release
Vivlodex	NSAID	Prior authorization required		2 generic NSAIDs including meloxicam (non- micronized)
Vraylar	Atypical Antipsychotic	Prior authorization required		aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone

GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Plus or Standard Drug Formularies with coverage restrictions (other new generic drugs are covered on formulary without restrictions):

Newly available generic	Coverage Restriction	Standard Formulary (if differs)
dutasteride/tamsulosin *(generic for Jalyn)*	Prior authorization required	
metformin extended release *(generic for Glumetza)*	Prior authorization required	
repaglinide/metformin *(generic for Prandimet)*	Prior authorization required	
linezolid *(generic for Zyvox suspension)*	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	Standard Formulary (if differs)
Alecensa	Prior authorization required	
Chenodal	Prior authorization required	
Uptravi	Prior authorization required	
Veltassa	Prior authorization required	
Viberzi	Prior authorization required	
Xuriden	Prior authorization required	
Zepatier	Prior authorization required	

EXISTING DRUGS with NEW RESTRICTIONS

The following drugs have no change in formulary status in 2016, but have NEW restrictions as noted

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary (if differs)
Aromasin	Non formulary	Prior authorization required	NA
exemestane (generic for Aromasin)	Generic	Prior authorization required	NA
Dibenzyline	Non formulary	Prior authorization required	NA
phenoxybenzamine (generic for Dibenzyline)	Generic	Prior authorization required	NA
Entocort EC	Non formulary	Prior authorization required	NA
budesonide EC (generic for Entocort EC)	Generic	Prior authorization required	NA
Evzio	Non formulary	Prior authorization required	
Fortamet	Non formulary	Prior authorization required	
metformin er (generic for Fortamet)	Generic	Prior authorization required	
Migranal	Non formulary	Step therapy required	NA
dihydroergotamine mesylate nasal spray (generic for Migranal)	Generic	Step therapy required	NA

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary (if differs)
Quillivant XR	Non formulary	Prior authorization required if >12 years of age	
Seroquel XR	Formulary brand	Step therapy required	NA
Tresiba Flextouch	Non formulary	Step therapy required	NA
Topical Corticosteroids			
Ala-Scalp	Non formulary	Step therapy required	NA
amcinonide cream, lotion, ointment	Generic	Step therapy required	NA
ApexiConE	Generic	Step therapy required	NA
betamethasone valerate (generic Luxiq foam)	Generic	Step therapy required	NA
Cloderm cream	Non formulary	Step therapy required	NA
clocortolone pivalate (generic Cloderm cream)	Generic	Step therapy required	NA
Cordran cream, lotion, ointment, tape	Non formulary	Prior authorization required	NA
Cutivate lotion	Non formulary	Step therapy required	NA
fluticasone (generic for Cutivate)	Generic	Step therapy required	NA
Dema Smoothe FS scalp oil, body oil	Non formulary	Step therapy required	NA
fluocinolone (generic for Derma Smoothe FS scalp oil, body oil)	Generic	Step therapy required	NA
Desowen lotion	Non formulary	Step therapy required	NA
desonide lotion (generic for Desowen)	Generic	Step therapy required	NA
desoximetasone (generic for Topicort cream, gel. ointment)	Generic	Step therapy required	NA
diflorasone cream, ointment	Generic	Step therapy required	NA
hydrocortisone butyrate emollient cream (generic for Locoid emollient)	Generic	Step therapy required	NA
Locoid lotion, Locoid Lipocream	Non formulary	Prior authorization required	NA
Scalacort (hydrocortisone 2% lotion)	Generic	Steph therapy required	NA
Synalar solution	Non formulary	Step therapy required	NA

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary (if differs)
fluocinolone solution (generic Synalar solution)	Generic	Step therapy required	NA
Trianex ointment	Generic	Step therapy required	
Verdeso	Non formulary	Prior authorization required	NA
Vytone cream	Non formulary	Excluded	

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus or Standard Formulary as noted:

Drug	Coverage Restriction	Standard Formulary (if differs)
cyclopentolate *(generic for Cyclogyl)*		
fluticasone propionate *(generic for Flonase)*		
naloxone 0.4mcg/mL vials, syringes		
Tanzeum	Step therapy required	
Toujeo Solostar		(effective 2017)

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **March 17, 2016** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → 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.

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

- Adcetris – *Updated*
- Abraxane - *Updated*
- Alimta – *Updated*
- Anti-TNF therapies (Cimzia, Enbrel, Humira, Remicade, Simponi)- *Updated*
- Arzerra - *Updated*
- Avastin - *Updated*
- Bendeka - *New*
- Cosentyx - *Updated*
- Gazyva – *Updated*
- Halaven – *Updated*
- Human Growth Hormones (Genotropin, Humatrope, Norditropin, Omnitrope, Saizen, Tev-Tropin, Zomacton)- *Updated*
- Kanuma – *New*

- Kyprolis - *Updated*
- Makena, 17-a hydroxyprogesterone - *Updated*
- Neulasta - *Updated*
- Portrazza – *Updated*
- Repatha - *Updated*

BLUE SHIELD OF CALIFORNIA
SECOND QUARTER 2016 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE JUNE 16, 2016
for Large Group, Small Group, and Individual & Family Plans

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 2016 P&T Committee decisions on formulary changes, which apply to Commercial members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information available at blueshieldca.com → drop down "Members", select "Pharmacy" under Public Links, and select the appropriate drug formulary – Standard Drug Formulary, or 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 and non-preferred generic drugs that do not require prior authorization or step therapy*
- *Brand-name medications that are now non-formulary or non-preferred because these medications have newly available generic equivalents covered on the formulary*

Summary of changes to the Medicare formularies are available at blueshieldca.com → drop down "Members", select "Pharmacy" under Public Links, select "Medicare Drug Formulary", select the appropriate plan, and select the "Summary of Changes" PDF.

DRUGS REMOVED from FORMULARY

The following drug(s) were moved to the non-formulary tier for Plus, or removed from the Standard Formulary, or excluded from the Plus or Standard Formulary.

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

Drug	Coverage Restriction	Standard Formulary (if differs)	Rationale for Decision	Plus Formulary Alternatives
budesonide nasal spray (generic Rhinocort Aqua)	Excluded		OTC equivalent available (Rhinocort® Allergy Spray); Cost effective alternatives available	flunisolide nasal (generic Nasarel) fluticasone nasal (generic Flonase)
One Touch Blood Glucose Test Strips (*effective 10/5/2016*)	Prior authorization required		Cost effective alternatives available	Accu-chek Blood Glucose Test Strips
ProAir HFA, Pro Air Respimat (*effective 8/8/2016*)	Step therapy required	(effective 2017)		Ventolin HFA
Sumavel Dosepro	Step therapy required		Cost effective alternatives available	sumatriptan vial, prefilled syringe, or prefilled cartridge

DRUGS NOT ADDED to FORMULARY

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

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

Drug	Indication	Coverage Restriction	Standard Formulary (if differs)	Plus Formulary Alternatives
Adzenys XR-ODT	ADHD	Prior authorization required		Adderall XR
Briviact tablet, oral solution	Seizures	Prior authorization required		levetiracetam solution or tablet
Onzetra Xsail	Migraine	Prior authorization required		sumatriptan nasal spray, tablet, or injection
Xtampza ER	Pain (oxycodone myristate)	Prior authorization required		oxycodone er (generic Oxycontin)
Sernivo	Psoriasis (topical steroid)	Prior authorization required		2 preferred high to very high preferred potency topical steroids
Spritam	Seizures	Prior authorization required		levetiracetam solution or tablet
Zembrace Symtouch	Migraine	Prior authorization required		sumatriptan vial, prefilled syringe, or prefilled cartridge

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Plus or Standard Drug Formularies with coverage restrictions (other new generic drugs are covered on formulary without restrictions):

Newly available generic	Coverage Restriction	Standard Formulary (if differs)
alogliptin *(generic for Nesina)*	Step therapy required	
alogliptin/metformin *(generic for Kazano)*	Step therapy required	
alogliptin/pioglitazone *(generic for Oseni)*	Step therapy required	
benzphetamine *(generic for Regimex)*	Prior authorization required	
clindamycin/benzoylperoxide *(generic for Benzaclin)*	Step therapy required	Non formulary, Step therapy required
darifenacin hydrobromide *(generic for Enablex)*	Step therapy required	
flurandrenolide *(generic for Cordran cream)*	Prior authorization required	Non formulary
frovatriptan succinate *(generic for Frova)*	Step therapy required	
mebendazole *(generic for Emverm)*	Prior authorization required	
mometasone furoate *(generic for Nasonex)*	Step therapy required	

Newly available generic	Coverage Restriction	Standard Formulary (if differs)
oxiconazole nitrate *(generic for Oxistat)*	Step therapy required	
oxycodone extended release 15mg, 30mg, 60mg *(generic for Oxycontin tablet)*	Prior authorization required	
quazepam *(generic for Doral)*	Prior authorization required if ≥ 65 years of age and > 90 days cumulative therapy	
zolpidem tartrate *(generic for Intermezzo)*	Prior authorization required, if ≥ 65 years of age and > 90 days cumulative therapy	

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	Standard Formulary (if differs)
Cabometyx	Prior authorization required	
Impavido	Prior authorization required	
Nuplazid	Prior authorization required	
Taltz	Prior authorization required	
Venclexta	Prior authorization required	
Vistogard	Prior authorization required	

EXISTING DRUGS with NEW RESTRICTIONS

The following drugs have no change in formulary status in 2016, but have NEW restrictions as noted effective 9/1/2016

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary (if differs)
Medications and Stimulants for ADHD			
dexamphetamine oral solution (generic for Procentra	Generic	Prior authorization required	NA
dextroamphetamine sulfate (generic Dexedrine)	Generic	Prior authorization required	NA
dextroamphetamine sulfate ER (generic for Dexedrine Spansule)	Generic	Prior authorization required	NA
methamphetamine (generic Desoxyn)	Generic	Prior authorization required	NA

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary (if differs)
Medications and Stimulants for ADHD cont'd			
dexmethylphenidate ER (generic for Focalin XR)	Generic	Prior authorization required	NA
methylphenidate CD (generic Metadate CD)	Generic	Prior authorization required	NA
methylphenidate ER, Metadate ER	Generic	Prior authorization required	NA
Adderall (IR)	Non formulary	Prior authorization required	NA
Aptensio XR	Non formulary	Prior authorization required	NA
Daytrana	Non formulary	Prior authorization required	NA
Desoxyn	Non formulary	Prior authorization required	NA
Dexedrine	Non formulary	Prior authorization required	NA
Dexedrine Spansule	Non formulary	Prior authorization required	NA
Evekeo	Non formulary, Step therapy required	Prior authorization required	NA
Focalin	Non formulary	Prior authorization required	NA
Focalin XR	Non formulary	Prior authorization required	NA
Metadate CD	Non formulary	Prior authorization required	NA
Ritalin LA	Non formulary	Prior authorization required	NA
Zenzedi	Non formulary	Prior authorization required	NA
Antihyperlipidemics and Antihyperlipidemc Combinations			
amlodipine-atorvastatin (generic for Caduet)	Generic	Prior authorization required	NA
fenofibrate (generic for Fenoglide)	Generic	Step therapy required	NA
fluvastatin, fluvastatin XL (generic for Lescol, Lescol XL)	Generic	Prior authorization required	NA
Antara	Non formulary	Step therapy required	NA
Caduet	Non formulary	Prior authorization required	NA
Fenoglide	Non formulary	Step therapy required	NA
Lescol, Lescol XL	Non formulary	Prior authorization required	NA
Triglide	Non formulary	Step therapy required	NA

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary (if differs)
Gastrointestinal Agents (Proton Pump Inhibitors)			
esomeprazole magnesium (generic for Nexium)	Generic	Prior authorization required	NA
omeprazole-sodium bicarbonate (generic for Zegerid)	Generic	Prior authorization required	NA
rabeprazole (generic for Aciphex)	Generic	Prior authorization required	NA
Aciphex	Non formulary	Prior authorization required	NA
Nexium	Non formulary	Prior authorization required	NA
Zegerid	Non formulary	Prior authorization required	NA
Multiple Sclerosis Agents			
Avonex	Specialty	Prior authorization required	NA
Glatopa	Specialty	Prior authorization required	
Rebif	Specialty	Prior authorization required	NA
Miscellaneous Agents			
doxycycline hyclate (generic for Doryx)	Generic	Prior authorization required	NA
Proventil HFA *(effective 8/8/2016)*	Non formulary	Step therapy required	NA

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus or Standard Formulary as noted:

Drug	Coverage Restriction	Standard Formulary (if differs)
Descovy		
Odefsey		Non formulary
Ventolin HFA* **currently formulary for Plus*		*(effective 8/8/2016)*
Viagra *(effective 7/1/2016)*	Prior authorization required	

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **June 16, 2016** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → 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.

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

- Abraxane - *Updated*
- Biologics for plaque psoriasis and/or psoriatic arthritis (Enbrel, Cimzia, Cosentyx, Humira, Remicade, Simponi, Stelara - *Updated*

- Cinqair - *New*
- Defitelio - *New*
- Evomela – *New*
- Gazyva – *Updated*
- GnRH analogs (Firmagon, Supprelin LA, Vantas) - *Updated*
- Hymovis - *New*
- Immune Globulins, IV and SC - *Updated*
- Multiple Sclerosis Agents (Avonex, Betaseron, Copaxone/glatiramer, Extavia, Lemtrada, Plegridy, Rebif, Tysabri)- *Updated*
- Rituxan - *Updated*
- Taltz – *New*
- Tecentriq – *New*

The following policies were sunsetted:

- *peginterferon alfa-2a (Pegasys)*
- *peginterferon alfa-2b (PEG-Intron)*

BLUE SHIELD OF CALIFORNIA
THIRD QUARTER 2016 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE SEPTEMBER 15, 2016
for Large Group, Small Group, and Individual & Family Plans

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 2016 P&T Committee decisions on formulary changes, which apply to Commercial members with an outpatient drug benefit, and medication policy changes are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information available at blueshieldca.com → drop down "Members", select "Pharmacy" under Public Links, and select the appropriate drug formulary – Standard Drug Formulary, or 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 and non-preferred generic drugs that do not require prior authorization or step therapy*
- *Brand-name medications that are now non-formulary or non-preferred because these medications have newly available generic equivalents covered on the formulary*

Summary of changes to the Medicare formularies are available at blueshieldca.com → drop down "Members", select "Pharmacy" under Public Links, select "Medicare Drug Formulary", select the appropriate plan, and select the "Summary of Changes" PDF.

DRUGS NOT ADDED to FORMULARY

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

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

Drug	Indication	Coverage Restriction	Standard Formulary (if differs)	Plus Formulary Alternatives
Bevespi Aerosphere	COPD	Step therapy required		Anoro Ellipta
Byvalson	Hypertension	Step therapy required		Beta blockers: acebutolol, atenolol, betaxolol, bisoprolol, metoprolol
Delzicol	Ulcerative Colitis	Step therapy required		Apriso, Lialda
Obrelis oral solution	Hypertension, CHF, post MI	Prior authorization required		lisinopril oral tablet
Xiidra	Dry Eyes	Prior authorization required		Restasis
Emend powder for oral suspension	Chemotherapy induced N/V	Prior authorization required		

NEW GENERICS with RESTRICTIONS

The following drugs are <u>newly available</u> GENERIC drugs that were <u>ADDED to the Plus or Standard Drug Formularies with coverage restrictions</u> (other new generic drugs are covered on formulary without restrictions):

Newly available generic	Coverage Restriction	Standard Formulary (if differs)
armodafinil *(generic for Nuvigil)*	Prior authorization required	Non preferred brand, Prior authorization required (2017: Non formulary, Prior authorization required)
clindamycin/tretinoin *(generic for Veltin)*	Step therapy required, PA required if age > 40 years	Non formulary, Step therapy required, PA required if age > 40 years
doxycycline hyclate *(generic for Doryx 50mg, 200mg delayed Release tab)*	Prior authorization required	Non formulary, Prior authorization required
ethacrynic acid *(generic for Edecrin)*	Prior authorization required	Non formulary, Prior authorization required
omeprazole/sodium bicarbonate *(generic for Zegerid)*	Prior authorization required	Step therapy required (2017: Non formulary, Prior authorization required)
oxycodone 10mg/0.5mL oral solution, unit dose syringe	Prior authorization required	Non formulary Prior authorization required

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were <u>ADDED</u> 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*

Specialty Drug	Coverage Restriction	Standard Formulary (if differs)
Epclusa	Prior authorization required	
nilutamide *(generic for Nilandron)*		Prior authorization required
Ocaliva	Prior authorization required	
Orencia ClickJect	Prior authorization required	
Orfadin suspension	Prior authorization required	
Repatha Pushtronex	Prior authorization required	
Viekira XR	Prior authorization required	
Zinbryta	Prior authorization required	

EXISTING DRUGS with NEW RESTRICTIONS

The following drugs have no change in formulary status in 2016, but have NEW restrictions as noted

Drug	Current Plus Formulary Status	New Coverage Restriction	Standard Formulary
Emend 125mg capsule	Non formulary	Prior authorization required	Non Formulary
tolcapone *(generic for Tasmar)*	Generic	Step therapy required	Tier 1 (2017: Non formulary, Step therapy required)
Vanatol LQ	Generic	Prior authorization required	Tier 1, Prior authorization required (2017: Non formulary, Prior authorization required)

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus or Standard Formulary as noted:

Drug	Coverage Restriction	Standard Formulary (if differs)
Suboxone sublingual film	Prior authorization required	Non-preferred brand, Prior authorization required

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **September 15, 2016** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → 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.

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

- Actemra – *Updated*
- Aveed - *Updated*
- Biologics for plaque psoriasis and psoriatic arthritis (Cimzia, Cosentyx, Simponi, Stelara, Taltz) – *Updated*
- Enbrel - *Updated*
- Humira - *Updated*
- hydroxyprogesterone caproate (generic Delalutin) - *New*
- Keytruda – *Updated*
- Opdivo – *Updated*
- Ophthalmic anti-VEGF Agents (Eylea, Lucentis) – *Updated*
- Orencia - *Updated*
- Probuphine – *New*
- Prolia – *Updated*
- Relistor – *Updated*
- Somavert – *Updated*
- Vivitrol – *Updated*
- Xolair – *Updated*
- Zinbryta - *Updated*

Blue Shield of California
Fourth Quarter 2016 Formulary and Medication Policy Updates

Effective January 1, 2017
for Large Group, Small Group, and Individual & Family Plans

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 2016 P&T Committee decisions on formulary changes, which apply to Commercial members with an outpatient drug benefit, and medication policy changes are summarized below:

Pharmacy Benefit Formulary Update:

Please refer to the appropriate drug formulary posted on our website for the following information available at blueshieldca.com → drop down "Be Well", select "Drugs" under Public Links, and select the appropriate drug formulary – Standard Drug Formulary, or 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 and non-preferred generic drugs that do not require prior authorization or step therapy*
- *Brand-name medications that are now non-formulary or non-preferred because these medications have newly available generic equivalents covered on the formulary*

Summary of changes to the Medicare formularies are available at blueshieldca.com → drop down "Be Well", select "Drugs" under Public Links, select "Medicare Drug Formulary", select the appropriate plan, and select the "Summary of Changes" PDF. Please note that the "Summary of Changes" document will be posted starting March 1st.

DRUGS REMOVED from FORMULARY

The following drug(s) were removed from the Standard Formulary.

- *These drugs require a formulary exception based on medical necessity for coverage at Tier 3 unless noted as excluded from coverage.*

Drug	Coverage Restriction	Rationale for Decision	Formulary Alternatives
almotriptan *(generic Axert)*	Step therapy required	Cost effective alternatives available	naratriptan, rizatriptan, sumatriptan, zolmitriptan
Demser		Cost effective alternatives available	doxazosin, prazosin, propranolol
Edarbi, Edarbyclor	Step therapy required	Cost effective alternatives available	losartan, losartan/hctz, irbesartan, irbesartan/hctz, valsartan, valsartan/hctz
fenoprofen calcium 400mg *(generic Nalfon)*		Cost effective alternatives available	Ibuprofen, naproxen, flurbiprofen
Novacort	Excluded	Not FDA approved	
paricalcitol capsule *(generic Zemplar)*		Cost effective alternative available	calcitriol capsule
Narcotic analgesics			
belladonna-opium rectal suppository	Excluded	Not FDA approved	dicyclomine, hyoscyamine, phenobarbital/hyoscyamine/atr

Drug	Coverage Restriction	Rationale for Decision	Formulary Alternatives
			opine/scopolamine tablet
hydromorphone ER tablet *(generic Exalgo)*	Prior authorization required	Cost effective alternatives available	morphine extended-release (generic MS Contin), fentanyl patch, methadone tablet
levorphanol tablet	Prior authorization required	Cost effective alternatives available	hydromorphone tablet, oxycodone tablet and capsule
morphine sulfate ER capsule *(generic Avinza, and Kadian)*	Prior authorization required	Cost effective alternatives available	morphine extended-release (generic MS Contin), fentanyl patch, methadone tablet
oxycodone ER capsule *(generic Oxycontin)*	Prior authorization required	Cost effective alternatives available	morphine extended-release (generic MS Contin), fentanyl patch, methadone tablet
oxycodone 20mg/ml oral concentrate		Cost effective alternatives available	morphine oral solution
oxymorphone tablet *(generic Opana)*	Prior authorization required	Cost effective alternatives available	hydromorphone tablet, oxycodone tablet and capsule
oxymorphone ER tablet *(generic Opana ER)*	Prior authorization required	Cost effective alternatives available	morphine extended-release (generic MS Contin), fentanyl patch, methadone tablet
tramadol ER capsule *(generic Conzip)*	Step therapy required	Cost effective alternative available	tramadol extended release tablet (generic Ultram ER)
Chelating Agents			
Cuprimine	Prior authorization required	Cost effective alternative available	Depen
Syprine	Prior authorization required	Cost effective alternative available	Depen
Anti-diabetic Agents			
alogliptin *(generic Nesina)*	Step therapy required	Cost effective alternatives available	metformin, sulfonylurea, pioglitazone
alogliptin/metformin *(generic Kazano)*	Step therapy required	Cost effective alternatives available	metformin, sulfonylurea, pioglitazone
alogliptin/pioglitazone *(generic Oseni)*	Step therapy required	Cost effective alternatives available	metformin, sulfonylurea, pioglitazone
metformin extended release *(generic for Glumetza)*	Prior authorization required	Cost effective alternative available	metformin extended release (generic Glucophage XR)
Antifungals			
flucytosine capsule *(generic Ancobon)*	Step therapy required	Cost effective alternatives available	fluconazole
naftifine 1% and 2% cream	Step therapy required	Cost effective alternative available	econazole 1% cream
Antihistamines			
carbinoxamine 4mg tablet		Cost effective alternatives available	desloratadine, clemastine, cyproheptadine, promethazine
carbinoxamine 4mg/5ml oral liquid		Cost effective alternatives available	promethazine syrup, promethazine/phenylephrine syrup, cyproheptadine syrup

Drug	Coverage Restriction	Rationale for Decision	Formulary Alternatives
azelastine 0.15% nasal spray *(generic Astepro)*		Cost effective alternative available	azelastine 0.1% nasal spray
Anti-infectives			
cefixime 100mg/5ml oral suspension *(generic Suprax)*		Cost effective alternatives available	cefpodoxime oral suspension, cefdinir oral suspension, ceftibuten oral suspension
doxycycline monohydrate *(generic for Oracea)*	Prior authorization required	Cost effective alternatives available	doxycycline tablet or capsule, metronidazole 0.75% lotion, gel, and cream, metronidazole 1% gel
Noritate --*(effective 3/1/2017)*	Prior authorization required	Cost effective alternatives available	metronidazole 0.75% lotion, gel, and cream, metronidazole 1% gel

The following drug(s) were moved to the non-formulary tier, or removed from the Plus Formulary.

- *These drugs are available at the non-formulary, Tier 3, copayment when prior authorization is approved, unless noted as excluded from coverage.*

Drug	Coverage Restriction	Rationale for Decision	Formulary Alternatives
Fluoroplex --*effective 3/1/2017*	Prior authorization required	Cost effective alternatives available	5-fluorouracil 5% cream, 2% and 5% topical solution (generic Efudex); imiquimod
Noritate	Prior authorization required	Cost effective alternatives available	metronidazole 0.75% lotion, gel, and cream, metronidazole 1% gel
Novacort	Excluded	Not FDA approved	
belladonna-opium rectal suppository	Excluded	Not FDA approved	dicyclomine, hyoscyamine, phenobarbital/hyoscyamine/atropine/scopolamine tablet

DRUGS NOT ADDED to FORMULARY

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

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

Drug	Indication	Coverage Restriction	Standard Formulary (if differs)	Formulary Alternatives
Bromsite	Cataract	Prior authorization required		bromfenac 0.09% eye drops
Gonitro	Angina	Prior authorization required		nitroglycerin sublingual tablet, nitroglycerin spray
Micort-HC cream	Inflammatory skin condition	Prior authorization required		hydrocortisone 2.5% cream, hydrocortions 2.5% lotion, hydrocortisone 2.5% ointment
Synera	Local skin anesthesia	Prior authorization required		lidocaine 2.5%/prilocaine 2.5% cream

Drug	Indication	Coverage Restriction	Standard Formulary (if differs)	Formulary Alternatives
Taytulla	Contraception			junel fe 24, larin 24 fe, lomedia 24 fe, blisovi 24 fe
Yosprala	Prevent cardiovascular and cerebrovascular events	Prior authorization required		omeprazole 40mg capsule used with aspirin
Zurampic	Hyperuricemia	Step therapy required		allopurinol, Uloric (Plus only)
Anti-infectives				
Otovel	Acute otitis media			ofloxacin 0.3% ear solution, ciprofloxacin 0.2% ear solution
Targadox	Bacterial infection	Prior authorization required		doxycycline capsule, doxycycline tablet

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Plus or Standard Drug Formularies with coverage restrictions (other new generic drugs are covered on formulary without restrictions):

Newly available generic	Coverage Restriction	Standard Formulary (if differs)
esomeprazole strontium	Step therapy required	Non formulary, Step therapy required
flurandrenolide 0.05% lotion *(generic Cordran)*	Prior authorization required	Non formulary, Prior authorization required
lomaira	Prior authorization required	
mesalamine *(generic Asacol HD)*	Step therapy required	Non formulary, Step therapy required
olmesartan *(generic Benicar)*	Step therapy required	Non formulary, Step therapy required
olmesartan/amlodipine *(generic Azor)*	Step therapy required	Non formulary, Step therapy required
olmesartan/hctz *(generic Benicar HCT)*	Step therapy required	Non formulary, Step therapy required
olmesartan/amlodipine/hctz *(generic Tribenzor)*	Step therapy required	Non formulary, Step therapy required

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4)

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

Specialty Drug	Coverage Restriction	Standard Formulary (if differs)
Oxandrin	Prior authorization required	Non formulary**
phenoxybenzamine *(generic Dibenzyline)* *--effective 3/1/2017*	Prior authorization required	
Relistor tablet*	Prior authorization required	Non formulary**
Synribo*	Prior authorization required	Non formulary**

**These drugs are obtained through the BSC specialty pharmacy network*
*** Non-formulary drugs that meet the Tier 4 description require a formulary exception based on medical necessity to be covered at the Tier 4 share of cost.*

EXISTING DRUGS with NEW RESTRICTIONS

The following drugs have no change in formulary status in 2017, but have NEW restrictions as noted

Drug	New Coverage Restriction	Plus Formulary Status	Standard Formulary Status
Daraprim	Prior authorization required	Formulary brand	Tier 3
doxycycline monohydrate *(generic for Oracea)*	Prior authorization required	Generic	Tier 1
Dutoprol *--effective 11/2016*	Prior authorization required	Non formulary	Non formulary
Dyrenium	Step therapy required	Non formulary	Non formulary
Tussicaps *--effective 3/1/2017*	Prior authorization required	Non formulary	Non formulary
Actinic Keratosis therapy			
diclofenac sodium *(generic Solaraze)* *--effective 3/1/2017*	Prior authorization required	Generic	Non formulary
fluorouracil 0.5% cream *(generic Carac)* *--effective 3/1/2017*	Prior authorization required	Generic	Tier 1
Narcotic analgesics			
levorphanol tablet *--effective 3/1/2017*	Prior authorization required	Generic	Non formulary
Oxaydo	Prior authorization required	Non formulary	Non formulary

Anti-diabetic therapy			
Levemir, Levemir Flextouch	Prior authorization required	Non formulary	Non formulary
Tresiba Flextouch	Prior authorization required	Non formulary	Non formulary

DRUGS MOVED to a DIFFERENT TIER

The following drugs were moved to a higher or lower tier for the Standard Formulary as noted:

Drug	New Tier Status for Standard Formulary
Eliquis	Tier 2
Xarelto	Tier 2
gabapentin 250mg/5ml, 300mg/5ml oral solution, unit-dose	Tier 2 with prior authorization requirement
nimodipine capsule	Tier 3
potassium citrate extended release tablet *(generic Urocit-K)*	Tier 2
sirolimus tablet *(generic Rapamune)*	Tier 2
Tobradex 0.3%/0.1% eye ointment	Tier 3

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus or Standard Formulary as noted:

Drug	Coverage Restriction	Standard Formulary (if differs)
Invokamet XR	Step therapy required	Tier 3
Novolin N, Novolin R, Novolin 70/30 *--effective 1/1/2017*		No change
Novolog, Novolog penfill, Novolog Flexpen, Novolog Mix 70/30, Novolog Mix 70/30 Flexpen *--effective 1/1/2017*		No change
Tabloid		Tier 4

<u>MEDICAL BENEFIT MEDICATION POLICIES:</u>

The following coverage policies were created or updated and changes are effective on **December 1, 2016** (unless stated otherwise) and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → 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.

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

- Abraxane (nab-paclitaxel) – *Updated*
- Adcetris (brentuximab vedotin) – *Updated*
- Aranesp (darbepoetin) – *Updated*
- Arzerra (ofatumumab) – *Updated*
- Avastin (bevacizumab) – *Updated*
- Azacitadine – *Updated*
- Beleodaq (belinostat) – *Updated*
- Cuvitru (immune globulin, subcutaneous 20%) – *NEW*
- Cyramza (ramucirumab) – *Updated*
- Darzalex (daratumumab) – *Updated*
- Decitabine – *Updated*
- Elelyso (taliglucerase) – *Updated*
- Empliciti (elotuzumab) – *Updated*
- Erbitux (cetuximab) – *Updated*
- Exondys 51 (eteplirsen) – *NEW*
- Ilaris (canakinumab) – *Updated*
- Inflectra (infliximab-dyyb) – *NEW*
- Keytruda (pembrolizumab) – *Updated*
- Kyprolis (carfilzomib) – *Updated*
- Lartruvo (olaratumab) – *NEW*
- Marqibo (vincristine sulfate liposome) – *Updated*
- Opdivo (nivolumab) – *Updated*
- Procrit (erythropoietin) – *Updated*
- Stelara (ustekinumab) – *Updated*
- Sustol (granisetron) – *NEW*
- Tecentriq (atezolizumab) – *Updated*
- Torisel (temsirolimus) – *Updated*
- Vectibix (panitumumab) – *Updated*
- VPRIV (velaglucerase alfa) – *Updated*
- Yervoy (ipilimumab) – *Updated*
- Zaltrap (ziv-aflibercept) - *Updated*