BLUE SHIELD OF CALIFORNIA
FIRST QUARTER 2017 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE APRIL 3, 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 First Quarter 2017 P&T Committee decisions on formulary changes and medication policy changes, which apply to Commercial members with an outpatient drug benefit, are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information:

- *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*

Formularies are 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.

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.

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
Azilect		Generic equivalent available	rasagiline
Kaletra oral solution		Generic equivalent available	lopinavir/ritonavir
Tamiflu capsule		Generic equivalent available	oseltamivir phosphate
Differin 0.1% gel (adapalene)	Excluded	OTC available	
Xyzal (levocetirizine)	Excluded	OTC available	

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
Kaletra oral solution		Generic equivalent available	lopinavir/ritonavir
Seroquel XR	Step therapy required	Generic equivalent available	quetiapine fumarate
Tamiflu capsule		Generic equivalent available	oseltamivir phosphate
Pancreaze		More cost effective alternatives available	Creon, Zenpep
Differin 0.1% gel (adapalene)	Excluded	OTC available	
Xyzal (levocetirizine)	Excluded	OTC available	

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
Antibacterial				
Daxbia	Bacterial infection	Prior authorization required		cephalexin 250mg, 500mg capsule, tablet
Antidiabetics				
Adlyxin	Diabetes	Prior authorization required		Tanzeum
Soliqua	Diabetes	Prior authorization required		Tanzeum, Lantus
Xultophy	Diabetes	Prior authorization required		Tanzeum, Lantus, Toujeo
Basaglar	Diabetes	Prior authorization required		Lantus
Antihypertensive				
Epaned oral solution	Hypertension, Heart failure			enalapril tablet
Antiviral				
Vemlidy	Hepatitis B	Prior authorization required		Viread
GI agent				
Trulance	Chronic idiopathic constipation	Prior authorization required		Amitiza

Drug	Indication	Coverage Restriction	Standard Formulary (if differs)	Formulary Alternatives
Topical anti-inflammatory				
Eucrisa	Atopic dermatitis	Prior authorization required		Generic topical corticosteroids, topical tacrolimus, Elidel
Vitamin D analog				
Rayaldee	Hyperparathyroid	Prior authorization required		calcitriol

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Plus and 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)
aprepitant 80mg, 125mg capsule *(Emend)*	Prior authorization required	Tier 2, Prior authorization required
dexmethylphenidate 25mg, 35mg er capsule *(Focalin XR)*	Step therapy required, Age-limit	Tier 3, Step therapy required, Age-limit

The following drugs are newly available GENERIC drugs that were ADDED only to the Plus Formulary with coverage restriction (other new generic drugs are covered on formulary without restrictions):

Newly available generic	Coverage Restriction
metoprolol succinate/hctz *(Dutoprol)*	Prior authorization required
aprepitant 40mg capsule *(Emend)*	Prior authorization required
quetiapine er capsule *(Seroquel XR)*	Step therapy required
flurandrenolide 0.05% ointment *(Cordran)*	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)
Rubraca*	Prior authorization required	Non formulary**
Emflaza	Prior authorization required	Non formulary**

Specialty Drug	Coverage Restriction	Standard Formulary (if differs)
Auvi-Q	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 RESTRICTION REMOVAL

The following drugs have no change in formulary status in 2017 unless stated otherwise, but have restrictions removed as noted

Drug	Coverage Restriction Removed	Plus Formulary Status	Standard Formulary Status
calcitonin-salmon nasal spray *(Miacalcin)*	Prior authorization	Generic	Tier 1
Climara Pro	Age-limit	Formulary brand	Change to Tier 3
Combivent Respimat	Step therapy	Formulary brand	Tier 3
dutasteride *(Avodart)*	Prior authorization	Generic	Tier 1
ezetimibe *(Zetia)*	Prior authorization	Generic	Change to Tier 2
rabeprazole 20mg tablet *(Aciphex)*	Prior authorization	Generic	Change to Tier 2
Suboxone sublingual film	Prior authorization	Formulary brand	Tier 3
tranexamic acid *(Lysteda)*	Prior authorization	Generic	Tier 1
Topical Corticosteroids			
fluocinolone 0.01% scalp oil, body oil *(Derma-Smoothe FS)*	Step therapy	Generic	Change to Tier 2
fluocinolone 0.01% solution *(Synalar)*	Step therapy	Generic	Non formulary
Antiretrovirals			
Aptivus	Step therapy	Formulary brand	Tier 2
Intelence	Step therapy	Formulary brand	Tier 2
Aromatase Inhibitors			
anastrazole *(Arimidex)*	Age-limit	Generic	Tier 1
exemestane *(Aromasin)*	Removed prior authorization requirement. Add gender-edit	Generic	Tier 1
letrozole *(Femara)*	Age-limit	Generic	Tier 1

Removed age-limit on the following High Risk Medications (HRM):

chlordiazepoxide containing products	cyproheptadine	dipyridamole	estrogens
glyburide	micronized glyburide	hydroxyzine containing products	nifedipine
nitrofurantoin	promethazine containing products	thioridazine	trimethobenzamide
desiccated thyroids			

DRUGS ADDED to FORMULARY

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

Drug	Coverage Restriction	Standard Formulary Status
Cosopt PF		Tier 2
Zenpep 5,000 unit dr capsule		Tier 2
Glyxambi	Step therapy required	Tier 2
Jardiance	Step therapy required	Tier 2
Synjardy	Step therapy required	Tier 2
Bystolic		Tier 2

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

Drug	Coverage Restriction	Standard Formulary Status
Breo Ellipta		Tier 3
Flovent		Tier 2
diclofenac 1% topical gel *(Voltaren)*		Tier 2
Lotemax		Tier 3
Invokana	Step therapy required	Tier 2
Invokamet, Invokamet XR	Step therapy required	Tier 2

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **April 3, 2017** (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

- Cancidas (caspofungin) – *Updated*
- Eraxis (anidulafungin) – *Updated*
- Erbitux (cetuximab) – *Updated*
- Granix (tbo-filgrastim) – *Updated*
- Lucentis (ranibizumab) – *Updated*
- Mycamine (micafungin) – *Updated*
- Neulasta (pegfilgrastim) – *Updated*
- Noxafil (posaconazole) – *Updated*
- Opdivo (nivolumab) – *Updated*
- Spinraza (nusinersen) - *NEW*
- Sylatron (peginterferon alfa 2b) – *Updated*
- Vectibix (panitumumab) – *Updated*
- Vivitrol (naltrexone) – *Removal of policy due to removal of prior authorization requirement for coverage*
- Yervoy (ipilimumab) – *Updated*
- Zinplava (bezlotoxumab) – *NEW*

Blue Shield of California
Second Quarter 2017 Formulary and Medication Policy Updates

Effective September 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 Second Quarter 2017 P&T Committee decisions on formulary changes and medication policy changes, which apply to Commercial members with an outpatient drug benefit, are summarized below:

Pharmacy Benefit Formulary Update:

Please refer to the appropriate drug formulary posted on our website for the following information:

- *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*

Formularies are 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.

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.

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
Pristiq		Generic equivalent available	desvenlafaxine succinate
Tanzeum *(effective 1/2018)*	Prior authorization	More cost effective alternatives available	Trulicity, Victoza *(effective 1/2018)*

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
Pristiq		Generic equivalent available	desvenlafaxine succinate
Tanzeum	Prior authorization	More cost effective alternatives available	Trulicity, Victoza

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
Alpha-1A agonist				
Rhofade	Acne Rosacea	Prior authorization required		metronidazole 0.75% cream, gel, lotion; metronidazole 1% gel, topical sulfacetamide sodium 10%/sulfur 5%
Inhaled corticosteroid/LABA				
Airduo Respiclick	Asthma	Prior authorization required		Advair, Breo Ellipta
Opiate agonist				
Arymo ER	Pain	Prior authorization required		morphine sulfate extended-release tablet

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Plus and 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)
ezetimibe/simvastatin *(Vytorin)*	Step therapy required	Tier 2, Step therapy required

The following drugs are newly available GENERIC drugs that were ADDED only to the Plus Formulary with coverage restriction (other new generic drugs are covered on formulary without restrictions):

Newly available generic	Coverage Restriction
tazarotene 0.1% cream *(Tazorac)*	Age restriction
zileuton extended-release tablet *(Zyflo CR)*	Prior authorization 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
Alunbrig	Prior authorization required

Specialty Drug	Coverage Restriction
Austedo	Prior authorization required
Dupixent	Prior authorization required
Ingrezza	Prior authorization required
Kisqali, Kisqali Femara Co-pack	Prior authorization required
Rydapt	Prior authorization required
Siliq	Prior authorization required
Thiola	Prior authorization required
Tymlos	Prior authorization required
Ure-K *(effective 1/2018)*	Prior authorization required
Xermelo	Prior authorization required
Zejula	Prior authorization required

EXISTING DRUGS with NEW RESTRICTIONS

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

Drug	New Coverage Restriction	Plus Formulary Status
Zyflo	Prior authorization	Non-formulary[Ψ]
Zyflo CR	Prior authorization	Non-formulary[Ψ]
Antidiabetic drug, DPP-IV inhibitor		
alogliptin (Nesina) *(effective 7/1/2017)*	Prior authorization	Generic
alogliptin/metformin (Kazano) *(effective 7/1/2017)*	Prior authorization	Generic
alogliptin/pioglitazone (Osenia) *(effective 7/1/2017)*	Prior authorization	Generic
Kombiglyze XR *(effective 7/1/2017)*	Prior authorization	Non-formulary
Onglyza *(effective 7/1/2017)*	Prior authorization	Non-formulary
Antidiabetic drug, GLP-1 agonist		

Bydureon	Prior authorization	Non-formulary
Byetta	Prior authorization	Non-formulary
Antidiabetic drug, SGLT-2 inhibitor		
Farxiga	Prior authorization	Non-formulary
Xigduo XR	Prior authorization	Non-formulary

Ψ Covered at Specialy tier in 2018

DRUGS MOVED to a DIFFERENT TIER

The following drugs were moved to a higher or lower tier for the Standard Formulary as noted, effective July 1, 2017:

Drug	New Tier Status for Standard Formulary
Januvia	Tier 2
Janumet, Janumet XR	Tier 2
Zyflo	Non-formulary**
Zyflo CR	Non-formulary**

*** Effective 1/1/2018, 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.*

DRUGS ADDED to FORMULARY

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

Drug	Coverage Restriction	Standard Formulary Status
Jentadueto, Jentadueto XR *(effective 7/1/2017)*	Step therapy required	Tier 2
Tradjenta *(effective 7/1/2017)*	Step therapy required	Tier 2
Trulicity	Step therapy required	Tier 2 *(effective 1/2018)*
Victoza	Step therapy required	Tier 2 *(effective 1/2018)*

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

Drug	Coverage Restriction	Standard Formulary Status
Incruse Ellipta *(effective 7/1/2017)*		Tier 3

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **July 1, 2017** (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 (tocilizumab) - Updated*
- *Avastin (bevacizumab) - Updated*
- *Bavencio (avelumab) - NEW*
- *Brineura (cerliponase alfa) – NEW*
- *Dupixent (dupilumab) – NEW*
- *Enbrel (etanercept) - Updated*
- *Erbitux (cetuximab) - Updated*
- *Gazyva (obinutumumab) - Updated*
- *Imfinzi (durvalumab) – NEW*
- *Intron A (interferon alfa 2b) - Updated*
- *Keytruda (pembrolizumab) - Updated*
- *Ocrevus (ocrelizumab) - NEW- Updated*
- *Odactra House Dust Mite (Dermato-phagoides farinae and Dermato-phagoides pteronyssinus) sublingual allergen extract (1st dose) - NEW*
- *Opdivo (nivolumab) - Updated*
- *Orencia (abatacept) - Updated*
- *Remicade (infliximab) - Updated*
- *Rituxan (rituximab) - Updated*
- *Siliq (brodalumab)- NEW*
- *Sylatron (peginterferon alfa-2b) - Updated*
- *Sylvant (siltuximab) - Updated*
- *Tecentriq (atezolizumab) - Updated*
- *Tymlos (abaloparatide) - NEW*

BLUE SHIELD OF CALIFORNIA
THIRD QUARTER 2017 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE DECEMBER 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 Third Quarter 2017 P&T Committee decisions on formulary changes and medication policy changes, which apply to Commercial members with an outpatient drug benefit, are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information:

- *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*

Formularies are available at blueshieldca.com/pharmacy. Select the appropriate drug formulary – Standard Drug Formulary or Plus Drug Formulary.

Summary of changes to the Medicare formularies are available at blueshieldca.com/pharmacy. Select "Medicare Drug Formulary", then select the appropriate plan, and the corresponding "Summary of Changes" PDF.

DRUGS REMOVED from FORMULARY

The following drug(s) were removed from the Standard Formulary, effective January 1, 2018.

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

Drug	FDA Indication(s)	Formulary Alternative(s)
Dexilant	GERD, Erosive esophagitis	pantoprazole, lansoprazole, rabeprazole, omeprazole
methamphetamine 5mg tablet (generic Desoxyn)*	ADHD	dextroamphetamine IR tablet, dextroamphetamine-amphetamine IR tablet
Omnaris	Allergic rhinitis	azelastine nasal (generic Astepro), fluticasone nasal, flunisolide nasal
Pazeo	Allergic conjunctivitis	olopatadine eye drops
Plegridy*	Multiple sclerosis	Copaxone

**Effective 1/1/2018, non-formulary drugs for the Standard formulary that meet the Tier 4 description require a formulary exception based on medical necessity to be covered at the Tier 4 share of cost*

The following drug(s) were moved to the non-formulary tier or removed from the Plus Formulary, effective January 1, 2018.

- *These drugs are available at the non-formulary, Tier 3, copayment when prior authorization is approved.*

Drug	FDA Indication(s)	Restriction(s)	Formulary Alternative(s)
diflorasone 0.05% cream	Corticosteroid responsive dermatoses	Step therapy	augmented betamethasone dipropionate, betamethasone dipropionate, betamethasone valerate, fluocinonide 0.05%, triamcinolone 0.5%

NEW GENERICS with RESTRICTIONS

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

Drug	FDA Indication(s)	Coverage Restriction(s)
adapalene/benzoyl peroxide (generic Epiduo)	Acne vulgaris	Step therapy. Age restriction
atomoxetine (generic Strattera)	ADHD	Age restriction

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

Drug	FDA Indication(s)	Coverage Restriction(s)
buprenorphine transdermal patch (generic Butrans)	Pain	Prior authorization
doxycycline hyclate (generic Acticlate)	Bacterial infection	Prior authorization
eletriptan (generic Relpax)	Migraine	Step therapy
testosterone 30mg/15ml topical solution (generic Axiron)	Hypogonadism	Step therapy

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) for the Standard formulary, effective January 1, 2018:

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

Specialty Drug	Coverage Restriction(s)
Actimmune	Prior authorization
Arcalyst	Prior authorization
bexarotene capsule (generic Targretin)	Prior authorization
Briviact	Prior authorization

Specialty Drug	Coverage Restriction(s)
capecitabine (generic Xeloda)	
Ergomar	
Nityr**	Prior authorization
Tymlos	Prior authorization

*** preferred drug*

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

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

Specialty Drug	Coverage Restriction(s)
Benlysta syringe, autoinjector	Prior authorization
dihydroergotamine (generic D.H.E. 45) *(effective 1/1/2018)*	Prior authorization
dihydroergotamine nasal (generic Migranal) *(effective 1/1/2018)*	Prior authorization
Haegarda	Prior authorization
Hycamtin capsule *(effective 1/1/2018)*	Prior authorization
Idhifa	Prior authorization
Jadenu Sprinkle	
Kevzara	Prior authorization
Lynparza tablet	Prior authorization
Mavyret	Prior authorization
methamphetamine 5mg tablet (generic Desoxyn) *(effective 1/1/2018)*	Step therapy, Age restriction.
Nerlynx	Prior authorization
Nityr**	Prior authorization
Syndros	Prior authorization
Tremfya	Prior authorization
Vosevi	Prior authorization
Xatmep	Age restriction

*** preferred drug*

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status in 2017, but have restrictions removed as noted for the Plus and Standard formulary:

Drug	FDA Indication(s)	Restriction removed
omega-3 acid ethyl esters (generic Lovaza)	Hypertriglyceridemia	Prior authorization requirement

The following drugs have no change in formulary status in 2017, but have restrictions removed as noted for the Plus formulary:

Drug	FDA Indication(s)	Restriction removed
Miacalcin injection	Osteoporosis, Paget's disease, Hypercalcemia	Prior authorization requirement

DRUGS ADDED to FORMULARY

The following drugs were ADDED only to the Standard Formulary as noted, effective January 1, 2018:

Drug	FDA Indication(s)	Coverage Restriction(s)
Alinia	Diarrhea due to Giardia or Cryptosporidium	Prior authorization
azelastine (generic Astepro)	Allergic rhinitis	
Carafate oral suspension	Duodenal ulcer	
desoximetasone 0.05%, 0.25% cream (generic Topicort)	Corticosteroid responsive dermatoses	Step therapy
diflorasone 0.05% cream	Corticosteroid responsive dermatoses	Step therapy
Elmiron	Interstitial cystitis	
fluocinolone 0.01% solution (generic Synalar)	Corticosteroid responsive dermatoses	
ketoprofen (generic Orudis)	RA, OA, Pain, Primary dysmenorrhea	
Lastacaft	Allergic conjunctivitis	
Odefsey	HIV-1 infection	
Paser	Tuberculosis	
Radiogardase	Radiation exposure	
Sulfamylon	Burn wounds	
Tirosint	Hypothyroidism, TSH suppression	
Uloric	Gout	Step therapy
Xifaxan	Travelers' diarrhea, Hepatic encephalopathy	Prior authorization

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on **December 1, 2017** (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

- *Abilify Maintena (aripiprazole) - Updated*
- *Actemra (tocilizumab) - Updated*
- *Blincyto (blinatumomab) - Updated*
- *Calcitonin-salmon injection (generic Miacalcin) - Removal of policy due to removal of prior authorization requirement for coverage*
- *Cimzia (certilizumab pegol) - Updated*
- *Cosentyx (secukinumab) - Updated*
- *Darzalex (daratumumab) - Updated*
- *Enbrel (etanercept) - Updated*
- *Entyvio (vedolizumab) - Updated*
- *Forteo (teriparatide) - Updated*
- *Haegarda (C1 esterase inhibitor [human]) - NEW*
- *Humira (adalimumab) - Updated*
- *Ibandronate- Updated*
- *Inflectra (infliximab-dyyb) - Updated*
- *Kevzara (sarilumab) - NEW*
- *Keytruda (pembrolizumab) - Updated*
- *Kineret (anakinra) - Updated*
- *Opdivo (nivolumab) - Updated*
- *Orencia (abatacept) - Updated*
- *Prolia (denosumab) - Updated*
- *Radicava (edaravone) - NEW*
- *Remicade (infliximab) - Updated*
- *Renflexis (infliximab-abda) - NEW*
- *Rituxan (rituximab) - Updated*
- *Rituxan Hycela (rituximab/hyaluronidase human, subcutaneous injection) - NEW*
- *Simponi (golimumab) - Updated*
- *Stelara (ustekinumab) - Updated*
- *Taltz (ixekizumab) - Updated*
- *Tremfya (guselkumab) - NEW*
- *Tymlos (abaloparatide) - Updated*
- *Tysabri (natalizumab) - Updated*
- *Yervoy (ipilimumab) - Updated*
- *zoledronic acids (generic Reclast, generic Zometa) - Removal of policy due to removal of prior authorization requirement for coverage*

BLUE SHIELD OF CALIFORNIA
FOURTH QUARTER 2017 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE MARCH 1, 2018
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 2017 P&T Committee decisions on formulary changes and medication policy changes, which apply to Commercial members with an outpatient drug benefit, are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information:

- *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*

Formularies are available at blueshieldca.com/pharmacy. Select the appropriate drug formulary – Standard Drug Formulary or Plus Drug Formulary.

Summary of changes to the Medicare formularies are available at blueshieldca.com/pharmacy. Select "Medicare Drug Formulary", then select the appropriate plan, and the corresponding "Summary of Changes" PDF.

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	FDA Indication(s)	Formulary Alternative(s)
Tudorza Pressair	COPD	Incruse Ellipta, Spiriva

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.*

Drug	FDA Indication(s)	Restriction(s)	Formulary Alternative(s)
Alrex *(effective 1/1/2018)*	Allergic conjunctivitis		cromolyn, Lotemax, fluorometholone 0.1% drops, prednisolone acetate 1% drops, prednisolone sodium phosphate 1% drops

Drug	FDA Indication(s)	Restriction(s)	Formulary Alternative(s)
Edarbi, Edarbyclor	Hypertension	Step therapy	irbesartan, losartan, valsartan, irbesartan/hctz, losartan/hctz, valsartan/hctz
Onfi	Lennox-Gastaut syndrome	Step therapy	clonazepam, felbamate, lamotrigine, topiramate
Tudorza Pressair	COPD	Step therapy	Incruse Ellipta, Spiriva

NEW GENERICS with RESTRICTIONS

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

Drug	FDA Indication(s)	Coverage Restriction(s)
chlorzoxazone	Musculoskeletal pain	Age restriction

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

Drug	FDA Indication(s)	Coverage Restriction(s)
dapsone 5% gel (generic Aczone)	Acne vulgaris	Prior authorization. Quantity limit
glycopyrrolate 1.5mg tablet	Peptic ulcer	Prior authorization. Quantity limit
theophylline 30mg/15ml oral solution, unit-dose	Asthma	Prior authorization

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) for the Standard formulary, effective January 1, 2018:

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

Specialty Drug	Coverage Restriction(s)
Cosentyx	Prior authorization. Quantity limit
Mavyret	Prior authorization. Quantity limit
Vosevi	Prior authorization. Quantity limit

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

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

Specialty Drug	Coverage Restriction(s)
Calquence	Prior authorization. Quantity limit

Specialty Drug	Coverage Restriction(s)
glatiramer acetate 40mg (Copaxone)	Prior authorization. Quantity limit
Gocovri	Prior authorization. Quantity limit
sodium phenylbutyrate tablet (Buphenyl)	Prior authorization. Quantity limit
Verzenio	Prior authorization. Quantity limit
vigabatrin powder packet (Sabril)	Prior authorization. Quantity limit

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have restrictions removed as noted for the Plus and Standard formulary, effective December 8, 2017:

Drug	FDA Indication(s)	Restriction removed
amlodipine-valsartan (Exforge)	Hypertension	Step-therapy
amlodipine-valsartan-hctz (Exforge HCT)	Hypertension	Step-therapy
telmisartan (Micardis)	Hypertension, Reduce cardiovascular risk	Step-therapy

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus and Standard formulary, effective January 1, 2018:

Drug	FDA Indication(s)	Coverage Restriction(s)
Aptiom	Partial-onset seizures	Step therapy
Briviact	Partial-onset seizures	Step therapy
Fycompa	Partial-onset seizures, Tonic-clonic seizures	Step therapy
Nuedexta *(effective 11/1/2017)*	Pseudobulbar affect	Prior authorization
Vimpat	Partial-onset seizures	Step therapy

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
Anoro Ellipta *(effective 1/1/2018)*	Tier 2
Incruse Elliipta	Tier 2
Restasis *(effective 1/1/2018)*	Tier 2

Vyvanse *(effective 1/1/2018)*	Tier 2

DRUGS ADDED to FORMULARY

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

Drug	FDA Indication(s)	Coverage Restriction(s)
abacavir sulfate solution (Ziagen)	HIV infection	Quantity limit
fluticasone-salmeterol (Airduo)	Asthma	Quantity limit
fosamprenavir calcium tablet (Lexiva)	HIV infection	Quantity limit
oseltamivir phosphate suspension (Tamiflu)	Influenza	Quantity limit
Spiriva	COPD	Quantity limit

The following drugs were ADDED only to the Plus formulary as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
Acuvail	Cateract surgery	
diazepam rectal gel (Diastat)	Seizures	Quantity limit
FML Forte	Corticosteroid responsive inflammation	
lamotrigine starter kit (Lamictal)	Seizures, Bipolar disorder	
lanthanum carbonate (Fosrenol)	Hyperphosphatemia	
Lastacaft	Allergic conjunctivitis	Quantity limit
paroxetine mesylate (Brisdelle)	Hot flashes	Quantity limit
Pred Mild	Allergy and inflammation	
Xiidra	Dry eyes disease	

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on January 2, 2018 (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 - Update*
- *Actemra - Update*
- *Adcetris - Update*
- *Alimta - Update*
- *Aliqopa– NEW*
- *Avastin - Update*
- *Besponsa - Update*
- *Blincyto- Update*
- *Cimzia - Update*
- *Clolar - Update*
- *Cyramza - Update*
- *Faslodex - Update*
- *Halaven - Update*
- *Herceptin - Update*
- *Imfinzi - Update*
- *Imlygic - Update*
- *Istodax - Update*
- *Keytruda - Update*
- *Kymriah – NEW*
- *Kyprolis - Update*
- *Lartruvo - Update*
- *Mylotarg– NEW*
- *Onivyde - Update*
- *Opdivo - Update*
- *Opdivo - Update*
- *Orencia - Update*
- *Rituxan Hycela - Update*
- *Siliq - Update*
- *Simponi, Simponi Aria - Update*
- *Soliris - Update*
- *Stelara - Update*
- *Taltz- Update*
- *Torisel - Update*
- *Tremfya - Update*
- *Triptodur - NEW*
- *Yervoy - Update*
- *Yondelis - Update*