BLUE SHIELD OF CALIFORNIA
FIRST QUARTER 2021 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE MARCH 3, 2021
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 2021 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", "Value 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.

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Standard/Value and Plus Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
icosapent ethyl 1 gm capsule (Vascepa)	Hypertriglyceridemia	Prior authorization, Quantity limit
nitazoxanide tablet (Alinia)	Giardiasis, Cryptosporidiosis	Prior authorization, Quantity limit

The following drugs are newly available GENERIC drugs that were ADDED to the Plus Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
meloxicam submicronized (Vivlodex)[1]	Osteoarthritis	Prior authorization, Quantity limit
rufinamide (Banzel)	Lennox-Gastaut syndrome	Step therapy, Quantity limit
tavaborole (Kerydin)[1]	Onychomycosis	Prior authorization, Quantity limit

1.Applies to Grandfather plans

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

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

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

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Alkindi Sprinkle[2]	Adrenal insufficiency	Prior authorization, Quantity limit
Imcivree	Obesity	Prior authorization, Quantity limit
Nyvepria	Chemotherapy- induced neutropenia	Prior authorization
Orgovyx	Prostate cancer	Prior authorization, Quantity limit
Orladeyo	Hereditary angioedema	Prior authorization, Quantity limit
Qdolo[2]	Pain	Prior authorization, Quantity limit
Reditrex	Rheumatoid arthritis, Psoriasis, Juvenile idiopathic arthritis	Prior authorization, Quantity limit
Reltone[2]	Gallstones	Prior authorization, Quantity limit
tavaborole (Kerydin)[2]	Onychomycosis	Prior authorization, Quantity limit
Trianz[2]	Prenatal vitamin	Prior authorization, Quantity limit
Wynzora[2]	Plaque psoriasis	Prior authorization, Quantity limit
Zokinvy	Progeria	Prior authorization, Quantity limit

2. Does not apply to Grandfathered plans.

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Standard/Value and Plus formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
Linzess	IBS-constipation, Chronic idiopathic constipation	Age-limit, Quantity limit
Movantik	Opioid-induced constipation	Age-limit, Quantity limit

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus Drug Formulary:

Drug	FDA Indication(s)	Coverage Restriction(s)
Amicar[3]	Hemorrhage	
aminocaproic acid (Amicar)[3]	Hemorrhage	

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Standard/Value and Plus Drug Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
Iclevia	Prevent pregnancy	
Lyllana	Vasomotor symptoms, Post-menopausal osteoporosis	Quantity limit
Microgestin 24 Fe	Prevent pregnancy	
Nymyo	Prevent pregnancy	
Zovia 1-35	Prevent pregnancy	

The following drugs were ADDED to the Plus Drug Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
asenapine (Saphris)	Schizophrenia, Bipolar disorder	Quantity limit
Gemmily	Prevent preganacy	
ivemectin (Sklice)	Head lice	
Merzee	Prevent pregnancy	
timolol maleate/pf (Timoptic Ocudose)	Glaucoma	
tolvaptan 15mg tablet (Samsca)	Hyponatremia	Prior authorization, Quantity limit

MEDICAL BENEFIT MEDICATION POLICIES:

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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

New Policies
• Danyelza (naxitamab-gqgk) • Imcivree (setmelanotide) • Oxlumo (lumosiran)
Updated Policies
• Actemra (tocilizumab) • Abilify Maintena (aripiprazole) • Alimta (pemetrexed) • Arcalyst (rilonacept)

- Aristada (aripiprazole)
- Aristada Initio (aripiprazole lauroxil))
- Belrapzo (bendamustine)
- Bendeka (bendamustine)
- Benlysta (belimumab)
- Cinryze (C-1 esterase Inhibitor, human)
- Darzalex (daratumumab)
- Darzalex Faspro (daratumumab and hyaluronidase-fihj)
- Difitelio (defibrotide)
- Dupixent (dupilumab)
- Enbrel (etanercept)
- Forteo (teriparatide)
- Gazyva (obinutuzumab)
- Genotropin (somatropin)
- Haegarda (C-1 esterase Inhibitor, human)
- Herceptin (trastuzumab) *
- Humatrope (somatropin)
- Imfinzi (durvalumab)
- Invega Sustenna (paliperidone)
- Invega Trinza(paliperidone)
- Kadcyla (ado-trastuzumab)
- Keytruda (pembrolizumab)
- Kineret (anakinra)
- Norditropin (somatropin)
- NutropinAQ (somatropin)
- Omnitrope (somatropin)
- Opdivo (nivolumab)
- Orencia (abatacept)
- Perjeta (pertuzumab)
- Perseris (risperidone)
- Proleukin (aldesleukin)
- Reblozyl (luspatercept-aamt)
- Remicade (infliximab)*
- Risperdal Consta (risperidone)
- Rituxan (rituximab)*
- Saizen (somatropin)
- Takhzyro (lanadelumab-flyo)
- Treanda (bendamustine)
- Unituxin (dinutuximab)
- Xolair (omalizumab)
- Yervoy (ipilimumab)
- Yondelis (trabectedin)
- Zomacton(somatropin)
- Zyprexa Relprevv (olanzapine)

*Includes biosimilars

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New Policies

- Alkindi (hydrocortisone)
- Eysuvis (loteprednol)
- Impeklo (clobetasol)
- Orgovyx (relugolix)
- Orladeyo (berotralstat)
- Qdolo (tramadol)
- RediTrex (methotrexate)
- Reltone (ursodiol)
- Sutab (sodium sulfate/magnesium sulfate/potassium chloride)
- Trinaz (PNV #162/Fe/Folate)
- Winlevi (clascoterone)
- Wynzora (calcipotriene/betamethasone)
- Zokinvy (lonafarnib)

Updated Policies

- Adlyxin (lixisenatide)
- Amitiza (lubiprostone)
- Ampyra (dalfampridine)
- Bydureon (exenatide)
- Byetta (exenatide)
- Calquence (acalabrutinib)
- Caplyta (lumateperone)
- Caprelsa (vandetanib)
- Elidel (pimecrolimus)
- Entocort EC (budesonide)
- Gavreto (pralsetinib)
- Gleevac (imatinib)
- Fanapt (iloperidone)
- Hetlioz (tasimelteon)
- Imbruvica (ibrutinib)
- Jakafi (ruxolitinib)
- Janumet (sitagliptin/metformin)
- Janumet XR (sitagliptin/metformin ER)
- Januvia (sitagliptin)
- Jentadueto (linagliptin/metformin)
- Jentadueto XR (linagliptin/metformin ER)
- Kazano (alogliptin/metformin)
- Kombiglyze XR (saxagliptin/metformin)
- Latuda (lurasidone)
- Lenvima (lenvatinib)
- Migranal NS(dihydroergotamine)
- Nerlynx (neratinib)
- Nesina (alogliptin)
- Ofev (nintedanib)
- Onglyza (saxagliptin)
- Oseni (alogliptin/pioglitazone)
- Ortikos (budesonide)
- Ozempic (semaglutide)
- Protopic (tacrolimus)
- Qtern (dapagliflozin/saxagliptin)
- Regranex (becaplermin)
- Rexulti (brexpiprazole)
- Rybelsus (semaglutide)
- Rydapt (midostaurin)
- Saphris (asenapine)
- Saxenda (liraglutide)

• Secuado (asenapine) • Soliqua (lixisenatide/glargine) • Steglujan (ertugliflozin/sitagliptin) • Sutent (sunitinib) • Tagrisso (osimertinib) • Tanzeum (albiglutide) • Tradjenta (linagliptin) • Trikafta (elexacaftor/tezacaftor/ivacaftor) • Trulicity (dulaglutide) • Uceris (budesonide) • Venclexta (venetoclax) • Victoza (liraglutide) • Vimpat (lacosamide) • Vraylar (cariprazine) • Xalkori (crizotinib) • Xifaxan (rifaximin) • Xiidra (lifitegrast) • Xultophy (liraglutide/degludec) • Zytiga (abiraterone)
Retired Policies
• Daklinza (daclatasvir)[a]

[a] Product discontinued

BLUE SHIELD OF CALIFORNIA
SECOND QUARTER 2021 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE JUNE 2, 2021
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 2021 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:

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NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED only to the Plus Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
brinzolamide 1% ophthalmic suspension (Azopt)	Glaucoma	Step therapy
hydrocodone bitartrate tablet (Hysingla ER)[1]	Pain	Prior authorization, Quantity limit
imiquimod 3.75% cream packet (Zyclara)[1]	Actinic keratosis, External genital warts	Step therapy, Quantity limit

1. Applies only to Grandfathered plans

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) only for the Plus Drug Formulary:

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

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Bronchitol	Cystic fibrosis	Prior authorization, Quantity limit
droxidopa (Northera)	Neurogenic orthostatic	Prior authorization, Quantity limit

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
	hypotension	
Elepsia XR[2]	Partial seizures	Prior authorization, Quantity limit
Fortivda	Renal cell carcinoma	Prior authorization, Quantity limit
Hetlioz LQ	Smith-Magenis Syndrome	Prior authorization, Quantity limit
hydrocodone bitartrate 80mg, 100mg, 120mg tablet (Hysingla ER)[2]	Pain	Prior authorization, Quantity limit
Klisyri[2]	Actinic keratosis	Prior authorization, Quantity limit
Lupkynis	Lupus nephritis	Prior authorization, Quantity limit
Ponvory	Multiple sclerosis	Prior authorization, Quantity limit
Tepmetko	Non-small cell lung cancer	Prior authorization, Quantity limit
Ukoniq	Marginal zone lymphoma, Follicular lymphoma	Prior authorization, Quantity limit
Xeljanz oral solution	Polyarticular juvenile idiopathic arthritis	Prior authorization, Quantity limit
Xolair syringe	Asthma, Nasal polyps, Chronic urticaria	Prior authorization, Quantity limit

2. Does not apply to Grandfathered plans

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus and Standard/Value formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
Adzenys ER, Adzenys XR-ODT	ADHD	Prior authorization, Age-limit, Quantity limit
amphetamine er 1.25mg/ml suspension		
Mydayis		
Qullivant XR		
Baqsimi	Hypoglycemia	Quantity limit
Estring	Vulvar and vaginal atrophy due to menopause	
solifenacin succinate (Vesicare)	Overactive bladder	

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Gvoke Hypopen, Gvoke PFS	Hypoglycemia	Quantity limit
Vesicare	Overactive bladder	

DRUGS MOVED to a DIFFERENT TIER

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

Drug	FDA Indication(s)	New Tier Status for Plus Formulary
calcipotriene-betamethasone propionate topical suspension (Taclonex)	Plaque psoriasis	Tier 1 with Prior authorization[1] Tier 3 with Prior authorization[2]

1. Applies only to Grandfathered plans; 2. Does not apply to Grandfathered plans

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus and Standard/Value Drug Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
entricitabine-tenofovir disoproxil fumarate (Truvada)	HIV infection	
Entresto	Heart failure	Quantity limit
Zafemy	Contraceptive	

The following drugs were ADDED only to the Standard/Value Drug Formulary as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
Repatha, Repatha Sureclick, Repatha Pushtronix	Prevent cardiovascular events, Hyperlipidemia, Homozygous familial hypercholesterolemia	Prior authorization, Quantity limit
Xeljanz oral solution	Polyarticular juvenile idiopathic arthritis	

MEDICAL BENEFIT MEDICATION POLICIES:

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

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New Policies

- Abecma (idecabtagene vicleucel)
- Amondys 45 (casimersen)
- Breyanzi (lisocabtagene maraleucel)
- Cabenuva (cabotegravir ER; rilpivirine ER)
- Cosela (trilaciclib)
- Evkeeza (evinacumab-dgnb)
- Margenza (margetuximab-cmkb)
- Nulibry (fosdenopterin)

- Pepaxto (melphalan flufenamide)

Updated Policies

- Actemra (tocilizumab)
- Arcalyst (rilonacept)
- Cancidas (caspofungin)
- Clolar (clofarabine)
- Cresemba (isavuconazonium)
- Enhertu (fam-trastuzumab deruxtecan-nxki)
- Eraxis (anidulafungin)
- Exondys 51 (eteplirsen)
- Fabrazyme (agalsidase beta)
- Herceptin Hylecta (trastuzumab and hyaluronidase-oysk)
- Imfinzi (durvalumab)
- Kadcyla (ado-trastuzumab)
- Keytruda (pembrolizumab)
- Kyprolis (carfilzomib)
- Libtayo (cemiplimab-rwlc)
- Mycamine (micafungin)
- Mylotarg (gemtuzumab ozogamicin)
- Opdivo (nivolumab)
- Perjeta (pertuzumab)
- Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf)
- Praluent (alirocumab)
- Repatha (evolocumab)
- Sarclisa (isatuximab-irfc)
- Tecentriq (atezolizumab)
- Trastuzumab containing agents (Herceptin, Kanjinti, Ogivri, Ontruzant, Herzuma, Trazimera)
- Trodelvy (sacituzumab govitecan-hziy)
- Tyvaso (treprostinil)
- Yescarta (axicabtagene ciloleucel)

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New Policies

- Bronchitol (mannitol)
- Elepsia XR (levetiracetam)
- Fotivda (tivozanib)
- Gemtesa (vibegron)
- Hetlioz LQ (tasimelteon) suspension
- Klisyri (tirbanibulin)
- Lupkynis (voclosporin)
- Ponvory (ponesimod)
- Pregen DHA (PNV/FE carbonyl/Folate/DHA)
- Tepmetko (tepotinib)
- Ukoniq (umbralisib)
- Verquvo (vericiguat)

- Vesicare LS (solifenacin) suspension
- Xeljanz (tofacitinib) solution

Updated Policies

- Alinia (nitazoxanide)
- Ayvakit (avapritinib)
- Belsomra (suvorexant)
- Bidil (isosorbide dinitrate/ hydralazine)
- Bosulif (bosutinib)
- Carbaglu (carglumic acid)
- Clindamycin agents (Clindagel)
- Cresemba (isavuconazonium)
- Darifenacin Hydrobromide ER (Enablex)
- Daurismo (glasdegib)
- Dayvigo (lemborexant)
- Emverm (mebendazole)
- Erivedge (vismodegib)
- Hepatitis C Virus
- Galafold (migalastat)
- Gelnique (oxybutynin chloride)
- Gocovri (amantadine extended-release)
- Iclusig (ponatinib)
- Icosapentyl ethyl (Vascepa)
- Idhifa (Enasidenib)
- imatinib (Gleevec)
- Insulin delivery devices (Inpen for Humalog)
- Inrebic (fedratinib)
- Jakafi (ruxolitinib)
- Juxtapid (lomitapide)
- Lorbrena (lorlatinib)
- Lynparza (olaparib)
- Mepron (atovaquone suspension)
- metformin containing agents ER (Riomet/Riomet ER)
- Micort-HC (hydrocortisone acetate)
- Myrbetriq (mirabegron ER)
- Nexavar (sorafenib)
- Odomzo (sonidegib)
- Ofev (nintedanib)
- Osmolex ER (amantadine ER)
- Oxytrol patch (oxybutynin)
- Pemazyre (pemigatinib)
- Pomalyst (pomalidomide)
- ramelteon (Rozerem)
- Rhofade (oxymetazoline HCl)
- SGLT-2 inhibitors
- Stendra (avanafil)
- Sutent (sunitinib)
- Rubraca (rucaparib)
- Rydapt (midostaurin)
- Sprycel (dasatinib)
- Stivarga (regorafenib)
- Synarel (nafarelin)
- tolterodine tartrate (Detrol, Detrol LA)
- Toviaz (fesoterodine fumarate ER)
- Taclonex (calcipotriene/betamethasone)
- Tasigna (nilotinib)

• Tibsovo (ivosidenib) • Vardenafil (Levitra, Staxyn ODT) • Veregen (sinecatechins) • Xifaxan (rifaximin) • Xospata (gilteritinib) • Zejula (niraparib) • Zyclara (imiquimod)
Retired Policies
• Entresto (sacubitril/valsartan)

BLUE SHIELD OF CALIFORNIA
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EFFECTIVE JANUARY 1, 2022
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DRUGS REMOVED from FORMULARY

The following drug(s) are no longer covered on the Plus and Standard/Value Drug Formularies because it is available without a prescription.

Drug	FDA Indication(s)	Alternative(s)
lansoprazole 15mg ODT (Prevacid Solutab)	Duodenal ulcer, H. Pylori, Gastric ulcer, GERD, Erosive esophagitis, Hypersecretory conditions	omeprazole capsule, lansoprazole 30mg capsule
Prevacid Solutab 15mg ODT		

The following drug(s) were removed from the Standard/Value Drug Formularies.

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

Drug	FDA Indication(s)	Alternative(s)
Granix[3]	Neutropenia	Zarxio
Levemir, Levemir Flextouch	Diabetes	Lantus
mupirocin 2% cream	Secondarily infected traumatic skin lesions	mupirocin 2% ointment
Picato	Actinic keratosis	imiquimod 5% cream
Qvar MDI	Asthma	Qvar Redihaler

3. Non-formulary drugs that meet the Tier 4 description require a medical necessity exception 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.

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

Drug	FDA Indication(s)	Restriction(s)	Alternative(s)
Picato	Actinic keratosis	Quantity limit	imiquimod 5% cream, Tolak
Qvar MDI	Asthma, COPD	Quantity limit	Qvar Redihaler

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus and Standard/Value formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
Acuvail	Cataract surgery	Quantity limit
desloratadine 5mg tablet (Clarinex)	Allergic rhinitis, Chronic idiopathic urticaria	
ibandronate 150mg tablet (Boniva)	Postmenopausal osteoporosis	Quantity limit
Intron A	Hairy cell leukemia, Malignant melanoma, Follicular Lymphoma, Condylomata acuminata, AIDs-related kaposi's sarcoma, Chronic Hep C, Chronic Hep B	
methylergonovine tablet, Methergine tablet	Postpartum bleeding	Quantity limit
Peg-Intron, Peg-Intron Redipen	Chronic hepatitis C	
tramadol er tablet (Ultram ER)	Pain	Quantity limit
tramadol er tablet, biphasic (Ryzolt)		Prior authorization, Quantity limit

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Altoprev[1]	Coronary heart disease, Hyperlipidemia	Prior authorization, Quantity limit
Boniva	Postmenopausal osteoporosis	Quantity limit
Cipro HC	Otitis externa	Step therapy
Clarinex	Allergic rhinitis, Chronic idiopathic urticaria	

Drug	FDA Indication(s)	Coverage Restriction(s)
Conzip	Pain	Prior authorization, Quantity limit
DDAVP Rhinal Tube	Diabetes insipidus	Prior authorization
erythromycin base film coated tablet 250mg, 500mg	Bacterial infection	
erythromycin base, ery-tab delayed release tablet 250mg, 333mg, 500mg		
ethacrynic acid (Edecrin)[1]	Edema	Prior authorization, Quantity limit
Edecrin[1]		
Ezallor Sprinkle	Hypertriglyceridemia, Hyperlipoproteinemia, Hypercholesterolemia	Quantity limit
Migergot rectal suppository[1]	Headache	Prior authorization, Quantity limit
Nayzilam[1]	Seizure clusters	Prior authorization, Quantity limit
Valtoco[1]		
Norgesic Forte[1] orphenadrine-asa-caffeine[1] Orphengesic Forte[1]	Musculoskeletal pain	Prior authorization, Quantity limit
Silenor	Insomnia	Step therapy, Quantity limit
Sylatron	Melanoma	
timolol maleate 0.5% ophthalmic solution, pf (Timoptic Ocudose)	Glaucoma	Step therapy
Timoptic Ocudose 0.5%		

1. Applies only to Grandfathered plans

DRUGS MOVED to a DIFFERENT TIER

The following drugs were moved to a higher or lower tier for the Plus and Standard/Value Drug Formularies as noted:

Drug	FDA Indication(s)	New Tier Status for both Formularies
risedronate (Actonel)[2]	Postmenopausal osteoporosis, Glucocorticoid-induced osteoporosis, Osteoporosis in men	Tier 2 with Step therapy, Quantity limit
risedronate (Atelvia)[2]	Postmenopausal osteoporosis	

2. Does not apply to Grandfathered plans

The following drugs were moved to a higher or lower tier for the Standard/Value Drug Formularies as noted:

Drug	FDA Indication(s)	New Tier Status for Standard Formulary
cromolyn sodium nebulizer solution	Asthma	Tier 3 with Quantity limit

diphenoylate-atropine oral liquid	Diarrhea	Tier 2

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

Drug	FDA Indication(s)	New Tier Status for Plus Formulary
Abstral[2]	Pain	Tier 4 with Prior authorization, Quantity limit
hydrocodone bitartrate 60mg tablet[2]		
Hysingla ER 60mg[2]		
Lazanda[2]		
Subsys[2]		
hydromorphone 1mg/ml oral solution[2]		Tier 2 with Quantity limit
hydromorphone 1mg/ml rectal suppository[2]		
morphine sulfate er capsule (Avinza)[2] morphine sulfate er capsule (Kadian)[2]		Tier 2 with Prior authorization, Quantity limit
tramadol er capsule (Conzip)		Tier 3 with Prior authorization
diclofenac epolamine 1.3% patch (Flector)[2]	Minor strains, sprains, and contusions	Tier 2 with Prior authorization, Quantity limit
meloxicam (Vivlodex)[2]	Osteoarthritis	Tier 4 with Prior authorization, Quantity limit
Vivlodex[2]		
naproxen 125mg/5ml oral suspension (Naprosyn)[2]	RA, OA, Ankylosing spondylitis, pJIA, Tendonitis, Bursitis, Acute gout, Pain, Dysmenorrhea	Tier 4 with Prior authorization
Naprosyn 125mg/5ml oral suspension[2]		
Norgesic Forte[2] orphenadrine-asa-caffeine[2] Orphengesic Forte[2]	Musculoskeletal pain	Tier 4 with Prior authorization, Quantity limit
alosetron (Lotronex)[2]	Diarrhea-predominant IBS	Tier 4 with Prior authorization
Lotronex[2]		
diphenoylate-atropine 2.5mg-0.025mg/5ml oral liquid[2]	Diarrhea	Tier 2
amoxicillin-clarithromycin-lansoprazole (Prevpac)[2]	H. Pylori	Tier 2 with Quantity limit
lansoprazole 30mg ODT (Prevacid)[2]	Duodenal ulcer, H. Pylori, Gastric ulcer, GERD, Erosive esophagitis, Hypersecretory conditions	Tier 2 with Step therapy
Altoprev[2]	Coronary heart disease, Hyperlipidemia	Tier 4 with Prior authorization, Quantity limit
aspirin-omeprazole (Yosprala)[2]	Prevent cardiovascular and cerebrovascular events and gastric ulcer	Tier 4 with Prior authorization, Quantity limit
Yosprala[2]		

Drug	FDA Indication(s)	New Tier Status for Plus Formulary
carvedilol er capsule (Coreg CR)[2]	Heart failure, Hypertension, Left ventricular dysfunction	Tier 2 with Step therapy
Inderal XL, Innopran XL	Hypertension	Tier 3 with Prior authorization[1] Tier 4 with Prior authorization[2]
ethacrynic acid (Edecrin)[2]	Edema	Tier 4 with Prior authorization, Quantity limit
Edecrin[2]		
cinacalcet (Sensipar)[2]	Hyperparathyroidism, Hypercalcemia	Tier 4 with Prior authorization
Sensipar[2]		
doxepin 3mg, 6mg tablet (Silenor)	Insomnia	Tier 1 with Step therapy, Quantity limit[1] Tier 2 with Step therapy, Quantity limit[2]
quazepam		Tier 3 with Quantity limit
Alomide	Vernal keratoconjunctivitis	Tier 3
Blephamide S.O.P. ointment	Steroid responsive eye conditions at risk for bacterial infection	Tier 3
FML 0.1% ophthalmic ointment	Steroid responsive eye disorders	Tier 3
halobetasol 0.05% foam[2]	Plaque psoriasis	Tier 4 with Prior authorization, Quantity limit
Lexette[2]		
Taclonex topical suspension[2]		Tier 4 with Prior authorization
Epiduo Forte	Acne vulgaris	Tier 3 with Step therapy, Age-limit
naftifine 1% cream[2], naftifine 1% gel[2], naftifine 2% cream[2]	Tinea pedis, Tinea cruris, Tinea corporis	Tier 2 with Step therapy
imiquimod 3.75% cream (Zyclara)[2]	Actinic keratosis, External genital warts	Tier 4 with Step therapy, Quantity limit
Zyclara 3.75% cream[2]		
Zyclara 2.5% cream[2]	Actinic keratosis	Tier 4 with Step therapy, Quantity limit
Veregen[2]	Genital and perianal warts	Tier 4 with Step therapy, Quantity limit
Condylox 0.5% gel	Anogenital warts	Tier 3 with Step therapy[1] Tier 4 with Step therapy[2]
Millipred, Millipred DP	Steroid responsive disorders	Tier 3 with Prior authorization
Nayzilam[2]	Seizure clusters	Tier 4 with Prior authorization, Quantity limit
Valtoco[2]		
Migergot rectal suppository[2]	Headache	Tier 3 with Prior authorization, Quantity limit
Onsetra Xsail[2]	Migraine	Tier 4 with Prior authorization,

Drug	FDA Indication(s)	New Tier Status for Plus Formulary
Zembrace Symtouch[2]		Quantity limit
Inpen[2]	Diabetes	Tier 4 with Prior authorization, Quantity limit
pioglitazone-glimepiride (Duetact)[2]		Tier 2 with Step therapy, Quantity limit
Sancuso[2]	Chemotherapy induced nausea/vomiting	Tier 4 with Prior authorization, Quantity limit
cromolyn sodium nebulizer solution[2]	Asthma	Tier 2 with Quantity limit
terbutaline sulfate tablet[2]	Asthma, COPD	Tier 2
vardenafil (Levitra)[2] vardenafil (Staxyn)[2]	Erectile dysfunction	Tier 2 with Prior authorization, Quantity limit
Xerese[2]	Herpes labialis (cold sores)	Tier 4 with Prior authorization, Quantity limit

1. Applies only to Grandfathered plans; 2. Does not apply to Grandfathered plans

DRUGS ADDED to FORMULARY

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Carbaglu	Hyperammonemia	Prior authorization, Quantity limit
erythromycin base film coated tablet 250mg, 500mg	Bacterial infection	
erythromycin base, ery-tab delayed release tablet 250mg, 333mg, 500mg		
Imbruvica	Mantle cell lymphoma, Chronic lymphocytic leukemia, Small lymphocytic lymphoma, Waldenstrom's macroglobulinemia, Marginal zone lymphoma, cGVHD	Prior authorization, Quantity limit
Mekinist	Melanoma, NSCLC, Thyroid cancer	Prior authorization, Quantity limit
Odomzo	Basal cell carcinoma	Prior authorization, Quantity limit
Orenitram	Pulmonary arterial hypertension	Prior authorization, Quantity limit
Phospholine iodide	Glaucoma, Estropia	

BLUE SHIELD OF CALIFORNIA
THIRD QUARTER 2021 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE SEPTEMBER 1, 2021
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 2021 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", "Value 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 Plus and Standard/Value Drug Formularies.

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

Drug	FDA Indication(s)	Alternative(s)
Ribasphere[1]	Hepatitis C	ribavirin tablet, capsule

1. effective 5/2021

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED only to the Plus Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
clemastine 0.67mg/5ml syrup[2]	Allergic rhinitis, Urticaria, Angioedema	Prior authorization, Quantity limit
pregabalin er tablet (Lyrica CR)	Diabetic peripheral neuropathy, Postherpetic neuralgia	Prior authorization, Quantity limit
rufinamide (Banzel)	Lennox-Gastaut Syndrome	Step therapy, Quantity limit

2. Applies only to Grandfathered plans

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) only for the Plus Drug Formulary:

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

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
calcitonin inj (Miacalcin)[3]	Paget's disease, Hypercalcemia, Postmenopausal osteoporosis	
clemastine 0.67mg/5ml syrup[3]	Allergic rhinitis, Urticaria, Angioedema	Prior authorization, Quantity limit
Empaveli	Paroxysmal nocturnal hemoglobinuria	Prior authorization, Quantity limit
Exervan	Amyotrophic lateral sclerosis	Prior authorization, Quantity limit
Lumakras	Non-small cell lung cancer	Prior authorization, Quantity limit
Myfembree[3]	Fibroids	Prior authorization, Quantity limit
tiopronin (Thiola)	Cystinuria	Prior authorization
Truseltiq	Choliangiocarcinoma	Prior authorization, Quantity limit
Wegovy	Chronic weight management	Prior authorization, Quantity limit

3. Does not apply to Grandfathered plans

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus and Standard/Value formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
Clindagel[1]	Acne vulgaris	
prednisolone sodium phosphate 15mg/5ml oral solution	Steroid responsive conditions	

1. effective 5/2021

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Standard/Value formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
Altreno	Acne vulgaris	Age-limit

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Absorica[1]	Acne vulgaris	
Altreno		Prior authorization, Age-limit
clindamycin 1% gel (Clindagel)[1,2]		

2. Applies only to Grandfathered plans

DRUGS MOVED to a DIFFERENT TIER

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

Drug	FDA Indication(s)	New Tier Status for Plus Formulary
aripiprazole tablet	Schizophrenia	Tier 1 with Quantity limit

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus and Standard/Value Drug Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
albuterol hfa (Ventolin HFA)[4]	Asthma	Quantity limit
clindamycin 1% gel (Clindagel)[3]	Acne vulgaris	
Lyumjev, Lyumjev Kwikpen	Diabetes	

3. Does not apply to Grandfathered plans; 4. Effective 7/2021

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

Drug	FDA Indication(s)	Coverage Restriction(s)
etravirine (Intelence)	HIV-infection	Quantity limit
lopinavir-ritonavir (Kaletra)		
tiopronin (Thiola)	Cystinuria	Prior authorization

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on September 1, 2021 and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → Guidelines & standards → Policy and standards → Medication Policies → Medication Policy List → Medical drug policies for Commercial plans.

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

New Policies
• Aduhelm (aducanumab-avwa) • Jemperli (dostarlimab -gxly) • Rybrevant (amivantamab-vmjw) • Zynlonta (loncvinastuximab tesirine-lpyl)
Updated Policies
• Abraxane (paclitaxel protein bound) • Aranesp (darbepoetin) • Azedra (iobenguane I-131) • Bevacizumab (Avastin, Myvasi, Zirabev) • Brineura (cerliponase alfa) • Crysvita (burosumab-twza) • Cyramza (ramucinumab) • Epoetin Alfa (Epogen, Procrit, Retacrit) • Faslodex (fulvestrant) • Filgrastim- containing agents (Neupogen, Nivestym, Zarxio) • Halaven (eribulin) • Ixempra (ixabepilone) • Keytruda (pembrolizumab) • Fusilev (levoleucovorin) • Granix (Tbo-filgrastim) • Khapzory (levoleucovorin) • Krystexxa (pegloticase) • Libtayo (cemiplimab-rwlc) • Mircera (methoxy polyethylene glycolepoetin beta) • Nplate (romiplostim) • Onpattro (patisiran) • Opdivo (nivolumab) • Padcev (enfortumab vedotin-ejfv) • Rituximab (Riabni, Rituxan, Ruxience, Truxima) • Rituxan Hycela (rituximab hyaluronidase) • Strensiq (asfotase alfa) • Synribo (omacetaxine) • Tazverik (tazemetostat) • Tecentriq (atezolizumab) • Tegsedi (inotersen) • Torisel (temsirolius) • Trodelvy (sacituzimab govitecan-hziy) • Vectibix (panitumumab) • Vyepti (eptinezumab-jmr) • Yervoy (ipilimumab) • Zevalin (ibritumomab)

PHARMACY BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on September 1, 2021 and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → Guidelines & standards → Policy and standards → Medication Policies → Medication Policy List → Outpatient drug policies for Commercial plans.

Refer to medication policy for complete details.

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

New Policies
• Accrufer (ferric maltol) • Azstarys (serdexmethylphenidate-dexmethylphenidate) • Brexafemme (ibrexafungerp citrate) • Clemastine fumarate • Empaveli (pegcetacoplan) • Exservan (riluzole) • Kloxxado (naloxone) • Lumakras (sotorasib) • Lybalvi (olanzapine/samidorphan) • Myfembree (relugolix-estradiol-norethindrone acetate) • Nextstellis (drospirenone and estetrol) • Qelbree ER (viloxazine ER) • Roszet (rosuvastatin-ezetimibe) • Truseltiq (infigratinib) • Wegovy (semaglutide) • Zegalogue (deasilucagon)
Updated Policies
• Adcirca (Tadalafil) • Adempas (riociguat) • Afinitor, Afinitor Disperz (everolimus) • Aimovig (erenumab-aooe) • Ajovy (fremanezumab-vfrm) • Allergen Extract Agents (Ragwitek) • Alyq (tadalafil) • Avyakit (avapritinib) • benzphetamine (Didrex) • Cabometyx (cabozantinib) • Cialis (tadalafil) • Contrave ER (bupropion/ naltrexone) • Cosentyx (secukinumab) • Daliresp (roflumilast) • diethylpropion (Tenuate, Tenuate Dospan) • Emgality (galcanezumab-gnlm) • Emend (aprepitant) • Epclusa (sofosbuvir/velpatasvir) • Erivedge (vismodegib) • Farxiga (dapagliflozin) • Hetlioz (tasimelteon) • Ibrance (palbociclib) • Inlyta (axitinib) • Invokamet/Invokamet tXR (canagliflozing/metformin) • Invokana (canagliflozin) • itraconazole

- Kisqali (ribociclib)
- Koselugo (selumetinib)
- Lenvima (lenvatinib)
- Letairis (ambrisentan)
- Levitra (vardenafil)
- Lonsurf (trifluridine-tipiracil)
- Nerlynx (neratinib)
- Nexavar (sorafenib)
- Noxafil (posaconazole)
- Nurtec (Rimegepant)
- Pemazyre (pemigatinib)
- phendimetrazine (Bontril, Bontril PDM)
- phentermine (Adipex-P, Fastin, Lomaira)
- Piqray (alpelisib)
- Qsymia (phentermine/ topiramate)
- Opsumit (macitentan)
- Orenitram (treprostinil)
- Ortikos (budesonide ER)
- Revatio (sildenafil)
- Reyvow (Lasmiditan)
- Saxenda (liraglutide)
- Solosec (secnidazole)
- Staxyn (vardenafil)
- Stendra (avanafil)
- Sutent (sunitinib)
- Tafinlar (dabrafenib)
- Targretin (bexarotene)
- Tavalisse (fostamatinib)
- Tiglutik (riluzole)
- Tolsura (itraconazole)
- Tracleer (bosentan)
- Trikafta (elexacaftor/tezacaftor/ivacaftor)
- Tykerb (lapatinib)
- Ubrelvy (ubrogepant)
- Uptravi (selexipag)
- Voriconazole
- Votrient (pazopanib)
- Vyndaqel, Vyndamax (tafamidis)
- Xenical (orlistat)
- Xigduo XR (dapagliflozing/metformin)
- Zelboraf (vemurafenib)
- Zeposia (ozanimod)

BLUE SHIELD OF CALIFORNIA
THIRD QUARTER 2021 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE JANUARY 1, 2022
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 2021 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", "Value 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) are no longer covered on the Plus and Standard/Value Drug Formularies because it is available without a prescription.

Drug	FDA Indication(s)	Alternative(s)
hydrocortisone 1% ointment, in absorbase	Steroid responsive dermatoses	hydrocortisone 2.5% cream, lotion

The following drug(s) were removed from the Plus and Standard/Value Drug Formularies.

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

Drug	FDA Indication(s)	Alternative(s)
phendimetrazine 105mg er capsule	Weight management	phendimetrazine tablet, phentermine capsule & tablet
Ventolin HFA	Asthma	albuterol hfa (Proair HFA, Proventil HFA, Ventolin HFA)

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 otherwise.*

Drug	FDA Indication(s)	Restriction(s)	Alternative(s)
Lortab10-300mg/15ml oral solution	Pain	Quantity limit	hydrocodone-acetaminophen 10mg-325mg tablet, hydrocodone-acetaminophen 7.5mg-325mg/ 15ml oral solution

DRUGS MOVED to a DIFFERENT TIER

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

Drug	FDA Indication(s)	New Tier Status for Plus Formulary
alogliptin (Nesina)	Diabetes	Tier 2 with Prior authorization, Quantity limit
alogliptin-metformin (Kazano)		
alogliptin-pioglitazone (Oseni)		
ivermectin 1% cream[3]	Acne rosacea	Tier 2 with Prior authorization, Quantity limit

3. Does not apply to Grandfathered plans

BLUE SHIELD OF CALIFORNIA
FOURTH QUARTER 2021 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE DECEMBER 1, 2021
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 2021 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", "Value 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/Value Drug Formularies.

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

Drug	FDA Indication(s)	Alternative(s)
Cosentyx[1]	Plaque psoriasis, Psoriatic arthritis, Ankylosing spondylitis, Spondyloarthritis	Taltz

1. effective 1/2022

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

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

Drug	FDA Indication(s)	Alternative(s)
doxycycline hyclate 50mg tablet[1,2]	Bacterial infection	doxycycline hyclate 50mg capsule, doxycycline monohydrate 50mg tablet

1. effective 1/2022; 2. Does not apply to Grandfathered plans

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Standard/Value Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
everolimus 10mg (Afinitor)	Breast cancer, Neuroendocrine tumor, Renal cell carcinoma, Tuberous sclerosis complex (TSC) -associated renal angiomyolipoma, TSC associated SEGA	Prior authorization
everolimus tablet for oral suspension (Afinitor Disperz)	Tuberous sclerosis complex (TSC) - associated SEGA, TSC-associated partial-onset seizures	Prior authorization
sunitinib (Sutent)	Renal cell cancer, GIST, pNET	Prior authorization

The following drugs are <u>newly available</u> GENERIC drugs that were ADDED to the Plus Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
buprenorphine buccal film (Belbuca)	Pain	Prior authorization
ibuprofen-famotidine (Duexis)[3]	OA, RA and increased risk of upper GI ulcers	Prior authorization

3. Applies only to Grandfathered plans

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were <u>ADDED</u> to the Blue Shield Specialty Tier (Tier 4) only for the Plus Drug Formulary:

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

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Bylvay	Pruritis associated with intrahepatic cholestasis	Prior authorization
chlorpromazine concentrated oral solution[2]	Schizophrenia, Nausea/vomiting, Porphyria, Hiccups, Opposition defiant disorder	Prior authorization
diclofenac potassium 25mg tablet[2]	Dysmenorrhea, OA, RA, Mild to moderate pain	Prior authorization
everolimus 10mg (Afinitor)	Breast cancer, Neuroendocrine tumor, Renal cell carcinoma, Tuberous sclerosis complex (TSC) -associated renal angiomyolipoma, TSC associated SEGA	Prior authorization
everolimus tablet for oral suspension (Afinitor Disperz)	Tuberous sclerosis complex (TSC) - associated SEGA, TSC-associated partial-onset seizures	Prior authorization
Exkivity	Non-small cell lung cancer	Prior authorization
Livmarli	Cholestatic pruritis associated with Alagille syndrome	Prior authorization
Lybalvi[2]	Schizophrenia, Bipolar disorder	Prior authorization
Opzelura[2]	Atopic dermatitis	Prior authorization
Qulipta[2]	Migraine	Prior authorization
Trudhesa[2]		

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Rezurock	Chronic graft vs host	Prior authorization
sunitinib (Sutent)	Renal cell cancer, GIST, pNET	Prior authorization
Welireg	von Hippel-Lindau disease	Prior authorization

2. Does not apply to Grandfathered plans

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus and Standard/Value formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
modafinil (Provigil)	Narcolepsy, Obstructive sleep apnea, Shift work disorder	
risedronate 5mg, 35mg, 150mg tablet (Actonel)	Osteoporosis	
risedronate 35mg dr tablet (Atelvia)		

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Actonel 5mg, 35mg, 150mg tablet	Osteoporosis	
Atelvia		
Fanapt[1]	Schizophrenia	Step therapy
Saphris[1]	Schizophrenia, Bipolar disorder	
Versacloz[1]	Schizophrenia, Schizoaffective disorder	
flac otic oil	Eczematous external otitis	
fluocinolone acetonide otic oil		
Provigil	Narcolepsy, Obstructive sleep apnea, Shift work disorder	

1. effective 1/2022

DRUGS MOVED to a DIFFERENT TIER

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

Drug	FDA Indication(s)	New Tier Status for Standard/Value Formulary
Suprep	Bowel cleanser for colonoscopy	Tier 2

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Plus and Standard/Value Drug Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
Klor-con M15	Hypokalemia	
nebivolol (Bystolic)	Hypertension	
SSD	Wound care	
varenicline (Chantix)	Smoking cessation	

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Latuda	Schizophrenia, Bipolar disorder	Step therapy
Taltz[1]	Plaque psoriasis, Psoriatic arthritis, Ankylosing spondylitis, Spondyloarthritis	Prior authorization
Verzenio	Breast cancer	Prior authorization

1. effective 1/2022

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

Drug	FDA Indication(s)	Coverage Restriction(s)
difluprednate (Durezol)	Pain and inflammation	
enalapril oral solution (Epaned)	Hypertension, Heart failure	
paroxetine oral suspension (Paxil)	MDD, OCD, PD, SAD, GAD, PTSD	
Targadox[3]	Bacterial infection	Prior authorization
Zenzedi[3]	ADHD, Narcolepsy	Step therapy, Age-limit

3. Applies only to Grandfathered plans

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on December 1, 2021, and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → Guidelines & standards → Policy and standards → Medication Policies → Medication Policy List → Medical drug policies for Commercial plans.

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

New Policies
• Nexviazyme (avalglucosidase alfa-ngpt) • Rylaze (asparaginase erwinia chrysanthemi [recombinant]-rywn) • Saphnelo (anifrolumab-fnia) • Tivdak (tisotumab vedotin-tftv) • Uptravi (selexipag)
Updated Policies
• Actemra (tocilizumab) • Avsola (infliximab-axxq) • Benlysta (belimumab) • Darzalex (daratumumab) • Darzalex Faspro (daratumumab; hyaluronidase-fihj) • Entyvio (vedolizumab) • Erbitux (cetuximab) • Ilumya (tildrakizumab-asmn) • Inflectra (infliximab-dyyb) • IVIG • Jemperli (dostarlimab-gxly) • Kevzara (sarilumab) • Keytruda (pembrolizumab) • Kyprolis (carfilzomib) • Nplate (romiplostim) • Opdivo (nivolumab) • Orencia (abatacept) • Polivy (polatuzumab vedotin-piiq) • Remicade (infliximab) • Renflexis (infliximab-abda) • Revatio (sildenafil) • Riabni (rituximab-arrx) • Rituxan (rituximab) • Ruxience (rituximab-pvvr) • Rybrevant (amivantamab-vmjw) • Simponi Aria (golimumab) • Stelara (ustekinumab) • Sylvant (siltuximab) • Tecartus (brexucabtagene autoleucel) • Tecentriq (atezolizumab) • Torisel (temsirolimus) • Truxima (rituximab-abbs) • Tysabri (natalizumab) • Velcade (bortezomib) • Yervoy (ipilimumab)

PHARMACY BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on December 1, 2021, and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → Guidelines & standards → Policy and standards → Medication Policies → Medication Policy List → Outpatient drug policies for Commercial plans.

Refer to medication policy for complete details.

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

New Policies
• Bylvay (odevixibat) • chlorpromazine • Diclofenac potassium • Exkivity (mobocertinib) • Fanapt (iloperidone) • Kerendia (finerenone) • Livmarli (maralixibat) • Loreev XR (lorazepam extended-release) • Myrbetriq granules (mirabegron) • Opzelura (ruxolitinib phosphate) • Qulipta (atogepant) • Rezurock (belumosudil mesylate) • Saphris (asenapine) • Thalitone (chlorthalidone) • Trudhesa (dihydroergotamine mesylate) • Versacloz (clozapine) • Welireg (belzutifan)
Updated Policies
• Actemra (tocilizumab) • Apokyn (apomorphine) • Balversa (erdafitinib) • Braftovi (encorafenib) • Brukinsa (zanubrutinib) • Cabometyx (cabozantinib) • Cimzia (certolizumab pegol) • Cometriq (cabozantinib) • Cosentyx (secukinumab) • Cotellic (cobimetinib) • Doptelet (avatrombopag) • Dupixent (dupilumab) • Enbrel (etanercept) • Gocovri (amantadine) • Hetlioz (tasimelteon) • Humira (adalimumab) • Inbrija (levodopa) • Jardiance (empagliflozin) • Kevzara (sarilumab) • Kineret (anakinra) • Kynmobi (apomorphine) • Lenvima (lenvatinib) • Lynparza (olaparib) • Mekinist (trametinib) • Mektovi (binimetinib) • Nexavar (sorafenib)

- Nourianz (istradefylline)
- Nucala (mepolizumab)
- Olumiant (baricitinib)
- Ongentys (opicapone)
- Orencia (abatacept)
- Osmolex ER (amantadine)
- Otezla (apremilast)
- Pomalyst (pomalidomide)
- Promacta (eltrombopag)
- Revlimid (lenalidomide)
- Rinvoq ER (upadacitinib)
- Sabril (vigabatrin)
- Siliq (brodalumab)
- Simponi (golimumab)
- Skyrizi (risankizumab-rzaa)
- Stelara (ustekinumab)
- Tafinlar (dabrafenib)
- Taltz (ixekizumab)
- Tavalisse (fostamatinib)
- Tremfya (guselkumab)
- Turalio (pexidartinib)
- Xeljanz, Xeljanz XR (tofacitinib)
- Xpovio (selinexor)
- Xywav (calcium/magnesium/potassium/sodium oxybate)
- Zelboraf (vemurafenib)
- Zeposia (ozanimod)