BLUE SHIELD OF CALIFORNIA
FIRST QUARTER 2018 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE MAY 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 First Quarter 2018 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)
Adderall XR*	ADHD	dextroamphetamine/amphetamine extended-release capsule
Sovaldi**	Hepatitis C	Epclusa, Harvoni, Mavyret, Vosevi

**Depending on the member's prescription benefit plan design, the member cost-share will be either the applicable copay or coinsurance, or the generic copayment plus the difference in cost between the generic and the brand-name drug.*
***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.

- *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)
Adderall XR*	ADHD	Prior authorization Age-limit	dextroamphetamine/amphetamine extended-release capsule

**Depending on the member's prescription benefit plan design, the member cost-share will be either the applicable copay or coinsurance, or the generic copayment plus the difference in cost between the generic and the brand-name drug.*

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)
methylphenidate 72mg extended-release tablet	ADHD	Prior authorization, Age restriction, and Quantity limit
sildenafil citrate (Viagra)	Erectile dysfunction	Prior authorization, Gender restriction, and Quantity limit

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)
carvedilol extended-release capsule (Coreg CR)	Heart failure, Hypertension, Left ventricular dysfunction	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 and Plus formulary, effective March 1, 2018:

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

Specialty Drug	Coverage Restriction(s)
Repatha	Prior authorization and 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 formulary, effective March 1, 2018:

Drug	FDA Indication(s)	Restriction removed
Bunavail	Opioid dependence	Prior authorization
Zubsolv	Opioid dependence	Prior authorization

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

Drug	FDA Indication(s)	Restriction removed
buprenorphine sublingual tablet (Subutex) *(effective April 1, 2018)*	Opioid dependence	Prior authorization

Drug	FDA Indication(s)	Restriction removed
buprenorphine-naloxone sublingual tablet (Suboxone) *(effective March 1, 2018)*	Opioid dependence	Prior authorization
dextroamphetamine/amphetamine extended-release capsule (Adderall XR)	ADHD	Prior authorization

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Ryvent	Allergic rhinitis, Allergic conjunctivitis, Vasomotor rhinitis, Urticaria, Angioedema	Prior authorization

DRUGS ADDED to FORMULARY

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Juluca	HIV-infection	Quantity limit

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

Drug	FDA Indication(s)	Coverage Restriction(s)
timolol maleate 0.5% ophthalmic drops (Istalol)	Glaucoma	

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

Drug	FDA Indication(s)	Coverage Restriction(s)
atazanavir sulfate capsule (Reyataz)	HIV-infection	Quantity limit
efavirenz capsule, tablet (Sustiva)	HIV-infection	Quantity limit
estradiol 0.01% vaginal cream (Estrace)	Vulvar and vaginal atrophy	
tenofovir disoproxil fumarate 300mg tablet (Viread)	HIV-infection	Quantity limit
Trelegy Ellipta	COPD	Quantity limit

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were created or updated and changes are effective on March 1, 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

- *Aranesp (darbepoietin) - Update*
- *Cinvanti (aprepitant) – NEW*
- *Epogen (epoetin alfa) - Update*
- *Fasenra (benralizumab) – NEW*
- *IVIG - Update*
- *Luxturna (voretigene neparvovec-rzyl) – NEW*
- *Mepsevii (vestronidase alfa-vjbk) – NEW*
- *Nucala (mepolizumab) - Update*
- *Perjeta (pertuzumab) - Update*
- *Praluent (alirocumab) - Update*
- *Prevymis (letermovir) – NEW*
- *Procrit (epoetin alfa) - Update*
- *Repatha (evolocumab) - Update*
- *Soliris (eculizumab) - Update*
- *Spinraza (nusinersen) - Update*
- *Sublocade (buprenorphine extended-release injection) – NEW*
- *Varubi (rolapitant) - NEW*
- *Velcade (bortezomib) - Update*
- *Xgeva (denosumab) - Update*
- *Yescarta (axicabtagene ciloleucel) – NEW*

BLUE SHIELD OF CALIFORNIA
SECOND QUARTER 2018 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE AUGUST 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 Second Quarter 2018 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)	Alternative(s)
Amitiza*	IBS with constipation, Chronic idiopathic constipation, Opioid induced constipation	Linzess, Movantik

*effective January 1, 2019

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)	Alternative(s)
Amitiza	IBS with constipation, Chronic idiopathic constipation, Opioid induced constipation	Prior authorization, Age limit, Quantity limit	Linzess, Movantik
Caverject	Erectile dysfunction	Prior authorization, Quantity limit	sildenafil, Muse
Edex	Erectile dysfunction	Prior authorization, Quantity limit	sildenafil, Muse

NEW GENERICS with RESTRICTIONS

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)
hydrocortisone butyrate 0.1% lotion (Locoid)	Atopic dermatitis	Step therapy
lansoprazole rapid dissolving tablet (Prevacid Solutab)	Duodenal ulcer, H. pylori, Gastric ulcer, GERD, Erosive esophagitis, Hypersecretory condition	Step therapy
minocycline 65mg, 115mg er tablet (Solodyn)	Acne vulgaris	Prior authorization, Quantity limit
sumatriptan/naproxen 85mg-500mg tablet (Treximet)	Migraine	Prior authorization, Quantity limit

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

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

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

Specialty Drug	Coverage Restriction(s)
Erleada	Prior authorization, Quantity limit

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

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

Specialty Drug	Coverage Restriction(s)
glatiramer, glatopa	Quantity limit

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

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

Specialty Drug	Coverage Restriction(s)
Lonhala Magnair	Prior authorization, Quantity limit
Symdeko	Prior authorization, Quantity limit
trientine (Syprine)	Prior authorization, Quantity limit
Treximet*	Prior authorization, Quantity limit

* effective January 1, 2019

EXISTING DRUGS with CHANGES TO RESTRICTIONS

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

Drug	FDA Indication(s)	Restriction removed
glatiramer, glatopa	Multiple sclerosis	Prior authorization
Movantik	Opioid induced constipation	Prior authorization

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

Drug	FDA Indication(s)	Coverage Restriction(s)
testosterone 1% gel (Androgel, Vogelxo pump)	Hypogonadism	Prior authorization, Quantity limit

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Locoid 0.1% lotion	Atopic dermatitis	Step therapy
Sucraid	Sucrase deficiency	Prior authorization, Quantity limit
testosterone 1% gel 5gm tube (Testim, Vogelxo)	Hypogonadism	Prior authorization, Quantity limit
testosterone 2% gel (Fortesta)	Hypogonadism	Prior authorization, Quantity limit
testosterone 30mg/actuation, topical solution (Axiron)	Hypogonadism	Prior authorization, Quantity limit
Zioptan	Glaucoma	Prior authorization

DRUGS ADDED to FORMULARY

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Cimduo	HIV infection	Quantity limit
drospirenone/ethinyl estradiol/levomefolate (Safyral)	Contraceptive	
Linzess	IBS with constipation, Chronic idiopathic constipation	Quantity limit
memantine er capsule (Namenda XR)	Alzheimer's disease	Quantity limit

Drug	FDA Indication(s)	Coverage Restriction(s)
phrenilin forte	Tension headache	Quantity limit
ritonavir 100mg tablet (Norvir)	HIV infection	

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Movantik	Opioid induced constipation	Quantity limit
Symfi, Symfi Lo	HIV infection	Quantity limit
testosterone 1% gel (Androgel, Vogelxo pump)	Hypogonadism	Prior authorization, Quantity limit

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on June 1, 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*
- *Actimmune*
- *Adcetris*
- *Alimta*
- *Arzerra*
- *Avastin*
- *Blincyto*
- *Erbitux*
- *Gazyva*
- *Hizentra*
- *Kadcyla*
- *Kepivance*
- *Keytruda*
- *Krystexxa*
- *Leukine*
- *Nplate*
- *Opdivo*
- *Probuphine*
- *Relistor*
- *Rituxan*
- *Sublocade*
- *Trogarzo – NEW*
- *Yervoy*

BLUE SHIELD OF CALIFORNIA
THIRD QUARTER 2018 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE SEPTEMBER 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 third quarter 2018 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.

NEW GENERICS with RESTRICTIONS

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)
doxycycline 50mg tablet (Targadox)	Bacterial infection	Prior authorization, Quantity limit
soloxide	Bacterial infection	Prior authorization, Quantity limit
urea 41% cream (Utopic)	Dry skin	Step therapy, Quantity limit

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

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

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

Specialty Drug	Coverage Restriction(s)
Tibsovo	Prior authorization, Quantity limit

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

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

Specialty Drug	Coverage Restriction(s)
Aimovig	Prior authorization, Quantity limit
Braftovi	Prior authorization, Quantity limit
Doptelet	Prior authorization, Quantity limit
Fulphila	Prior authorization
hydroxyprogesterone caproate 250mg/1ml vial (Makena)	Prior authorization, Quantity limit
Jynarque	Prior authorization, Quantity limit
Mektovi	Prior authorization, Quantity limit
miglustat (Zavesca)	Prior authorization, Quantity limit
Nuplazid	Prior authorization, Quantity limit
Olumiant	Prior authorization, Quantity limit
Palynziq	Prior authorization, Quantity limit
Retacrit	Prior authorization
Tavalisse	Prior authorization, Quantity limit
vigadrone (Sabril) powder pack	Prior authorization Quantity limit
Yonsa	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 formulary:

Drug	FDA Indication(s)	Restriction removed
amlodipine/olmesartan (Azor)	Hypertension	Step therapy
olmesartan (Benicar)	Hypertension	Step therapy
olmesartan/hctz (Benicar HCT)	Hypertension	Step therapy

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Androderm	Hypogonadism	Prior authorization, Quantity limit
Bacofen 10mg, 20mg tablet	Muscle spasticity	Quantity limit
Natesto	Hypogonadism	Prior authorization, Quantity limit
Pandel	Steroid responsive dermatoses	Prior authorization
Striant	Hypogondism	Prior authorization, Quantity limit

DRUGS ADDED to FORMULARY

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

Drug	FDA Indication(s)	Coverage Restriction(s)
baclofen 5mg tablet	Muscle spasticity	Quantity limit
colesevelam (Welchol)	Hyperlipidemia, Type 2 diabetes	
Droxia	Sickle cell anemia	
incassia (Ortho Micronor)	Contraceptive	
mili (Ortho Cyclen)	Contraceptive	
Ozempic*	Type 2 diabetes	Step therapy, Quantity limit
phenohytro	IBS, Acute enterocolitis	
praziquantel (Biltricide)	Schistosoma, Liver flukes	
relexxii	ADHD	Prior authorization, Age limit, Quantity limit
subvenite tablet *(non-starter pack)* (Lamictal)	Seizure, Bipolar disorder	
tri-mili (Ortho Tri-Cyclen)	Contraceptive	
tulana (Ortho Micronor)	Contraceptive	

* effective 1/1/2019

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

Drug	FDA Indication(s)	Coverage Restriction(s)
amlodipine/olmesartan (Azor)	Hypertension	Quantity limit
olmesartan (Benicar)	Hypertension	Quantity limit
olmesartan/hctz (Benicar HCT)	Hypertension	Quantity limit
olmesartan/amlodipine/hctz (Tribenzor)	Hypertension	Step therapy, Quantity limit
temazepam 7.5mg, 22.5mg capsule	Insominia	Quantity limit

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on September 5, 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 (paclitaxel, albumin bound)*
- *Actemra (toclizumab)*
- *Aimovig (ereumab-aooe) – NEW*
- *Anti-emetics (Cinvanti (aprepitant), Emend (fosaprepitant), palonesetron, Sustol (granisetron), Varubi (rolapitant))*
- *Avastin (bevacizumab)*
- *Cimzia (certolizumab pegol)*
- *Crysvita (burosumab-twza) – NEW*
- *Cyramza (ramucirumab)*
- *Darzalex (daratumumab)*
- *Erbitux (cetuximab)*
- *Fulphila (pegfilgrastim-jmdb) – NEW*
- *Intravitreal anti-VEGF agents [Avastin (bevacizumab), Lucentis (ranibizumab)]*
- *Keytruda (pembrolizumab)*
- *Kymriah (tisagenlecleucel)*
- *Lutathera (lutelium Lu 1777 dotate) – NEW*
- *Nplate (romiplostim)*
- *Opdivo (nivolumab)*
- *Yervoy (ipilimumab)*
- *Palynziq (pegvaliase-pqpz) – NEW*
- *Prolia (denosumab)*
- *Retacrit (epoetin alfa-epbx) – NEW*
- *Rituxan (rituximab)*
- *Tecentriq (atezolizumab)*
- *Trogarzo (ibalizumab-uiyk)*

BLUE SHIELD OF CALIFORNIA
FOURTH QUARTER 2018 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE FEBRUARY 1, 2019
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 2018 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 otherwise*.

Drug	FDA Indication(s)	Alternative(s)
Androgel 1.62% gel[1]	Hypogonadism	testosterone 1% gel
chlordiazepoxide-clidinium capsule[2]	IBS, Peptic ulcer, Enterocolitis	dicyclomine, hyoscyamine, omeprazole, pantoprazole
fluocinolone acetonide oil 0.01% otic drops	Chronic eczematous external otitis	Dermotic 0.01% otic drops
Invokana[2]	Type 2 diabetes	Jardiance, Farxiga
Invokamet, Invokamet XR[2]	Type 2 diabetes	Synjardy, Synjardy XR, Xigduo XR
Jentadueto, Jentadueto XR[2]	Type 2 diabetes	Janumet, Janumet XR
Procrit[3]	Anemia	Retacrit
Tradjenta[2]	Type 2 diabetes	Januvia

[1]. *Depending on the member's prescription benefit plan design, the member cost-share will be either the applicable copay or coinsurance, or the generic copayment plus the difference in cost between the generic and the brand-name drug.*
[2]. *Effective Jan 1, 2019*
[3]. *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.

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

Drug	FDA Indication(s)	Restriction(s)	Alternative(s)
Androgel 1.62% gel[1]	Hypogonadism	Prior authorization, Quantity limit	testosterone 1% gel, testosterone 1.62% gel
chlordiazepoxide-clidinium capsule[4]	IBS, Peptic ulcer, Enterocolitis		dicyclomine, hyoscyamine, omeprazole, pantoprazole
fluocinolone acetonide oil 0.01% otic drops[4]	Chronic eczematous external otitis	Prior authorization	Dermotic 0.01% otic drops
Invokana	Type 2 diabetes	Prior authorization, Quantity limit	Jardiance, Farxiga
Invokamet, Invokamet XR	Type 2 diabetes	Prior authorization, Quantity limit	Synjardy, Synjardy XR, Xigduo XR
Jentadueto, Jentadueto XR	Type 2 diabetes	Prior authorization, Quantity limit	Janumet, Janumet XR
Tradjenta	Type 2 diabetes	Prior authorization, Quantity limit	Januvia

1. *Depending on the member's prescription benefit plan design, the member cost-share will be either the applicable copay or coinsurance, or the generic copayment plus the difference in cost between the generic and the brand-name drug.*
4. *May be covered at a lower tier for some plans*

NEW GENERICS with RESTRICTIONS

The following drugs are <u>newly available</u> 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)
amphetamine sulfate (generic Evekeo)	Narcolepsy, ADHD, Exogenous obesity	Step therapy, Age limit, Quantity limit
bupropion 450mg er tablet (generic Forfivo XL)	Depression	Step therapy, Quantity limit
clindamycin 1.2%-benzoyl peroxide 2.5% gel in pump (generic Acanya)	Acne vulgaris	Step therapy
clobazam (generic Onfi)	Lennox-Gastaut syndrome	Step therapy, Quantity limit
desoximetasone 0.25% topical spray (generic Topicort)	Plaque psoriasis	Step therapy, Quantity limit
imiquimod 3.75% cream, metered-dose pump (generic Zyclara)	Actinic keratosis, Genital warts	Step therapy, Quantity limit
itraconazole oral solution (generic Sporanox)	Oropharyngeal and esophageal candidiasis	Prior authorization
luliconazole 1% cream (generic Luzu)	Tinea pedis, Tinea cruris, Tinea corporis	Step therapy, Quantity limit
ryclora	Allergic rhinitis, Vasomotor rhinitis, Allergic conjunctivitis, Urticaria, Angioedema, Dermographism	Step therapy, Age limit
tadalafil (generic Cialis)	Erectile dysfunction, BPH	Prior authorization, Gender edit, Quantity limit

Drug	FDA Indication(s)	Coverage Restriction(s)
testosterone 1.62% gel (generic Androgel)	Hypogonadism	Prior authorization, Quantity limit

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

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

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

Specialty Drug	Coverage Restriction(s)
tadalafil (generic Adcirca)	Prior authorization, Quantity limit

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

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

Specialty Drug	Coverage Restriction(s)
Ibrance	Prior authorization, Quantity limit
Retacrit	Prior authorization

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

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

Specialty Drug	Coverage Restriction(s)
Ajovy	Prior authorization, Quantity limit
Arikayce	Prior authorization, Quantity limit
Copiktra	Prior authorization, Quantity limit
dalfampridine (generic Ampyra)	Prior authorization, Quantity limit
Emgality	Prior authorization, Quantity limit
Epidiolex	Prior authorization, Quantity limit
Galafold	Prior authorization, Quantity limit
glycopyrrolate 1.5mg tablet (generic Glycate) [4]	Prior authorization, Quantity limit
guaifenesin 200mg-hydrocodone 2.5mg/5ml oral solution (generic Obredon)[4]	Prior authorization, Age limit, Quantity limit
lactulose powder packet (generic Kristalose) [4]	Prior authorization, Quantity limit
Lokelma	Prior authorization, Quantity limit
Mulpleta	Prior authorization, Quantity limit
Nivestym	Prior authorization
Orkambi granule packet	Prior authorization, Quantity limit

Specialty Drug	Coverage Restriction(s)
Takhzyro	Prior authorization, Quantity limit
Talzenna	Prior authorization, Quantity limit
Tegsedi	Prior authorization, Quantity limit
Tiglutik	Prior authorization, Quantity limit
Vizimpro	Prior authorization, Quantity limit

[4.] *May be covered at a lower tier for some plans.*

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:

Drug	FDA Indication(s)	Restriction removed
Belsomra[5]	Insomnia	Age limit

[5.] *Effective Oct 10, 2018*

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Glycate[6]	Peptic ulcer	Prior authorization, Quantity limit
Kristalose powder packet[7]	Constipation	Prior authorization, Quantity limit
cough and cold medications containing codeine or hydrocodone	Cough and cold	Age limit, Quantity limit
Zolpimist[8]	Insomnia	Prior authorization, Age limit, Quantity limit

[6.] *Effective Nov 1, 2018;* [7.] *Effective Nov 13, 2018;* [8.] *Effective Dec 1, 2018*

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

Drug	FDA Indication(s)	Coverage Restriction(s)
Clindagel[9]	Acne vulgaris	Prior authorization, Quantity limit
Dexpak[10]	Corticosteroid responsive diseases	Prior authorization
Dulera[8]	Asthma	Prior authorization, Quantity limit

[9.] *Effective Sept 5, 2018;* [10.] *Effective Aug 1, 2018;* [8.] *Effective Dec 1, 2018*

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
Breo Ellipta[2]	Tier 2

[2]*Effective Jan 1, 2019*

DRUGS ADDED to FORMULARY

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

Drug	FDA Indication(s)	Coverage Restriction(s)
albendazole (generic Albenza)	Neurocysticercosis, Hydatid disease	Quantity limit
Cyred EQ	Contraceptive	
Dermotic otic drops	Chronic eczematous external otitis	
dorzolamide 2%-timolol 0.5% ophthalmic drops (generic Cosopt PF)	Glaucoma	Quantity limit
Farxiga	Type 2 diabetes	Step therapy, Quantity limit
Humapen Luxura HD[11]	Diabetes	Prior authorization, Quantity limit
Tarina Fe 1-20	Contraceptive	
Xigduo XR	Type 2 diabetes	Step therapy, Quantity limit

[11]. *Effective Oct 1, 2018*

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

Drug	FDA Indication(s)	Coverage Restriction(s)
metformin 500mg/5ml oral solution (generic Riomet)	Type 2 diabetes	
Novopen Echo[11]	Diabetes	Prior authorization, Quantity limit

[11]. *Effective Oct 1, 2018*

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on December 4, 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 (nab-paclitaxel) - *Update*
- Actemra (tocilizumab) - *Update*
- Adcetris (brentuximab vedotin) - *Update*
- Aimovig (erenumab-aooe) - *Update*
- Ajovy (fremanezumab-vfrm) - NEW
- Alimta (pemetrexed) - *Update*

- Aranesp (darbepoietin) - *Update*
- Avastin (bevacizumab) - *Update*
- Azedra (iobenguane I-131) – NEW
- Berinert (c1 esterase inhibitor) - *Update*
- Botox (onabotulinum toxinA) - *Update*
- Brineura (cerliponase alfa) - *Update*
- Cinqair (reslizumab) - *Update*
- Cinryze (c1 esterase inhibitor) - *Update*
- Dupixent (dupilumab) - *Update*
- Emgality (galcanezumab-gnlm) – NEW
- Epogen (epoetin alfa) - *Update*
- Erbitux (cetuximab) - *Update*
- Fabrazyme (agalsidase beta) - *Update*
- Fasenra (benralizumab) - *Update*
- Firazyr (icatibant) - *Update*
- Gazyva (obinutuzumab) - *Update*
- Haegarda (c1 esterase inhibitor) - *Update*
- Ilumya (tildrakizumab-asmn) – NEW
- Istodax (romidepsin) - *Update*
- Keytruda (pembrolizumab) - *Update*
- Kyprolis (carfilzomib) - *Update*
- Libtayo (cemiplimab-rwlc) – NEW
- Lumoxiti (moxetumomab pasudotox-tdfk) - NEW
- Mircera (methoxy polyethylene glycol-epoetin beta) - *Update*
- Mylotarg (gemtuzumab ozogamicin) - *Update*
- Nivestym (filgrastim-aafi) – NEW
- Nucala (mepolizumab) - *Update*
- Onpattro (patisiran) – NEW
- Opdivo (nivolumab) - *Update*
- Palynziq (pegvaliase-pqpz)
- Panzyga (immune globulin intravenous, human–ifas) - NEW
- Perseris (risperidone extended-release injection) – NEW
- Poteligeo (mogamulizumab-kpkc) – NEW
- Procrit (epoetin alfa) - *Update*
- Retacrit (epoetin alfa-epbx) - *Update*
- Takhzyro (lanadelumab-flyo) - NEW
- Tecentriq (atezolizumab) - *Update*
- Tegsedi (inotersen) - NEW
- Torisel (temsirolimus) - *Update*
- Vectibix (panitumumab) - *Update*
- Xofigo (radium Ra 223 dichloride) – NEW
- Xolair (omalizumab) - *Update*
- Yervoy (ipilimumab) - *Update*