

BLUE SHIELD OF CALIFORNIA
MAY 2022 PLUS DRUG FORMULARY CHANGES

Blue Shield is committed to covering safe, effective and affordable medications, so we regularly review and update our drug formularies. Our Pharmacy and Therapeutics (P&T) Committee is made up of a group of practicing physicians and pharmacists who meet quarterly to recommend changes to our formulary based on the latest medical literature, new clinical guidelines, new information from key physician experts, and new information from the Food and Drug Administration.

Changes to the Plus Drug Formulary from the May 2022 P&T Committee meeting are outlined below. To view a copy of the Plus Drug Formulary, please [download a copy](#).

The drugs listed below are to be used for FDA-approved indications but may also be used for other conditions.

1. DRUGS ADDED TO FORMULARY

The following drugs were added to the formulary:

Drug	FDA Indication(s)	Coverage Restriction(s)
brimonidine-timolol 0.2%-0.5% ophthalmic drops (Combigan)	Glaucoma	
dapsone 7.5% gel (Aczone) ¹	Acne vulgaris	Step therapy, Quantity limit
diclofenac potassium capsule (Zipsor) ¹	Pain	Prior authorization, Quantity limit
Dodex	Vitamin B12 deficiency	
glycopyrrolate (Cuvposa) ¹	Chronic severe drooling	Prior authorization, Quantity limit
lacosamide tablet (Vimpat)	Seizures	Quantity limit
maraviroc (Selzentry)	HIV infection	Quantity limit
Xarelto oral suspension	Thromboembolism	Quantity limit

¹.Applies only to Grandfathered plans

2. FORMULARY DRUGS WITH CHANGES TO TIER AND/OR COVERAGE RESTRICTION

The following drugs have coverage restriction(s) added or removed, and/or change of tier status as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)	New Tier Status
carvedilol er capsule (Coreg CR) ^{2,3}	Heart Failure, Hypertension, Left ventricular dysfunction	Step therapy	Tier 1
clindamycin-tretinoin 1.2%-0.025% gel (Evoclin)	Acne vulgaris	Step therapy, Remove age-limit	Remains Tier 1
dapsone 5% gel		Remove Prior	Remains Tier 1

Drug	FDA Indication(s)	Coverage Restriction(s)	New Tier Status
(Aczone) ⁴		authorization, Add Step therapy, Quantity limit	
diflorasone diacetate 0.05% cream ^{1,5}	Steroid responsive dermatoses	Step therapy	Tier 1
Euthyrox	Hypothyroidism		Tier 1
insulin lispro junior kwikpen ²	Diabetes		Tier 1
ranolazine (Ranexa) ⁴	Chronic angina	Remove Prior authorization	Remains Tier 1
silodosin (Rapaflo) ⁴	Benign prostatic hyperplasia	Remove Step therapy	Remains Tier 1
sulfacetamide sodium-sulfur 8%-4% topical suspension ⁴	Acne vulgaris, Acne rosacea, Seborrheic dermatitis	Remove Prior authorization	Remains Tier 1
Sulfacleanse 8%-4% topical suspension ⁴			
sulfacetamide sodium 10% gel (Ovace Plus) ⁴		Add Step therapy, Remove Prior authorization	
sulfacetamide sodium-sulfur 9.8%-4.8% cleanser, cream, lotion (Plexion) ⁴			

1. Applies only to Grandfathered plans; 2. Effective 1/2022; 3. Does not apply to Grandfathered plans; 4. Effective 6/2022; 5. Effective 3/2022

3. DRUGS REMOVED FROM THE FORMULARY

The following brand-name drugs were removed from the formulary because generic is now available and was added to the formulary. Drug removal is effective August 2022.

Brand-name Drug	FDA Indication(s)	Restriction(s)	Alternative(s)
Combigan	Glaucoma		brimonidine-timolol 0.2%-0.5% eye drops
Revlimid ¹	Multiple myeloma, Myelodysplastic syndromes, Mantle cell lymphoma, Follicular lymphoma, Marginal zone lymphoma	Prior authorization, Quantity limit	lenalidomide
Selzentry	HIV infection	Quantity limit	maraviroc

4. NON-FORMULARY/NON-PREFERRED DRUGS WITH CHANGES TO RESTRICTIONS

The following drugs remain at their current formulary status but have new coverage restriction(s) as noted:

Drug	FDA Indication(s)	New Restriction(s)	Alternative(s)
Altreno ⁴	Acne vulgaris	Age-limit	tretinoin cream, gel
Atralin ⁴		Prior authorization	
Aczone 5%, 7.5% gel ⁴		Step therapy	tretinoin cream, gel; clindamycin 1% gel, lotion, solution
dapsone 7.5% gel (Aczone) ^{3,4}			
Veltin ⁵			
Ziana ⁵			
Avar 9.5%-5% pad ⁴	Acne vulgaris, Acne rosacea, Seborrheic dermatitis	Step therapy	sulfacetamide sodium- sulfur 10%-5% cleanser, 10%-4% pad
Avar LS 10%-2% pad ⁴			
sulfacetamide sodium- sulfur 9.8%-4.8% pad (Plexion) ⁴			
Ovace Plus Wash ⁴			
Plexion 9.8%-4.8% cleanser, cream, lotion, pad ⁴			sulfacetamide sodium- sulfur 10%-5% cleanser, cream, lotion; sulfacetamide sodium- sulfur 10%-4% pad
Ranexa ⁴	Chronic angina		ranolazine
Rapaflo ⁴	Benign prostatic hyperplasia		silodosin
Vimpat tablet ⁶	Seizures		lacosamide tablet

3. Does not apply to Grandfathered plans; 4. Effective 6/2022; 5. Effective 3/2022; 6. Effective 4/2022

5. DRUGS ADDED TO THE SPECIALTY TIER

The following drugs were added to the Blue Shield specialty tier (Tier 4):

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Adbry	Atopic dermatitis	Prior authorization, Quantity limit
Cibinqo		

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
baclofen (Ozobax) ³	Spasticity	Prior authorization, Quantity limit
Fleqsuvy ³		
apomorphine (Apokyn)	Parkinson's disease	Prior authorization
betaine (Cystadane)	Homocystinuria	
Cortrophin	Rheumatic disorders, Collagen diseases, Dermatologic diseases, Allergic states, Ophthalmic diseases, Respiratory disease, Edematous states, Nervous systems	Prior authorization
diclofenac potassium capsule (Zipsor) ³	Pain	Prior authorization, Quantity limit
lbsrela ³	IBS with constipation	Prior authorization, Quantity limit
lenalidomide (Revlimid)	Multiple myeloma, Myelodysplastic syndromes, Mantle cell lymphoma, Follicular lymphoma, Marginal zone lymphoma	Prior authorization, Quantity limit
Multi-Mac ³	Prenatal vitamin	Prior authorization, Quantity limit
Pyrukynd	Hemolytic anemia associated with pyruvate kinase deficiency	Prior authorization, Quantity limit
Recorlev	Cushing's syndrome	Prior authorization, Quantity limit
Releuko	Neutropenia associated with myelosuppressive chemotherapy, Congenital neutropenia, Cyclic neutropenia, Idiopathic neutropenia	Prior authorization
Verkazia ³	Vernal keratoconjunctivitis	Prior authorization, Quantity limit
Vonjo	Myelofibrosis	Prior authorization, Quantity limit

³. Does not apply to Grandfathered plans

6. DRUGS REMOVED FROM COVERAGE

The following drugs were excluded from coverage because they are not approved by the Food and Drug Administration (FDA):

Drug	Drug
Gordons 22% ointment	Urea Hydrating 35% foam
Hydro 35% foam	Urea 39% cream
Uredeb 39% cream	Xurea 39% cream
Hydro 40% foam	Umecta Mousse 40% foam
Urea 41% cream	Utopic 41% cream
Urea 45% cream	Urea 45% Nail gel
Uramaxin 45% gel	Urea 45% lotion

Drug	Drug
Cem-urea 45% topical solution	Urea 47% cream
Urea 50% cream	Urea 50% Nail stick
Gordons urea 40% cream ⁷	Uremez 40% cream ⁷
Rea Lo 40% cream ⁷	Urea 40% cream ⁷
Cerovel 40% lotion ⁷	Urea 40% lotion ⁷

7. effective 1/2023