

**BLUE SHIELD OF CALIFORNIA**  
**NOVEMBER 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 November 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)
dabigatran (Pradaxa)	Atrial fibrillation, DVT, PE, VTE	Prior authorization, Quantity limit
mifepristone (Mifeprex) <sup>1</sup>	Pregnancy termination	Quantity limit
phospho-trin K-500	Acidify urine	
Qsymia <sup>1</sup>	Weight management	Prior authorization, Quantity limit
sodium sulfate/potassium sulfate/ magnesium sulfate (Suprep)	Bowel prep for colonoscopy	
timolol 0.25% eye drops (Timoptic Ocudose)	Glaucoma	Step-therapy
Dovato	HIV infection	Quantity limit
Genvoya		
Symtuza		
Triumeq, Triumeq PD		

<sup>1</sup>. Effective 1/2023

**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
clonidine er (Kapvay)	ADHD	Quantity limit, Remove Prior authorization & Age-limit	Remains Tier 1
atomoxetine (Strattera)		Quantity limit,	Remains Tier 1

Drug	FDA Indication(s)	Coverage Restriction(s)	New Tier Status
guanfacine er (Intuniv)		Remove Age-limit	
azelastine/fluticasone nasal spray (Dymista)	Allergic rhinitis	Quantity limit, Remove Step-therapy	Remains Tier 2 <sup>2</sup> , Remains Tier 1 <sup>3</sup>
Cystagon	Nephropathic cystinosis	Quantity limit	Tier 3
pimecrolimus (Elidel)	Atopic dermatitis	Quantity limit, Remove Step-therapy	Remains Tier 1
tacrolimus 0.03% ointment (Protopic)		Quantity limit, Remove Step-therapy & Age-limit	
tacrolimus 0.1% ointment (Protopic)		Age-limit, Quantity limit, Remove Step-therapy	
Nurtec <sup>1</sup>	Migraine	Prior authorization, Quantity limit	Tier 2
Ubrelvy <sup>1</sup>			
clobetasol 0.05% lotion (Clobex)	Corticosteroid responsive dermatoses	Remove Prior authorization	Remains Tier 1
clobetasol 0.05% shampoo (Clobex)	Scalp psoriasis	Remove Step-therapy	Remains Tier 1
Clodan 0.05% shampoo (Clobex)			
clobetasol 0.05% spray (Clobex)	Plaque psoriasis	Quantity limit, Add Prior authorization, Remove Step-therapy	Remains Tier 3 <sup>2</sup> Remains Tier 1 <sup>3</sup>

1. Effective 1/2023; 2. Does not apply to Grandfathered plans; 3. Applies only to Grandfathered plans

### 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 January 1, 2023.

Brand-name Drug	FDA Indication(s)	Restriction(s)	Alternative(s)
Suprep	Bowel prep for colonoscopy		sodium sulfate/ potassium sulfate/ magnesium sulfate

2. Applies only to Grandfathered plans

### 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)
Kapvay	ADHD	Quantity limit, Remove Prior	clonidine er tablet

Drug	FDA Indication(s)	New Restriction(s)	Alternative(s)
		authorization & Age-limit	
Intuniv		Quantity limit, Remove Age-limit	guanfacine er tablet
Strattera			atomoxetine capsule
Dymista	Allergic rhinitis	Quantity limit, Remove Step-therapy	azelastine/fluticasone nasal
Timoptic Ocudose	Glaucoma	Add Step-therapy	timolol ophthalmic solution, gel forming solution
Elidel	Atopic dermatitis	Quantity limit, Remove Step-therapy	pimecrolimus cream
Protopic 0.1%		Quantity limit, Age-limit Remove Step-therapy	tacrolimus 0.1% ointment
Protopic 0.03%		Quantity limit, Remove Step-therapy & Age-limit	tacrolimus 0.03% ointment
Clobex 0.05% lotion	Corticosteroid-responsive dermatoses	Remove Prior authorization	clobetasol 0.05% lotion
Clobex 0.05% shampoo	Scalp psoriasis	Remove Step-therapy	clobetasol 0.05% shampoo
Clobex 0.05% spray	Plaque psoriasis	Add Prior authorization, Remove Step-therapy	clobetasol 0.05% cream, ointment, gel, solution, cream emollient

## 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)
Auvelity <sup>2</sup>	Depression	Prior authorization, Quantity limit
Calquence tablet	Mantel cell lymphoma, Chronic lymphocytic leukemia, Small lymphocytic lymphoma	Prior authorization, Quantity limit
Fylnetra	Chemotherapy induced neutropenia	Prior authorization
Hyftor	Facial angiofibroma associated with tuberous sclerosis	Prior authorization, Quantity limit
Imbruvica oral suspension	Mantel cell lymphoma, Chronic lymphocytic leukemia, Small lymphocytic lymphoma, Waldenstrom macroglobulinemia, Marginal zone lymphoma	Prior authorization, Quantity limit
Javygtor	PKU	Prior authorization, Quantity limit
lenalidomide (Revlimid)	Multiple myeloma, Myelodysplastic	Prior authorization, Quantity

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
	syndromes, Mantle cell lymphoma, Follicular lymphoma, Marginal zone lymphoma	limit
methocarbamol 1gm tablet <sup>2</sup>	Musculoskeletal pain	Prior authorization, Quantity limit
Pheburane	Urea cycle disorders	Prior authorization, Quantity limit
Relyvrio	Amyotrophic lateral sclerosis	Prior authorization, Quantity limit
Sotyktu	Plaque psoriasis	Prior authorization, Quantity limit
Tascenso ODT	Multiple sclerosis	Prior authorization, Quantity limit
Tadliq	PAH	Prior authorization, Quantity limit
Vivjoa <sup>2</sup>	Vulvovaginal candidiasis	Prior authorization, Quantity limit

2. Does not apply to Grandfathered plans

## 6. DRUGS REMOVED FROM COVERAGE

The following drugs were excluded from coverage because it is available without a prescription, effective January 1, 2023:

Drug		
mometasone nasal spray (Nasonex)	Nasonex	Lastacraft