Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

BCBSRI Pharmacy Program
April 1, 2023 Formulary Changes

The information below is effective as of April 1, 2023 and applies to all commercial BCBSRI products, including all Large Group and Small Group plan designs. These changes do not apply to the Blue CHiP for Medicare programs. Any changes to the Large Group and Small Group list are the result of a comprehensive review of relevant clinical information by the BCBSRI Pharmacy and Therapeutics Committee.

Large Group and Small Group Markets Formulary

Brand Name Drugs available with generic equivalents (Excluded from coverage)

For application across all commercial formularies the following Brand-name drugs are now **available with generic equivalents**, as a result the Brand name will be **excluded** from coverage, effective April 1, 2023. The generic equivalent will continue to be covered.

DALIRESP TAB 250MCG	DIVIGEL GEL 0.75MG	PRADAXA CAP 150MG
DALIRESP TAB 500MCG	DIVIGEL GEL 1.25MG	SUPREP BOWEL SOL PREP KIT
DENAVIR CRE 1%	DIVIGEL GEL 1MG/GM	TAZORAC GEL 0.05%
DEXILANT CAP 60MG DR	GILENYA CAP 0.5MG	TAZORAC GEL 0.1%
DIVIGEL GEL 0.25MG	HETLIOZ CAP 20MG	TRIMETHOPRIM TAB 100MG
DIVIGEL GEL 0.5MG	MIRVASO GEL 0.33%	ZIOPTAN DRO 0.0015%

For the Traditional Formulary, these brand products will continue to be covered with non-preferred or specialty co-pay.

Brand Name and generic Drugs with available alternatives (Excluded from coverage)

The following generic and Brand-name drugs are **available with preferred alternatives** will be **excluded** from coverage, effective April 1, 2023. Request for coverage will require documented medical necessity.

AUTOJECT 2 MISC INJ DEVICE	INPEN 100EL MIS - HUM INJ DEVICE	PENICILLAMIN CAP 250MG
AUTOPEN MIS 1-21UNIT INJ DEVICE	INPEN 100NN MIS - NOV INJ DEVICE	PICATO GEL 0.015%
AUTOPEN MIS 2-42UNIT INJ DEVICE	J-TIP KIT VIAL KIT ADAPTERS	PICATO GEL 0.05%
BD PEN MIS INJ DEVICE	LEUCOVORIN CALCIUM TAB 10MG	PREDNISONE CONC 5MG/ML
BD PEN MINI MIS INJ DEVICE	MATZIM LA TAB 180MG/24	PREVALITE POW 4GM PACKETS
CHOLESTYRAMINE POWD 4GM LITE PACK	MATZIM LA TAB 240MG/24	SUMATRIPTAN INJ 4MG/0.5 CART REF
CHOLESTYRAMINE POWD 4GM PACK	MEGESTROL SUS 625MG/5M	SUMATRIPTAN INJ 6MG/0.5 CART REF
CICLOPIROX SUS 0.77%	NORDIPEN DEL MIS SYSTEM	VORTEX HOLDING CHAMBER/MASK/CHILDS/FROG
DILTIAZEM ER TAB 180MG	OMNITROPE PEN 10 INJECTION DEVICE	ZOLMITRIPTAN TAB 2.5 MG ODT
DILTIAZEM ER TAB 240MG	OMNITROPE PEN 5 INJECTION DEVICE	ZOLMITRIPTAN TAB 5MG ODT
INJECT-EASE MIS AUTO INJ DEVICE	OXYCODONE CAP 5MG	

For the Traditional Formulary, these brand products will continue to be covered with non-preferred or specialty co-pay.

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Prior Authorization

The following drugs will now require prior authorization for coverage, effective April 1, 2023.

DEXCOM G7 MIS RECEIVER	**KRAZATI TAB 200MG**	**REZLIDHIA CAP 150MG**
DEXCOM G7 MIS SENSOR	**OZEMPIC INJ 2MG/3ML**	**SKYRIZI INJ 180/1.2 CARTRIDGE**
FYLNETRA INJ 6MG/0.6	**RELYVRIO POWD PAK 3-1GM**	

Tier changes

The following product will be moved to a **higher** co-pay tier, effective April 1, 2023. This product will move from a Preferred Brand Tier to a Non-Preferred Brand Tier.

VICTOZA INJ 18MG/3ML

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