



AUGUST 2022

Pharmacy Formulary Change Notice

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) is here to help you stay on top of your healthcare. We want to tell you about some upcoming changes to your Preferred Drug List (PDL) as of August 1, 2022.

Your PDL is a list of preferred drugs covered by Highmark BCBSWNY. A group of doctors and pharmacists check the PDL to make sure the drugs you're taking are safe and effective.

Effective for all members on August 1, 2022		
Medication	Changes	Your doctor may change it to one of these preferred drugs:
APRETUDE 600MG ER SUSPENSION TRIUMEQ PD TABLET	COVERED	N/A
PAXLOVID TABLET	COVERED	N/A
XARELTO 1MG/ML SUSPENSION	COVERED	N/A
OMNIPOD DASH KIT INTRO OMNIPOD 5 G6 KIT INTRO OMNIPOD 5 G6 MIS PODS	COVERED	N/A
MOLNUPIRAVIR 200MG CAPSULE	COVERED	N/A
REMDESIVIR 100MG INJ REMDESIVIR 150MG INJ	COVERED	N/A
SOTROVIMAB 500/8ML INJ	COVERED	N/A
BEBTELOVIMAB 175/2ML SOLUTION	COVERED	N/A
CELECOXIB 400MG CAPSULE DICLOFENAC 35MG CAPSULE ETODOLAC 200MG CAPSULE FENOPROFEN 600MG TABLET INDOCIN 25MG/5ML SUSPENSION KETOR TROMET 15.75MG SPRAY	NON- PREFERRED	NAPROXEN 125/5ML SUSPENSION IBUPROFEN 100/5ML SUSPENSION INDOMETHACIN CAPSULES DICLOFENAC DR TABLETS ETODOLAC TABLETS KETOPROFEN CAPSULES

MEFENAM ACID 250MG CAPSULE MELOXICAM 10MG CAPSULE MELOXICAM 5MG CAPSULE NALFON 400MG CAPSULE NAPROSYN 25/5ML SUSPENSION NAPROXEN SOD 375MG CR TABLET NAPROXEN SOD 500MG CR TABLET RELAFEN DS 1000MG TABLET ZIPSOR 25MG CAPSULE ZORVOLEX 18MG CAPSULE		PIROXICAM CAPSULES TOLMETIN SODIUM CAPSULE MELOXICAM TABLETS NABUMETONE TABLETS NAPROXEN 250 MG TABLETS IBUPROFEN TABLETS SULINDAC TABLETS
CYCLOSPORINE 0.05% EMULSION	PREFERRED WITH PA	N/A
XIIDRA 5% DROPS	NON- PREFERRED	CYCLOSPORINE 0.05% EMULSION
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2022 <i>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY</i>		
Medication		Change
DYANA VEL XR 5 MG TABLET DYANA VEL XR 10 MG TABLET DYANA VEL XR 15 MG TABLET DYANA VEL XR 20 MG TABLET		ADD PA AND QL LIMIT: 5MG: 1.5 TABLETS PER DAY 10,15 AND 20 MG: 1 TABLET PER DAY
YUSIMRY (ADALIMUMAB-AQVH) SYRINGE		ADD PA AND QL LIMIT: 2 SYRINGES PER 28 DAYS
RINVOQ 15MG ER TABLET RINVOQ 30MG ER TABLET RINVOQ 45MG ER TABLET		ADD PA AND QL: 1 TABLET PER DAY
ACETAMINOPHEN 160/5ML LIQUID		UPDATE QL: 120 ML PER 25 DAYS
LOREEV XR 1MG CAPSULE LOREEV XR 1.5MG CAPSULE LOREEV XR 2MG CAPSULE LOREEV XR 3MG CAPSULE		ADD STEP THERAPY
TEZSPIRE 210MG SOLUTION		ADD PA AND QL: 1 PREFILLED SYRINGE/VIAL PER 28 DAYS
CELONTIN 300MG CAPSULE		ADD QL: 4 CAPSULES PER DAY
FELBATOL 400MG TABLET FELBATOL 600MG TABLET		ADD QL: 6 TABLETS PER DAY

FELBATOL 600/5ML SUSPENSION	ADD QL: 30 ML PER DAY
MYSOLINE 50MG TABLET	ADD QL: 4 TABLETS PER DAY
MYSOLINE 250MG TABLET	ADD QL: 8 TABLETS PER DAY
ZARONTIN 250MG CAPSULE	ADD QL: 6 CAPSULES PER DAY
ZARONTIN 250/5ML SOLUTON	ADD QL: 30 ML PER DAY
RYBELSUS 3MG TABLET	UPDATE QL: 30 PER LIFETIME
CITALOPRAM 30MG CAPSULE CITALOPRAM 40MG TABLET	ADD QL: 1 PER DAY
PROMETHAZINE 12.5MG TABLET PROMETHAZINE 25MG TABLET	ADD QL: 4 TABLETS PER DAY
PROMETHAZINE 12.5MG SUPPOSITORY PROMETHAZINE 25MG SUPPOSITORY	ADD QL: 6 SUPPOSITORIES PER DAY
PROMETHEGAN 50MG SUPPOSITORY	ADD QL: 1 SUPPOSITORY PER DAY
LEQVIO SOLUTION	ADD PA AND QL: 1 SYRINGE PER 6 MONTHS
KIMMTRAK 100MCG SOLUTION	ADD PA
VONJO 100MG CAPSULE	ADD PA AND QL: 4 CAPSULES PER DAY
ARISTADA 1064MG INJ	ADD QL: 1 KIT EVERY 60 DAYS
APRETUDE 600MG ER SUSPENSION	ADD QL: 1 VIAL EVERY 2 MONTHS
CABENUVA 600-900 SUSPENSION	UPDATE QL: 1 KIT EVERY 2 MONTHS
CABENUVA 400-600 SUSPENSION	UPDATE QL: 1 KIT PER MONTH
LIVTENCITY 200MG TABLET	ADD PA AND QL: 4 TABLETS PER DAY
VALACYCLOVIR 500MG TABLET VALACYCLOVIR 1GM TABLET	500 MG- 60 PER FILL AND 1 FILL PER MONTH 1G- 30 PER FILL, 1 FILL PER MONTH
VEKLURY 100MG INJ	REMOVE QTY LIMIT

DEXTROMETHORPHAN 15MG CAPSULE	ADD QL: 8 CAPSULES PER DAY 2 FILLS PER 30 DAYS
DEXTROMETHORPHAN 30MG/5ML SUSPENSION	ADD QL: 150 ML PER FILL 2 FILLS PER 30 DAYS
DEXTROMETHORPHAN 12.5 MG/5 ML ORAL LIQUID	ADD QL: 120 ML PER FILL 2 FILLS PER 30 DAYS
DEXTROMETHORPHAN 10 MG/5 ML ORAL LIQUID	
DEXTROMETHORPHAN 7.5 MG ORAL STRIP/CHEW TABLET DEXTROMETHORPHAN 5 MG LOZENGE	ADD QL: 8 PER FILL 2 FILLS PER 30 DAYS
GUAIFENESIN 200MG TABLET	ADD QL: 12 TABLETS PER DAY 2 FILLS PER 30 DAYS
GUAIFENESIN 400MG TABLET	ADD QL: 6 TABLETS PER DAY 2 FILLS PER 30 DAYS
ZARONTIN 250/5ML SOLUTON	ADD QL: 30 ML PER DAY
RYBELSUS 3MG TABLET	UPDATE QL: 30 PER LIFETIME
CITALOPRAM 30MG CAPSULE CITALOPRAM 40MG TABLET	ADD QL: 1 PER DAY
PROMETHAZINE 12.5MG TABLET PROMETHAZINE 25MG TABLET	ADD QL: 4 TABLETS PER DAY
PROMETHAZINE 12.5MG SUPPOSITORY PROMETHAZINE 25MG SUPPOSITORY	ADD QL: 6 SUPPOSITORIES PER DAY
PROMETHEGAN 50MG SUPPOSITORY	ADD QL: 1 SUPPOSITORY PER DAY
LEQVIO SOLUTION	ADD PA AND QL: 1 SYRINGE PER 6 MONTHS
KIMMTRAK 100MCG SOLUTION	ADD PA
VONJO 100MG CAPSULE	ADD PA AND QL: 4 CAPSULES PER DAY
ARISTADA 1064MG INJ	ADD QL: 1 KIT EVERY 60 DAYS
APRETUDE 600MG ER SUSPENSION	ADD QL: 1 VIAL EVERY 2 MONTHS
CABENUVA 600-900 SUSPENSION	UPDATE QL: 1 KIT EVERY 2 MONTHS
CABENUVA 400-600 SUSPENSION	UPDATE QL: 1 KIT PER MONTH

LIVTENCITY 200MG TABLET	ADD PA AND QL: 4 TABLETS PER DAY
VALACYCLOVIR 500MG TABLET VALACYCLOVIR 1GM TABLET	500 MG- 60 PER FILL AND 1 FILL PER MONTH 1G- 30 PER FILL, 1 FILL PER MONTH
VEKLURY 100MG INJ	REMOVE QTY LIMIT
DEXTROMETHORPHAN 15MG CAPSULE	ADD QL: 8 CAPSULES PER DAY 2 FILLS PER 30 DAYS
DEXTROMETHORPHAN 30MG/5ML SUSPENSION	ADD QL: 150 ML PER FILL 2 FILLS PER 30 DAYS
DEXTROMETHORPHAN 12.5 MG/5 ML ORAL LIQUID DEXTROMETHORPHAN 10 MG/5 ML ORAL LIQUID	ADD QL: 120 ML PER FILL 2 FILLS PER 30 DAYS
DEXTROMETHORPHAN 7.5 MG ORAL STRIP/CHEW TABLET DEXTROMETHORPHAN 5 MG LOZENGE	ADD QL: 8 PER FILL 2 FILLS PER 30 DAYS
GUAIFENESIN 200MG TABLET	ADD QL: 12 TABLETS PER DAY 2 FILLS PER 30 DAYS
GUAIFENESIN 400MG TABLET	ADD QL: 6 TABLETS PER DAY 2 FILLS PER 30 DAYS
GUAIFENESIN 600MG ER TABLET	ADD QL: 4 TABLETS PER DAY 2 FILLS PER 30 DAYS
GUAIFENESIN 1200 ER TABLET	ADD QL: 2 TABLETS PER DAY 2 FILLS PER 30 DAYS
GUAIFENESIN 150 MG/15 ML LIQUID	ADD QL: 250 ML PER FILL 2 FILLS PER 30 DAYS
GUAIFENESIN 200 MG/5 ML LIQUID	ADD QL: 240 ML PER FILL 2 FILLS PER 30 DAYS
PSEUDOEPHEDRINE 240 MG ER TABLET	ADD QL: 1 TABLET PER DAY 2 FILLS PER 30 DAYS
PSEUDOEPHEDRINE 120MG ER TABLET	ADD QL: 2 TABLETS PER DAY 2 FILLS PER 30 DAYS
PSEUDOEPHEDRINE 60MG TABLET	ADD QL: 4 TABLETS PER DAY 2 FILLS PER 30 DAYS
ADBRY 150MG/ML INJ	ADD PA AND QL: 2 SYRINGES PER 28 DAYS
ELIDEL 1% CREAM PROTOPIC 0.03% OINTMENT PROTOPIC 0.1% OINTMENT	UPDATE QL: 100 GRAMS PER 30 DAYS

RECORLEV 150MG TABLET	ADD PA AND QL: 8 TABLETS PER 28 DAYS
VOXZOGO 0.4MG INJ VOXZOGO 0.56MG INJ VOXZOGO 1.2MG INJ	ADD PA AND QL: 1 VIAL PER DAY
CIMETIDINE 300/5ML SOLUTION	ADD QL: 40 MLS PER DAY
ENJAYMO SOLUTION	ADD PA AND QL: 6 VIALS (6,600 MG TOTAL) PER 2 WEEKS
PYRUKYND 5MG TABLET PYRUKYND 20MG TABLET PYRUKYND 50MG TABLET	ADD PA AND QL: 2 TABLETS PER DAY
PYRUKYND TAPER PACK	ADD QL: 1 PACK PER 28 DAYS
MIDAZOLAM 2MG/ML SYRUP	ADD QL: 10 ML PER FILL
COLACE 100MG CAPSULE	ADD QL: 3 CAPSULES PER DAY
VEKLURY 100MG INJ	REMOVE PA
ENTADFI	ADD PA AND QL: 1 PER DAY
VYVGART 400/20ML INJ	ADD PA AND QL: 10 MG/KG ONCE WEEKLY FOR 4 WEEKS (4 WEEKS = 1 CYCLE) 1200 MG (TOTAL OF 3 VIALS) ONCE WEEKLY FOR 4 WEEKS (4 WEEKS = 1 CYCLE)
FENOPROFEN 600MG TABLET ETODOLAC 200MG CAPSULE	ADD PA
FENOPROFEN 400MG CAPSULE	REMOVE PA
EYSUVIS 0.25% DROPS	UPDATE QL: 20 ML PER 30 DAYS
TYRVAYA 0.03MG SOLUTION	ADD PA AND QL: 1 CARTON (2 BOTTLES) PER 30 DAYS
VUITY 1.25% OP SOLUTION	ADD PA AND QL: 2.5 ML PER 30 DAYS
VABYSMO 6/0.05ML INJ	ADD PA AND QL: 6 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 4 WEEKS

** THIS CHANGE WILL BE IMPLEMENTED ONCE THE MEDICATION IS ON THE MARKET*

*** THESE CHANGES ARE TO ALIGN WITH NATIONAL COVERAGE OF COVID THERAPY
AGENT'S*

What does this mean for you?

Some medications you take may no longer be preferred. You'll need approval from us to continue to get these medications.

What should I do if I use a nonpreferred drug?

Talk with your doctor to see if you can change to the new preferred drug. If your doctor says you can take the new preferred drug, ask them to write a new prescription for you. You and your doctor have the final say in your care.

Things to remember:

This doesn't change which pharmacy you go to or where you get your care.

If your doctor writes a prescription for or says you need to keep using a nonpreferred drug, they will need to get approval from Highmark BCBSWNY first by calling **866-231-0847 (TTY 711)**.

Your health is important to us — that's why we have our experienced team of doctors and pharmacists regularly review this list to keep you safe and healthy.

Questions? Call Member Services at **866-231-0847 (TTY 711)**, Monday through Friday from 8:30 a.m. to 6 p.m. Eastern time.

Enclosures: Get help in another language

Nondiscrimination notice

bcbswny.com/stateplans

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