December 2025

Pharmacy Formulary Change Notice

Highmark Blue Cross Blue Shield (Highmark BCBS) 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 February 1, 2026, for Child Health Plus (CHP) members.

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

Effective for all CHP members on February 1, 2026		
Medication	**Changes**	**Your doctor may change it to one of these preferred drugs:**
APRETUDE INJECTION YEZTUGO TABLET YEZTUGO INJECTION	NON-PREFERRED WITH PA	N/A
DOCETAXEL INJECTION FASLODEX INJECTION SYLVANT INJECTION ELITEK INJECTION VISTOGARD PAK BORUZU INJECTION BORTEZOMIB INJECTION VELCADE INJECTION AZACITIDINE INJECTION VIDAZA INJECTION	COVERED*	N/A
GENOTROPIN INJECTION	NON-PREFERRED WITH PA	ZOMACTON INJECTION NORDITROPIN INJECTION
SACUBITRIL-VALSARTAN 24-26MG TABLET SACUBITRIL-VALSARTAN 49-51MG TABLET SACUBITRIL-VALSARTAN 97-103MG TABLET (GENERIC ENTRESTO)	PREFERRED*	N/A
VITAMIN D2 400 UNIT TABLET VITAMIN D2 2000 UNIT CAPSULE/TABLET VITAMIN D 50000 UNIT CAPSULE	PREFERRED*	N/A
UM Edits – Effective for all members no later than February 1, 2026 No changes in preferred/nonpreferred status revision or addition to UM edit only		

ACTOS 15MG, ACTOS 45MG, ACTOS 30MG TABLETS	REMOVE STEP THERAPY
ALLERGY NASAL SPRAY 0.15% (AZELASTINE) (205.5 MCG/SPRAY) (30 ML/200 SPRAYS)	ADD QL 30 ML PER 25 DAYS
ANDEMBRY 200MG/1.2 ML PREFILLED AUTO-INJECTOR/PREFILLED SYRINGE	ADD PA AND QL 1 PREFILLED AUTOINJECTOR/SYRINGE PER 28 DAYS
ANZUPGO 2% CREAM	ADD PA AND QL 60 GRAMS PER 30 DAYS
APRETUDE 600MG ER SUSPENSION	ADD PA
ARYNTA 10MG/ML ORAL SOLUTION	ADD PA AND QL 7 ML PER DAY
ATMEKSI 750MG/5 ML ORAL SUSPENSION	ADD ST AND QL 30 ML PER DAY
AUSTEDO XR 6-24 12-30MG TITRATION KIT	ADD QL 1 KIT PER FILL, ONE TIME FILL
BRINSUPRI 10MG TABLET BRINSUPRI 25MG TABLET	ADD PA AND QL 1 TABLET PER DAY
BRUKINSA 160MG TABLET	ADD QL 2 TABLETS PER DAY
BUPRENORPHINE 2MG SUBLINGUAL TABLET	UPDATE QL16 TABLETS PER 90 DAYS
BUPRENORPHINE 8MG SUBLINGUAL TABLET	UPDATE QL 4 TABLETS PER 90 DAYS
BUTALBITAL-ACETAMINOPHEN-CAFFEINE 50 MG-325MG-40 MG/15ML ORAL SOLUTION	ADD PA AND QL 90 ML PER DAY
CAMCEVI ETM 21MG PRE-FILLED SYRINGE	ADD PA AND QL 1 SYRINGE PER 12 WEEKS**
CARBINOXAMINE MALEATE 4MG TABLET	ADD QL 6 TABLETS PER DAY
CARBZAH 4MG/ 5ML ORAL SOLUTION	ADD QL 20 MLS PER DAY
CENTRUM PRENATAL MULTIVITAMIN GUMMIES	ADD QL 2 GUMMIES PER DAY
CODITUSSIN DAC (PSEUDOEPHEDRINE-GUAIFENESIN WITH CODEINE) ORAL SOLUTION	ADD QL 200 ML PER 5 DAYS; 2 FILLS PER 30 DAYS
CORLANOR 5MG TABLET CORLANOR 7.5MG TABLET	REMOVE QL 2 TABLETS PER DAY
CORLANOR 5MG/5ML ORAL SOLUTION AMPULE	REMOVE QL 4 AMPULES PER DAY (4 CARTONS PER 28 DAYS)
DAWNZERA 80MG/0.8 ML AUTOINJECTOR	ADD QL 1 AUTOINJECTOR PER 28 DAYS
DOPTELET SPRINKLE 10 MG CAPSULE	ADD PA AND QL 2 CAPSULES PER DAY
EKTERLY 300MG TABLET	ADD PA AND QL 24 TABLETS (6 CARTONS) PER 30 DAYS
ELFABRIO 5MG/2.5 ML INEJCTION	ADD DOSING LIMIT
FORTEO 560 MG/2.24 ML INJECTION	ADD QL 1 PEN PER 28 DAYS
FRAICHE 5000 DENTAL GEL	ADD QL 100 G/ML PER 30 DAYS
HARLIKU 2MG TABLET	ADD PA AND QL 1 TABLET PER DAY
HERNEXEOS 60MG TABLET	ADD PA AND QL 3 TABLETS PER DAY

HYDROCORTISONE ACETATE 2.5% CREAM (MICORT HC)	ADD ST AND QL 30 GRAMS PER 30 DAYS
IBTROZI 200MG CAPSULE	ADD PA AND QL 3 TABLETS PER DAY
IBUPROFEN 300MG TABLET	ADD ST AND QL 4 TABLETS PER DAY
KERENDIA 40 MG TABLET	ADD QL 1 TABLET PER DAY
KHINDIVI 1MG/ML ORAL SOLUTION	ADD PA
LASTACAFT 0.25% OPHTHALMIC SOLUTION (OTC)	UPDATE QL 5 ML PER 30 DAYS
LEQEMBI IQLK 360MG/1.8ML AUTOINJECTOR	ADD PA AND QL 4 AUTOINJECTORS PER 28 DAYS
LEUCOVORIN 5MG, 10MG,15MG AND 20MG TABLETS	ADD QL 2 TABLETS PER DAY
LOPRESSOR ORAL SOLUTION	ADD PA
LUMAKRAS 240MG TABLET	ADD QL 4 TABLETS PER DAY
LYNOZYFIC INJECTION	ADD PA
METAXALONE 640MG TABLET	ADD ST AND QL 4 TABLETS PER DAY
MODEYSO 125MG CAPSULES	ADD PA AND QL 20 CAPSULES PER 28 DAYS
OLOPATADINE 0.2% OPHTHALMIC SOLUTION (OTC)	UPDATE QL 3.5 ML PER 30 DAYS
OTEZLA XR 75MG TABLET	ADD PA AND QL 1 TABLET PER DAY
OTEZLA/OTEZLA XR 28-DAY STARTER PACK	ADD PA AND QL 1 PACK (28 DAY SUPPLY, ONE TIME FILL)
PAXLOVID 300 MG/100 MG + 150 MG/100 MG DOSE PACK	ADD QL 1 DOSE PACK PER FILL; 1 FILL PER 90 DAYS
PREZCOBIX 675 MG-150MG TABLET	ADD QL 1 TABLET PER DAY
PROMETRIUM 100 MG CAPSULE PROMETRIUM 200 MG CAPSULE	REMOVE QL 2 CAPSULES PER DAY
PROVERA 2.5MG TABLET PROVERA 5MG TABLET PROVERA 10 MG TABLET	REMOVE QL 1 TABLET PER DAY
RISEDRONATE 30MG TABLET	UPDATE QL 1 TABLET PER DAY, MAXIMUM OF 16 TREATMENT WEEKS
SACUBITRIL-VALSARTAN 24-26MG TABLET SACUBITRIL-VALSARTAN 49-51MG TABLET SACUBITRIL-VALSARTAN 97-103MG TABLET (GENERIC ENTRESTO)	REMOVE PA
SDAMLO 2.5MG SDAMLO 5MG SDAMLO 10MG ORAL SOLUTION	ADD PA AND QL 1 SINGLE-DOSE BOTTLE PER DAY**
SEPHIENCE ORAL POWDER	ADD PA
SKYTROFA 0.7MG CARTRIDGE SKYTROFA 1.4MG CARTRIDGE	ADD QL 4 CARTRIDGES PER 28 DAYS

SKYTROFA 1.8MG CARTRIDGE SKYTROFA 2.1MG CARTRIDGE SKYTROFA 2.5MG CARTRIDGE	
STARJEMZA 130 MG/26 ML (5 MG/ML) VIAL	ADD PA AND DOSING LIMIT
STARJEMZA 45 MG/0.5 ML VIAL STARJEMZA 45 MG/0.5 ML SINGLE-USE PREFILLED SYRINGE STARJEMZA 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE	ADD PA AND QL 1 VIAL/SYRINGE PER 84 DAYS (12 WEEKS)
SUNLENCA 300MG TABLET	ADD QL 4 TABLETS PER 28 DAYS, MAXIMUM OF 6 MONTHS
TONMYA 2.8 MG SUBLINGUAL TABLET	ADD PA AND QL 2 SUBLINGUAL TABLETS PER DAY
TRYPTYR 0.003% OPHTHALMIC SOLUTION	ADD PA AND QL 2 VIALS PER DAY
TWIIST INSULIN PUMP STARTER KIT	UPDATE QL 1 KIT A ONE TIME FILL
TYBOST 90MG TABLET	ADD QL 1 TABLET PER DAY
UPTRAVI 200MCG STARTER BOTTLE	ADD QL 1 PACK, ONE TIME FILL
VABRINTY 22.5MG KIT	ADD PA AND QL 1 KIT PER 12 WEEKS
VABRINTY 30MG KIT	ADD QL 1 KIT PER 16 WEEKS
VABRINTY 45MG KIT	ADD PA AND QL 1 KIT PER 24 WEEKS (6 MONTHS)
VABRINTY 7.5MG KIT	ADD PA ANDADD QL 1 KIT PER 4 WEEKS**
VENXXIVA 100MG TABLET	ADD PA AND QL 10 TABLETS PER DAY
VENXXIVA 300MG TABLET	ADD PA AND QL 3 TABLETS PER DAY
VIRAZOLE INHALATION	REMOVE PA
VIZZ 1.44% OPHTHALMIC SOLUTION	ADD PA AND QL 1 VIAL PER DAY
VOSTALLY 1 MG/ML ORAL SOLUTION	ADD PA AND QL 20 ML PER DAY**
VYSCOXA 10MG/ML ORAL SUSPENSION	ADD PA AND QL 40 ML PER DAY
WEGOVY 0.25MG PEN WEGOVY 0.5 MG PEN WEGOVY 1 MG PEN WEGOVY 1.7 MG PEN WEGOVY 2.4 MG PEN	UPDATE QL 1 PEN PER WEEK 4 PENS PER 28 DAYS FOR CV OR MASH INDICATION
WIDAPLIK 10MG/1.25MG/ 0.625MG TABLET WIDAPLIK 20MG/2.5MG/1.25MG TABLET WIDAPLIK 40 MG/5MG/2.5MG TABLET	ADD QL 1 TABLET PER DAY**
XOFLUZA 30MG ORAL SUSPENSION PACKET	ADD QL 1 PACKET PER FILL; 1 FILL PER 90 DAYS**
XOFLUZA 40MG ORAL SUSPENSION PACKET	ADD QL 2 PACKETS PER FILL; 1 FILL PER 90 DAYS**
YEZTUGO 300MG TABLET	ADD PA AND QL 1 BOTTLE (4 TABLETS) PER ONE TIME FILL

YEZTUGO 463.5MG/1.5 ML KIT	ADD PA AND QL 1 KIT (2 VIALS) PER 24 WEEKS
YUTREPIA 106MCG CAPSULE	ADD PA AND QL 8 CAPSULES PER DAY
YUTREPIA 26.5MCG CAPSULE YUTREPIA 53MCG CAPSULE	ADD PA AND QL 5 CAPSULES PER DAY
YUTREPIA 79.5MCG CAPSULE	ADD PA AND QL 10 CAPSULES PER DAY
ZEGFROVY 150MG TABLET ZEGFROVY 200 MG TABLET	ADD PA AND QL 1 TABLET PER DAY**
ZEJULA 100MG TABLET	UPDATE QL 1 TABLET OR CAPSULES PER DAY
ZUSDURI 80MG INJECTION	ADD PA

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

LEGEND
In each class, drugs are listed alphabetically by either brand name or generic name.
BRAND-NAME DRUG: Uppercase in bold type
GENERIC DRUG: Lowercase in plain type
AL: Age limit restriction
DO: Dose Optimization Program
GR: Gender restriction
OTC: Over-the-counter medication available without a prescription. (Prescribers please indicate OTC on the prescription)
PA: Prior authorization is required. Prior authorization is the process of obtaining approval of benefits before certain prescriptions are filled.
QL: Quantity limits; certain prescription medications have specific quantity limits per prescription per month.
SP: Specialty pharmacy
ST: Step therapy is required. You may need to use one medication before benefits for the use of another medication can be authorized.

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 BCBS first by calling **1-866-231-0847 (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 **1-866-231-0847 (TTY 711)**, Monday through Friday from 8:30 a.m. to 6:00 p.m. Eastern time.

www.bcbswny.com/stateplans

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