March 2026

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 May 1, 2026, for Child Health Plus (CHPlus) 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 May 1, 2026	
ANZEMET 50MG TABLETS	UPDATE QL 5 TABLETS PER 30 DAYS
ARMLUPEG 6MG/0.6ML PREFILLED SYRINGE	ADD PA AND QL 2 SYRINGES PER 28 DAYS
AUKELSO, BILPREVDA, JUBEREQ, XTRENBO 120MG/1.7ML VIAL	ADD PA AND QL 1 VIAL PER 28 DAYS
BILDYOS, BOSAYA, ENOBY, OSVYRTI 60MG/ML PREFILLED SYRINGE OR VIAL	ADD PA AND QL 60 MG (1 PREFILLED SYRINGE OR 1 VIAL) EVERY 6 MONTHS
BLENREP 70MG INJECTION	ADD PA
BONDLIDO 10% PATCH	ADD PA AND QL 2 PATCHES PER DAY
CIMZIA (CERTOLIZUMAB PEGOL) 200MG/ML STARTER KIT	UPDATE QL 1 STARTER KIT (ONE TIME FILL)
DESLORATADINE 0.5MG/ML ORAL SOLUTION	ADD ST AND QL 10 ML PER DAY
DHIVY 25-100MG TABLET	REMOVE QL
ECONAZOLE 1% FOAM FORMULA 7 1% GEL KETODAN 2% FOAM	ADD ST
ECONAZOLE 1% FOAM	ADD QL 70 GM PER 30 DAYS

ELIQUIS 0.5MG TABLETS FOR ORAL SUSPENSION	UPDATE QL 32 TABLETS PER DAY
ELIQUIS SPRINKLE 0.15MG POWDER FOR ORAL SUSPENSION	UPDATE QL 4 CAPSULES PER DAY
ENBUMYST 0.5MG UNIT DOSE NASAL SPRAY	ADD PA AND QL 12 NASAL SPRAYS PER 30 DAYS
EXDENSUR 100MG/ML PREFILLED PEN/SYRINGE	ADD PA AND QL 1 PEN/SYRINGE EVERY 6 MONTHS
EYDENZELT 2MG VIAL & SYRINGE	ADD PA AND QL DIABETIC MACULAR EDEMA, DIABETIC RETINOPATHY, NEOVASCULAR "WET" AGE-RELATED MACULAR DEGENERATION, RETINAL VEIN OCCLUSION: 2 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 4 WEEKS. RETINOPATHY OF PREMATURITY: 0.4 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 10 DAYS.
FAMOTIDINE ORAL SUSPENSION	REMOVE PA
FASLODEX 250MG/5ML INJECTION	REMOVE PA
FORZINITY 280MG/3.5ML VIAL	ADD PA AND QL 4 VIALS PER 28 DAYS
GAMMAGARD LIQUID ERC 10% INJECTION QIVIGY 10% INJECTION	ADD PA
GLASSIA 4000MG VIAL GLASSIA 5000MG VIAL	ADD DOSING 60 MG/KG ONCE PER WEEK
HARLIKU 2MG TABLET	ADD ST
HUMALOG TEMPO U-200 PEN	ADD QL 30 ML PER 30 DAYS
HYRNUO 10MG CAPSULE	ADD PA AND QL 4 TABLETS PER DAY
INLEXZO 225MG IMPANT	ADD PA
INLURIYO 200MG TABLET	ADD PA AND QL 2 TABLETS PER DAY

IVERMECTIN 6MG TABLET	UPDATE QL 4 TABLETS PER FILL; 1 FILL PER 90 DAYS
JASCAYD 9MG TABLET JASCAYD 18MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
JAVADIN 0.02MG/ML INJECTION	ADD PA AND QL 60 ML PER DAY
KETODAN 2% FOAM	ADD QL 100 GM PER 30 DAYS
KEYTRUDA QLEX 395MG/2.4 ML INJECTION	ADD QL 2.4 ML (1 VIAL) PER 21 DAYS
KEYTRUDA QLEX 790MG/4.8ML INJECTION	ADD QL 4.8 ML (1 VIAL) PER 42 DAYS
KEYTRUDA QLEX INJECTION	ADD PA
KIRSTY U-100 (INSULIN ASPART-XJHZ) PEN	ADD ST AND QL 30 ML PER 30 DAYS
KOMZIFTI 200MG CAPSULE	ADD PA AND QL 3 CAPSULES PER DAY
KOSELUGO 5MG ORAL GRANULE	ADD QL 20 ORAL GRANULES PER DAY
KOSELUGO 7.5MG ORAL GRANULE	ADD QL 6 ORAL GRANULES PER DAY
KOSELUGO ORAL GRANULES	ADD PA
KYGEVVI POWDER FOR ORAL SOLUTION	ADD PA AND QL 16 PACKETS PER DAY
LASIX ONYU 80MG/2.67ML KIT	ADD QL 6 KITS PER 30 DAYS
LASIX ONYU KIT AND STARTER KIT	ADD PA
LASIX ONYU STARTER KIT	ADD QL 1 KIT PER 8 MONTHS
LYNKUET 60MG CAPSULE	ADD PA AND QL 2 CAPSULES PER DAY
OMVOH 200MG/2ML PREFILLED PEN/SYRINGE	1 PENS/SYRINGE [1 CARTON] PER 28 DAYS (4 WEEKS)
OMVOH 300MG/15ML SINGLE-DOSE VIAL	UPDATE QL 9 VIALS TOTAL; ONE TIME FILL
ORMALVI 50MG TABLET	ADD PA AND QL 4 TABLETS PER DAY
PALSONIFY 20MG TABLET PALSONIFY 30MG TABLET	ADD PA AND QL 20 MG: 2 TABLETS PER DAY 30 MG: 4 TABLETS PER DAY

POHERDY INJECTION	ADD PA
PYZCHIVA 45MG/0.5ML VIAL	ADD QL 1 VIAL PER 84 DAYS (12 WEEKS)
PYZCHIVA 45MG/0.5ML SINGLE-USE PREFILLED SYRINGE/AUTOINJECTOR PYZCHIVA 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE/AUTOINJECTOR	ADD QL 1 SYRINGE/AUTOINJECTOR PER 84 DAYS (12 WEEKS)
RADICAVA 30MG/ 100ML INJECTION	ADD QL 2,000 ML PER 28 DAYS
RADICAVA 60MG/ 100ML INJECTION	ADD QL 1,000 ML PER 28 DAYS
REDEMPLO 25MG/0.5ML SYRINGE	ADD PA AND QL 1 SYRINGE EVERY 3 MONTHS
REPATHA 140MG/ML PREFILLED SYRINGE/AUTO-INJECTOR	UPDATE QL 3 PREFILLED SYRINGES/AUTO-INJECTORS PER 28 DAYS
RHAPSIDO 25MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
SIMLANDI (ADALIMUMAB-RYVK) 80MG/0.8ML AUTOINJECTOR	ADD QL 2 SYRINGES PER 28 DAYS
SKYRIZI 180MG/ 1.2ML SYRINGE	ADD QL 1 PREFILLED SYRINGE PER 56 DAYS (8 WEEKS)
SKYRIZI 600MG/10ML SINGLE-DOSE VIAL	UPDATE QL 6 VIALS TOTAL; ONE TIME FILL
SPEVIGO 300MG/2ML PREFILLED SYRINGE	ADD QL 1 PREFILLED SYRINGE PER 28 DAYS*
STEQEYMA 45MG/0.5ML VIAL	ADD QL 1 VIAL PER 84 DAYS (12 WEEKS)
SUBVENITE 10MG/1ML ORAL SUSPENSION	ADD PA AND QL 50 ML PER DAY
SYLVANT 100MG INJECTION SYLVANT 400MG INJECTION	REMOVE PA
TREMFYA (GUSELKUMAB) INDUCTION PACK FOR ULCERATIVE COLITIS OR CROHN'S DISEASE 200MG/2ML PEN	ADD QL 3 PACKS TOTAL: ONE TIME SUPPLY

TREMFYA 200MG/20ML SINGLE-DOSE VIAL	UPDATE QL 3 VIALS TOTAL; ONE TIME FILL
TRYNGOLZA 80MG/0.8ML INJECTION	ADD ST
TYZAVAN 500MG INJECTION TYZAVAN 750MG INJECTION TYZAVAN 1GM INJECTION TYZAVAN 1.25GM INJECTION TYZAVAN 1.5GM INJECTION TYZAVAN 1.75GM INJECTION TYZAVAN 2GM INJECTION	ADD QL 2 VIALS/BAGS PER DAY
VOYXACT 400MG/2ML PREFILLED SYRINGE	ADD PA AND QL 1 PREFILLED SYRINGE PER 4 WEEKS
WAYRILZ 400MG TABLET	ADD PA AND QL 2 TABLETS PER DAY
ZOLYMBUS 0.01% OPHTHALMIC GEL	ADD QL 30 SINGLE-DOSE UNITS PER 30 DAYS
ZORYVE 0.05% CREAM	ADD QL 60 GM PER 30 DAYS
ZORYVE 0.15% AND 0.05% CREAM	ADD PA
ZORYVE 0.3% FOAM	ADD ST

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

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