HIGHMARK

September 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 November 1, 2025, 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 11/1/2025		
Medication	**Changes**	**Your doctor may change it to one of these preferred drugs:**
ACITRETIN 10MG CAPSULES ACITRETIN 17.5MG CAPSULE ACITRETIN 25MG CAPSULES	PREFERRED	N/A
RX FLUTICASONE PROPIONATE 50 MCG NASAL SPRAY	PREFERRED	N/A
LEVALBUTEROL 45MCG HFA INHALER LEVALBUTEROL 0.31MG NEBULIZER LEVALBUTEROL 0.63MG NEBULIZER LEVALBUTEROL 1.25MG NEBULIZER LEVALBUTEROL 1.25/0.5ML NEBULIZER	NON-PREFERRED WITH PA	ALBUTEROL 90MCG HFA INHALER ALBUTEROL 0.63MG/3ML NEBULIZER ALBUTEROL 0.083% NEBULIZER ALBUTEROL 1.25MG/3ML NEBULIZER
SELARSDI 130/26ML INJECTION	PREFERRED WITH PA	N/A
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN NOVEMBER 1, 2025 NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY		
ACID CONTROL TAB 10MG ACID REDUCER TAB 20MG FAMOTIDINE TAB 40MG FAMOTIDINE SUS 40MG/5ML CIMETIDINE TAB 200MG		

CIMETIDINE TAB 300MG CIMETIDINE TAB 400MG CIMETIDINE TAB 800MG CIMETIDINE SOL 300/5ML NIZATIDINE CAP 150MG NIZATIDINE CAP 300MG	REMOVE QL
ALA-HIST IR 2MG TABLET HISTEX 2.5MG/5ML SYRUP HISTEX PD OR PDX 1.25MG DROPS TRIPROLIDINE HCL 2.5MG TABLETS MICLARA LQ 1.25/5ML LIQUID PEDIACLEAR 8 LIQUID	REMOVE QL REMOVE QL
ALBUTEROL 0.5% NEBULIZER	UPDATE QL 180 VIALS (90 ML) PER 30 DAYS
ALBUTEROL 0.63MG/3MG NEBULIZER ALBUTEROL1.25MG/3MG NEBULIZER ALBUTEROL 0.083% NEBULIZER	UPDATE QL 180 VIALS (540 ML) PER 30 DAYS
ALIVE DAILY SUPPORT PRENATAL GUMMIES	ADD QL 2 GUMMIES PER DAY
ANASTROZOLE 1MG TABLET EXEMESTANE 25MG TABLET FARESTON 60MG TABLET LETROZOLE 2.5MG TABLET	REMOVE QL
ARBLI 10MG/ML SUSPENSION	ADD PA AND QL 10ML PER DAY
ATZUMI (DIHYDROERGOTAMINE) 5.2 MG NASAL POWDER DEVICE	ADD PA AND QL 1 CARTON (8 DEVICES) PER 28 DAYS
AVMAPKI FAKZYNJA CO-PACK CAPSULES AND TABLETS	ADD PA AND QL 1 PACK (66 TABLETS/CAPSULES) PER 28 DAYS
BLUJEPA 750MG TABLET	ADD PA AND QL 20 TABLETS PER FILL; 1 FILL PER 30 DAYS
BOMYNTRA 120 MG/1.7ML VIAL OR PRE-FILLED SYRINGE	ADD PA 120 MG (1 VIAL OR 1 PREFILLED SYRINGE) PER 28 DAYS
BREKIYA 1MG/ML PREFILLED SINGLE-DOSE AUTOINJECTOR	ADD PA AND QL 6 CARTONS (24 AUTOINJECTORS) PER 28 DAYS
BRYNOVIN 25 MG/ML ORAL SOLUTION	ADD PA AND QL 4 ML PER DAY
BUCAPSOL 15MG CAPSULE	ADD ST AND QL 4 CAPSULES PER DAY
BUCAPSOL 7.5 MG AND 10 MG CAPSULE	ADD ST AND QL 3 CAPSULES PER DAY
BYQLOVI 0.05% SUSPENSION	ADD QL 3.5 ML PER 30 DAYS
CARVEDILOL 10MG ER CAPSULE	UPDATE QL 8 CAPSULES PER DAY
CARVEDILOL 12.5MG ER TABLET	UPDATE QL 8 TABLETS PER DAY
CARVEDILOL 3.125MG TABLET	UPDATE QL 32 TABLETS PER DAY
CARVEDILOL 6.25MG TABLET	UPDATE QL 16 TABLETS PER DAY

CLONIDINE 0.1MG TABLET	UPDATE QL 12 TABLETS PER DAY
COMBOGESIC 325/97.5MG TABLET	ADD QL 12 TABLETS PER DAY
CONEXXENCE 60MG/ML INJECTION	ADD PA AND QL 60 MG (1 PREFILLED SYRINGE) EVERY 6 MONTHS
CTEXLI 250MG TABLET	ADD PA AND QL 3 TABLETS PER DAY
DDAVP 0.1MG TABLET	UPDATE QL 12 TABLETS PER DAY
DOCETAXEL 20MG/ML INJECTION DOCETAXEL 80MG/4ML INJECTION DOCETAXEL 160/8ML INJECTION DOCETAXEL 20MG/2ML INJECTION DOCETAXEL 80MG/8ML INJECTION DOCETAXEL 160/16ML INJECTION VIDAZA 100MG INJECTION BORUZU 3.5 INJECTION VELCADE 3.5MG INJECTION	REMOVE PA REMOVE PA
EGRIFTA WR 11.6 MG INJECTABLE SOLUTION	ADD QL 4 VIALS PER 28 DAYS
ELIQUIS 0.5MG TABLETS FOR ORAL SUSPENSION	ADD QL 592 TABLETS PER 30 DAYS
ELIQUIS SPRINKLE 0.15MG POWDER FOR ORAL SUSPENSION	ADD QL 74 CAPSULES PER 30 DAYS
ELITEK 1.5MG INJECTION ELITEK 7.5MG INJECTION	REMOVE PA
EMRELIS 20MG INJECTION	ADD PA
ESLICARBAZEPINE 200MG TABLETS	ADD PA
FENOPRON 300MG CAPSULE	ADD ST AND ADD QL 4 CAPSULES PER DAY
FILSUVEZ 10% GEL	ADD QL 60 TUBES (1404 GRAMS) PER 30 DAYS
FOSAPREPITANT INJECTION CINVANTI INJECTION POSFREA INJECTION	REMOVE PA
HEMICLOR 2.5MG TABLET	ADD PA
HISTEX-DM SYRUP	REMOVE QL
IMAAVY 300 MG/1.62 ML (185 MG/ML) SINGLE DOSE VIAL; 1200 MG/6.5 ML (185 MG/ML) SINGLE DOSE VIAL	ADD DOSING INITIAL DOSE: ONE 30 MG/KG INFUSION SUBSEQUENT DOSES: 15 MG/KG EVERY 2 WEEKS
IMAAVY INJECTION	ADD PA
INZIRQO 10MG/ML SUSPENSION	ADD PA

JOBEVNE INJECTION	ADD PA AND QL
LABETALOL 100MG TABLET	UPDATE QL 24 TABLETS PER DAY
LABETALOL 400MG TABLET	ADD QL 6 TABLETS PER DAY
LACTULOSE 10GM/15ML SOLUTION	REMOVE QL
LIVMARLI 10MG TABLET	ADD QL 4 TABLETS PER DAY
LIVMARLI 15MG TABLET LIVMARLI 20MG TABLET	ADD QL 2 TABLETS PER DAY
LIVMARLI 30MG TABLET	ADD QL 1 TABLET PER DAY
LOREEV XR 2MG CAPSULE	UPDATE QL 3 CAPSULES PER DAY
LUTRATE DEPO 22.5MG INJECTION	ADD PA AND QL 1 KIT PER 12 WEEKS
MAG OXIDE 400MG TABLET MAGNESIUM 400MG TABLET MAGDELAY 64MG TABLET MGO 400MG TABLET SLOW MAG/CA 64-106MG TABLET	REMOVE QL
METFORMIN 750MG TABLET	ADD PA AND QL 3 TABLETS PER DAY
METHYLDOPA 250MG TABLET	UPDATE QL 12 TABLETS PER DAY
MEZOFY 5MG ORAL FILM MEZOFY 10MG ORAL FILM MEZOFY 15MG ORAL FILM	ADD PA AND QL 5 MG 1 FILM PER DAY; 10MG AND 15 MG 2 FILM PER DAY
NADOLOL 20MG TABLET	UPDATE QL 16 TABLETS PER DAY
NADOLOL 40MG TABLET	UPDATE QL 8 TABLETS PER DAY
NIMODIPINE 60MG/20ML SOLUTION	ADD QL 120 ML PER DAY
OMLYCLO 75 MG/0.5 ML PREFILLED SYRINGE	ADD PA AND QL 2 PREFILLED SYRINGES PER 28 DAYS
OMLYCLO 150 MG/ML PREFILLED SYRINGE	ADD PA AND QL 4 PREFILLED SYRINGES PER 28 DAYS
ORAPRED 15MG ODT TABLET	UPDATE QL 4 TABLETS PER DAY
ORAPRED ODT 10MG TABLET	UPDATE QL 6 TABLETS PER DAY
ORLYNVAH 500MG/500MG TABLET	ADD PA AND QL 10 TABLETS PER FILL; 1 FILL PER 30 DAYS
PINDOLOL 5MG TABLET	UPDATE QL 12 TABLETS PER DAY
PROPRANOLOL 10MG TABLET	UPDATE QL 64 TABLETS PER DAY
PROPRANOLOL 120MG ER CAPSULE	UPDATE QL 5 CAPSULES PER DAY
PROPRANOLOL 20MG TABLET	UPDATE QL 32 TABLETS PER DAY
PROPRANOLOL 40MG TABLET	UPDATE QL 16 TABLETS PER DAY
PROPRANOLOL 60MG ER CAPSULE	UPDATE QL 10 CAPSULES PER DAY
PROPRANOLOL 60MG TABLET	UPDATE QL 10 TABLETS PER DAY
PROPRANOLOL 80MG ER CAPSULE	UPDATE QL 8 CAPSULES PER DAY

QFITLIA 20/0.2ML INJECTION QFITLIA 50/0.5ML INJECTION	ADD PA
RALDESY 10MG/ML ORAL SOLUTION	ADD PA AND QL 60 ML PER DAY
REVUFORJ 25 MG TABLET	UPDATE QL 8 TABLETS PER DAY
RIZAFILM (RIZATRIPTAN) 10 MG ORAL FILM	UPDATE QL 9 FILMS PER 30 DAYS
ROFLUMILAST 250MCG TABLET ROFLUMILAST 500MCG TABLET	REMOVE PA
RYBELSUS 4MG TABLET RYBELSUS 9MG TABLET	ADD QL 1 TABLET PER DAY
RYBELSUS 1.5MG TABLET	ADD QL 1 BOTTTLE OF 30 TABLETS PER ONE TIME FILL
STELARA (USTEKINUMAB) 130MG/26ML VIAL	ADD DOSING LIMIT
STELARA (USTEKINUMAB) 45MG.0.5ML VIAL STELARA (USTEKINUMAB) 45MG/0.5ML PREFILLED SYRINGE STELARA (USTEKINUMAB) 90MG/1ML PREFILLED SYRINGE STELARA (USTEKINUMAB) 90MG/1ML PREFILLED SYRINGE OTULFI 45 MG/0.5 ML VIAL	ADD QL 1 VIAL/SYRINGE PER 84 DAYS (12 WEEKS)
SYMBRAVO 20-10MG TABLET	ADD PA AND QL 9 TABLETS PER 30 DAYS
TEMPO REFILL KIT	REMOVE QL AND PA
TIMOLOL MALEATE 5MG TABLET	UPDATE QL 12 TABLETS PER DAY
TREMFYA CROHN'S 200MG/2ML INJECTION	ADD QL 3 PACKS TOTAL: ONE TIME SUPPLY
TWIIST INSULIN PUMP STARTER KIT	UPDATE QL 1 KIT PER 30 DAYS, ONE TIME FILL
TWIIST STARTER / REFILL KIT	ADD PA
UPSPRING PRENATAL COMPLETE	ADD QL 3 SOFTGELS PER DAY
USTEKINUMAB 130 MG/26 ML (5 MG/ML) VIAL USTEKINUMAB 45 MG/0.5 ML VIAL USTEKINUMAB 45 MG/0.5 ML SINGLE-USE PREFILLED SYRINGE USTEKINUMAB 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE	ADD PA
VANCOMYCIN 1.75GM INJECTION VANCOMYCIN 2GM INJECTION	ADD QL 2 VIALS/BAGS PER DAY
VANRAFIA 0.75MG TABLET	ADD PA AND QL 1 TABLET PER DAY
VISTOGARD 10GM PAK	REMOVE PA
VITAFUSION PRENATAL CHEWABLE	ADD QL 2 CHEWABLE TABLETS PER DAY

VITAMIN D3 400UNIT TABLET VITAMIN D3 2000UNIT CAPSULE VITAMIN D3 5000UNIT CAPSULE	REMOVE QL
VYKAT XR 25MG TABLET VYKAT XR 75MG TABLET VYKAT XR 150MG TABLET	ADD PA AND QL 25MG: 21 TABLETS PER DAY 75MG: 7 TABLETS PER DAY 150MG: 3 TABLETS PER DAY
VYVGART HYTRULO PREFILLED SYRINGE	ADD QL 4 PREFILLED SYRINGES PER 28 DAYS
ZELVYSIA ORAL POWDER FOR SOLUTION	ADD PA

THIS CHANGE WILL BE IMPLEMENTED ONCE THE 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 p.m. Eastern time.

Enclosure: Get help in another language

www.bcbswny.com/stateplans