November 2019

Pharmacy Formulary Change Notice

BlueCross BlueShield of Western New York Medicaid is here to help you stay on top of your health care. We want to tell you about some upcoming changes to your Preferred Drug List (PDL) as of November 1, 2019.

Your PDL is a list of preferred drugs covered by BlueCross BlueShield Medicaid. 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 November 1, 2019		
Medication	**Changes**	**Your doctor may change it to one of these preferred drugs**
HAEGARDA 2;000 UNIT VIAL HAEGARDA 3;000 UNIT VIAL TAKHZYRO 300 MG/2 ML VIAL	PREFERRED WITH PRIOR AUTHORIZATION (PA)	N/A
BERINERT 500 UNIT KIT FIRAZYR 30 MG/3 ML SYRINGE KALBITOR 10 MG/ML VIAL RUCONEST 2;100 UNIT VIAL	PREFERRED WITH PA	N/A
DOVATO TAB 50-300MG	COVERED ADD QUANTITY LIMIT (QL) 1 PER DAY	N/A
TEMIXYS*	PREFERRED	N/A
INSULIN LISPRO (AUTHORIZED GENERIC HUMALOG) INSULIN LISPRO KWIKPEN (AUTHORIZED GENERIC HUMALOG)	PREFERRED	N/A
AUBAGIO TAB 14MG AUBAGIO TAB 7MG GLATOPA INJ 40MG/ML GLATIRAMER INJ 40MG/ML	PREFERRED WITH PA	N/A
GILENYA CAP 0.5MG	NON-PREFERRED WITH PA	AUBAGIO TAB 7 MG AUBAGIO TAB 14 MG
CHLORZOXAZONE 250 MG TABLET	NON-PREFERRED	TIZANIDINE HCL TABS CARISOPRODOL TABS CYCLOBENZAPRINE 5 MG TAB CYCLOBENZAPRINE 10 MG TAB METHOCARBAMOL TABS ORPHENADRINE CITRATE ER TABS

(OTC GENERIC) BUDESONIDE SUS 32MCG RHINOCORT SUS ALLERGY	PREFERRED	N/A
(OTC BRAND) FLONASE ALLERGY SPRAY 50MCG NASACORT ALLERGY SPRAY 55MCG/AC	NON-PREFERRED	(OTC GENERIC) BUDESONIDE SUS 32MCG RHINOCORT SUS ALLERGY
OTC PRENATAL VITAMINS (VARIOUS)	PREFERRED	N/A
NESTAB TABLETS (RX)	PREFERRED	N/A
PRENATAL VITAMINS (RX) EXCEPT NESTAB	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	OTC PRENATAL VITAMINS (VARIOUS)
NATURE-THROID WESTHROID NP THYROID LEVOTHYROXINE/LIOTHYRONINE (ALL STRENGTHS)	NON-PREFERRED (CURRENT UTILIZERS WILL BE GRANDFATHERED)	LEVOTHYROXIN TABS LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)
LEVO-T TAB EUTHYROX TAB (ALL STRENGTHS)	PREFERRED	NA
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN NOVEMBER 1, 2019 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
GUANFACINE 2 MG TABLET	REVISE QL; 1 PER DAY	
EVEKEO ODT 5 MG TABLET EVEKEO ODT 10 MG TABLET EVEKEO ODT 15 MG TABLET EVEKEO ODT 20 MG TABLET	PA REQUIRED ADD QL 2 TABLETS PER DAY	
ADHANSIA XR 25 MG CAPSULE ADHANSIA XR 35 MG CAPSULE ADHANSIA XR 45 MG CAPSULE ADHANSIA XR 55 MG CAPSULE ADHANSIA XR 70 MG CAPSULE ADHANSIA XR 85 MG CAPSULE	ADD PA ADD STEP THERAPY (ST) ADD QL 1 CAPSULE DAILY	
XYOSTED	ADD PA ADD QL 60 CAP KIT 5 KITS PER 30 DAYS 92 CAP KIT 3 KITS PER 30 DAYS	
LOVENOX 30 MG/0.3 ML SYRINGE LOVENOX 40 MG/0.4 ML SYRINGE LOVENOX 60 MG/0.6 ML SYRINGE LOVENOX 80 MG/0.8 ML SYRINGE LOVENOX 100 MG/ML SYRINGE LOVENOX 120 MG/0.8 ML SYRINGE LOVENOX 150 MG/ML SYRINGE	REVISE QL 30 SYRINGES PER 30 DAYS	

LOVENOX 300 MG/3 ML VIAL	
ZULRESSO	ADD PA
BUPROPION XL SSB	ADD PA
TOLSURA 65 MG CAPSULE	ADD PA AND ST ADD QL 126 CAPSULES PER 30 DAYS
ARAKODA 100 MG TABLET	REVISE QL 64 TABLETS PER YEAR
SIGNIFOR LAR 10 MG KIT SIGNIFOR LAR 30 MG KIT	ADD QL 1 KIT PER 28 DAYS
BALVERSA 3 MG TABLET	ADD PA ADD QL 3 PER DAY
BALVERSA 4 MG TABLET	ADD PA ADD QL 2 PER DAY
BALVERSA 5 MG TABLET	ADD PA ADD QL 1 PER DAY
SKYRIZ 75 MG/0.83 ML	ADD PA ADD QL 2 PREFILLED SYRINGES (1 CARTON) PER 84 DAYS (12 WEEKS)
KAPSPARGO SPRINKLE 200 MG CAP	REVISE QL 2 PER DAY
CORLANOR 5 MG/5 ML ORAL SOLUTION AMPULE	ADD QL 4 AMPULES PER DAY 4 CARTONS/28 DAYS
CABLIVI 11 MG KIT	ADD PA
UDENYCA 6 MG/0.6 ML SYRINGE	PA REQUIRED ADD QL 2 SYRINGES PER 28 DAYS
YUTIQ	ADD PA
GLOPERBA 0.6 MG/5 ML	ADD PA ADD QL; 300 MLS (2 BOTTLES) PER 30 DAYS
AIMOVIG 140 MG/ML AUTOINJECTOR	ADD PA AND ST ADD QL 1 PER 30 DAYS
AIMOVIG 70 MG/ML SYRINGE/AUTOINJECTOR	ADD PA AND ST ADD QL 1 PER 30 DAYS

AIMOVIG 140 MG/2ML DOSE-2 AUTOINJ	ADD PA AND ST ADD QL 2 PER 30 DAYS
EMGALITY 120 MG/ML	ADD PA AND ST ADD QL 1 PER 30 DAYS
SUNOSI 37.5 MG SUNOSI 75 MG SUNOSI 150 MG	ADD PA AND ST ADD QL 1 PER DAY
AFREZZA 90-8 UNIT / 90-12 UNIT 180 CARTRIDGES	ADD QL 2 BOXES PER 30 DAYS
TRESIBA 100 UNIT/ML VIAL	ADD QL 30 MLS PER 30 DAYS
FLONASE SENSIMIST 27.5 MCG SPR	REVISE QL 2 INHALERS PER 30 DAYS
ROCKLATAN 0.02% - 0.005% OPHTHALMIC SOLN	ADD QL 2.5ML PER 30 DAYS
MAYZENT 0.25MG STARTER PACK	ADD PA AND ST ADD QL 1 PACK PER FILL, ONE TIME FILL
MAYZENT 0.25MG	ADD PA AND ST ADD QL 4 PER DAY
MAYZENT 2MG	ADD PA AND ST ADD QL 1 PER DAY
MAVENCLAD 10MG	ADD PA AND ST ADD QL 1 BOX PER FILL; 2 FILLS PER 46 WEEKS
APADAZ 4.08-325 MG TABLET APADAZ 6.12-325 MG TABLET APADAZ 8.16-325 MG TABLET	ADD QL 6 PER DAY
QMIIZ 7.5 MG QMIIZ 15 MG	ADD ST ADD QL 1 TABLET PER DAY
FLECTOR 1.3% PATCH	REVISE QL 2 PER DAY
LICART TOPICAL SYSTEM	ADD QL 1 PER DAY
ASPARLAS 4.08/325 MG ASPARLAS 8.16/325 MG	ADD PA ADD QL 6 PER DAY
EVENITY 105 MG/1.17 ML SYRINGE EVENITY 210 MG DOSE-2 SYRINGES	ADD QL 1 CARTON (2 PREFILLED SYRINGES) PER MONTH
INFUMORPH 200 MG/20 ML AMPUL INFUMORPH 500 MG/20 ML AMPUL	REVISE QL 2 VIALS (40 ML) PER MONTH

LEVORPHANOL 3 MG	ADD QL 6 PER DAY
INBRIJA 60 CAPSULE KIT	ADD PA AND ST ADD QL 5 KITS PER 30 DAYS
INBRIJA 92 CAPSULE KIT	ADD PA AND ST ADD QL 3 KITS PER 30 DAYS
VYNDAMAX 61 MG	ADD PA ADD QL 1 PER DAY
VYNDAQEL	ADD PA ADD QL 4 PER DAY
HCTZ 12.5 mg	REMOVE QL
DUOBRII 0.01%-0.045% LOTION 100 GM TUBE	ADD PA ADD QL 2 TUBES PER MONTH
SUMATRIPTAN 4 MG/0.5 ML SUMATRIPTAN 6 MG/0.5 ML PEN INJECTOR/SYRINGE SUMAVEL DOSEPRO 4 MG/0.5 ML	REVISE QL 6 UNITS PER 30 DAYS
TOSYMRA 10MG NASAL SPRAY	ADD QL 12 UNITS PER 30 DAYS

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, he or she will need to get approval from BlueCross BlueShield Medicaid first by calling 1-866-231-0847.

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.

www.bcbswny.com/stateplans

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