BlueCross BlueShield of Western New York

July 2021

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 August 1, 2021.

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 August 1, 2021		
Medication	**Changes**	**Your doctor may change it to one of these preferred drugs:**
GLUCOSAMINE CHONDROITIN COMPLEX CAPSULE	NON-PREFERRED	N/A
TIVICAY PD 5MG TABLET RUKOBIA 600MG ER TABLET	PREFERRED	N/A
RELION TRUEMETRIX BLOOD GLUCOSE METER RELION TRUEMETRIX TEST STRIPS	PREFERRED	N/A
OMNIPOD STARTER KIT OMNIPOD DASH	PREFERRED WITH PRIOR AUTHORIZATION (PA)	N/A
KETOSTIX TEST STRIP	NON-PREFERRED	KETO-DIASTIX TEST STRIP CHEMSTRIP UGK TEST STRIP
REVEAL URINAL INFECTION TEST STRIP	NON-PREFERRED	N/A
NUTRAPLUS 10% CREAM NUTRAPLUS 10% LOTION	NON-PREFERRED	N/A
BAND-AID PAD MOLESKIN	NON-PREFERRED	N/A
BP VIT 3 CAPSULE FOLIVANE-PLS CAPSULE CENTRATEX CAPSULE FOLIVANE-F CAPSULE	NON-PREFERRED	FOLBEE TABLET HEMAX TABLET HEMATOGEN CAPSULES
CLEAN&CLEAR 2% LIQUID	NON-PREFERRED	WART REMOVER 17% CALLUS REMOVER PAD 40% PAD
GLYCERIN LIQUID ETHY ALCOHOL 70% RUBBING SOLUTION ISOP ALCOHOL 91% SOLUTION	NON-PREFERRED	ISOPROPYL RUBBING ALCOHOL 70%

CAPSAICIN HP 0.1% CREAM	NOT COVERED	CAPSAICIN 0.1% CREAM CAPSAICIN 0.025% CREAM CAPSAICIN 0.025% PAD
TREXIMET SUMATRIPTAN-NAPROXEC TAB 85-500MG	NOT COVERED	SINGLE INGREDIENT SUMATRIPTAN TABLETS SUMATRIPTAN INJECTION SUMATRIPTAN 20MG NASAL SPRAY NAPROXEN TABLETS AND CAPSULES
NIVATOPIC PLUS CREAM PRUMYX CREAM	NON-PREFERRED	N/A
FISH OIL 500MG CAPSULE	NON-PREFERRED	OMEGA-3-ACID CAP 1GM PA REQUIRED
RA ALCOHOL WIPES	NON-PREFERRED	ALCOHOL SWABS
JOHNSONS BABY OIL MAXILUBE GEL	NON-PREFERRED	N/A
RA STERILE NASAL SOLUTION	NON-PREFERRED	SALINE NASAL SOLUTION
(BRAND) NITRO-DUR DIS 0.2MG/HR (BRAND) NITRO-DUR DIS 0.4MG/HR (BRAND) NITRO-DUR DIS 0.6MG/HR	NON-PREFERRED	NITROGLYCERIN DIS 0.2MG/HR NITROGLYCERIN DIS 0.4MG/HR NITROGLYCERIN DIS 0.6MG/HR
DUEXIS 800-26.6MG TABLET VIMOVO 500-20MG TABLET VIMOVO 375-20MG TABLET NAPROXEN-ESOMEPRAZOLE 500-20MG TABLET NAPROXEN-ESOMEPRAZOLE 375-20MG TABLET	NOT COVERED	SINGLE INGREDIENT NAPROXEN ESOMEPRAZOLE
QUETIAPINE 50MG ER TABLET QUETIAPINE 150MG ER TABLET QUETIAPINE 200MG ER TABLET QUETIAPINE 300MG ER TABLET QUETIAPINE 400MG ER TABLET ASENAPINE 5MG SUBLINGUAL TABLET ASENAPINE 10MG SUBLINGUAL TABLET ASENAPINE 2.5MG SUBLINGUAL TABLET	PREFERRED WITH PA	N/A
EPSOM SALT GRANULE	NON-PREFERRED	N/A
SCAR GEL	NOT COVERED	N/A

CREAM BASE CREAM	NON-PREFERRED	N/A
EUFLEXXA INJ 10MG/ML VISCO-3 INJ 25/2.5ML	NON-PREFERRED	N/A
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN AUGUST 1, 2021 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
CLINDAMYCIN AER 1%		ADD QTY LIMIT: 100 GM PER 30 DAYS
TOBRAMYCIN INJ 1.2GM		ADD QTY LIMIT: 30 VIALS PER 30 DAYS
EVKEEZA INJ 1200/8 EVKEEZA INJ 345/2.3		ADD PA
XOLAIR SOL 150MG XOLAIR INJ 75/0.5 XOLAIR INJ 150MG/ML		ADD QTY LIMIT: ASTHMA: 375 MG AS FREQUENTLY AS EVERY 2 WEEKS NASAL POLYPS: 600 MG AS FREQUENTLY AS EVERY 2 WEEKS CHRONIC IDIOPATHIC URTICARIA: 300 MG EVERY 4 WEEKS"
GENTAMICIN OIN 0.1% GENTAMICIN CRE 0.1%		ADD QTY LIMIT: 30 GM PER FILL; 1 FILL PER 30 DAYS
CARBAMAZEPINE 400 MG		ADD QTY LIMIT: 4 PER DAY
TEGRETOL SOLUTION		ADD QTY LIMIT: 50 ML PER DAY
CARBATROL CAP 200MG		UPDATE QTY LIMIT: 2 CAPSULES PER DAY
NYSTATIN SUS 100000		ADD QTY LIMIT: 750 ML PER 30 DAYS
PEPAXTO INJ 20MG RIABNI SOL 100/10ML RIABNI SOL 500/50ML		ADD PA
KLISYRI OIN 1%		ADD PA AND QTY LIMIT: 1 250 MG OINTMENT PACK PER DAY FOR 5 DAYS (5 SINGLE DOSE PACKETS); 1 FILL PER YEAR
TAGRISSO TAB 40MG		UPDATE QTY LIMIT: 1 TABLET PER DAY
IBRANCE TAB 75MG IBRANCE TAB 100MG IBRANCE TAB 125MG IBRANCE CAP 75MG IBRANCE CAP 100MG IBRANCE CAP 125MG		UPDATE QTY LIMIT: 21 TABLETS PER 28 DAYS

GLEEVEC TAB 100MG	UPDATE QTY LIMIT: 2 TABLETS PER DAY
INLYTA TAB 1MG	UPDATE QTY LIMIT: 6 TABLETS PER DAY
JAKAFI TAB 15MG JAKAFI TAB 20MG JAKAFI TAB 5MG JAKAFI TAB 10MG JAKAFI TAB 25MG	UPDATE QTY LIMIT: 2 TABLETS PER DAY
STIVARGA TAB 40MG	UPDATE QTY LIMIT: 84 TABLETSS PER 28 DAYS
SUTENT CAP 12.5MG	UPDATE QTY LIMIT: 1 CAPSULE PER DAY
BAVENCIO INJ 20MG/ML	REMOVE QTY LIMIT
ICLUSIG TAB 10MG ICLUSIG TAB 15MG ICLUSIG TAB 30MG ICLUSIG TAB 45MG	UPDATE QTY LIMIT: 1 TABLET PER DAY
ORGOVYX TAB 120MG	ADD PA AND QTY LIMIT: 1 TABLET PER DAY
TEPMETKO TAB 225MG	ADD PA AND QTY LIMIT: 2 TABLETS PER DAY
UKONIQ TAB 200MG	ADD PA AND QTY LIMIT: 4 TABLETS PER DAY
XTANDI TAB 40MG XTANDI TAB 80MG	ADD QTY LIMIT: 3 TABLETS PER DAY
FOTIVDA CAP 0.89MG FOTIVDA CAP 1.34MG	ADD PA AND QTY LIMIT: 21 CAPSULES PER 28 DAYS
XALKORI CAP 200MG XALKORI CAP 250MG	UPDATE QTY LIMIT: 4 CAPSULES PER DAY
XTANDI CAP 40MG	UPDATE QTY LIMIT: 3 CAPSULES PER DAY
TASMAR TAB 100MG	ADD QTY LIMIT: 6 TABLETS PER DAY
APOKYN INJ 10MG/ML	ADD QTY LIMIT: 2 ML PER DAY
MIRAPEX ER TAB 0.375MG MIRAPEX ER TAB 0.75MG MIRAPEX ER TAB 1.5MG MIRAPEX ER TAB 2.25MG MIRAPEX ER TAB 3MG MIRAPEX ER TAB 3.75MG MIRAPEX ER TAB 4.5MG	ADD QTY LIMIT: 1 TABLET PER DAY

NEUPRO DIS 1MG/24HR NEUPRO DIS 2MG/24HR NEUPRO DIS 3MG/24HR NEUPRO DIS 4MG/24HR NEUPRO DIS 6MG/24HR NEUPRO DIS 8MG/24HR	ADD QTY LIMIT: 1 PATCH PER DAY
XADAGO TAB 50MG XADAGO TAB 100MG	ADD QTY LIMIT (50 MG): 2 TABLETS PER DAY ADD QTY LIMIT (100 MG): 1 TABLET PER DAY
ZELAPAR TAB 1.25MG	ADD QTY LIMIT: 2 TABLETS PER DAY
CABENUVA SUS 600-900	ADD PA AND QTY LIMIT: 1 KIT PER FILL, ONE TIME
CABENUVA SUS 400-600	ADD PA AND QTY LIMIT: 1 KIT PER 28 DAYS
CEFTRIAXONE INJ 250MG	ADD QTY LIMIT: 1 VIAL PER 30 DAYS
CEFTRIAXONE INJ 500MG CEFTRIAXONE INJ 1GM CEFTRIAXONE INJ 2GM	ADD QTY LIMIT: 60 VIALS PER 30 DAYS
COSELA INJ 300MG	ADD PA
CLARITHROMYC TAB 250MG CLARITHROMYC TAB 500MG	ADD QTY LIMIT: 28 TABLETS PER FILL; 1 FILL PER 30 DAYS
CLARITHROMYC SUS 125/5ML	ADD QTY LIMIT: 300 ML PER FILL; 1 FILL PER 30 DAYS
WYNZORA CREAM	ADD PA
TACLONEX OINTMENT TACLONEX SUS	ADD PA
ENSTILAR AER	ADD PA
HYDROCORTISONE CRE 0.5% HYDROCORTISONE OIN 0.5% HALOG OIN 0.1% HALCINONIDE CRE 0.1% FLURANDRENOL OIN 0.05%	UPDATE QTY LIMIT: 60 GM PER 30 DAYS
IMPOYZ CRE 0.025%	UPDATE QTY LIMIT: 100 GM PER 30 DAYS
DIFLORASONE CRE 0.05% APEXICON E CRE 0.05% DIFLORASONE OIN 0.05% FLUOCINONIDE CRE E 0.05% FLUOCINONIDE OIN 0.05%	ADD QTY LIMIT: 60 GM PER 30 DAYS

FLUOCINONIDE ACET CRE 0.025% FLUOCINONIDE ACET OIN 0.025%	REMOVE QTY LIMIT
FLUOCINONIDE CRE 0.05% FLUOCINONIDE CRE 0.1%	UPDATE QTY LIMIT: 120 GMS PER 30 DAYS
OMNIPOD DASH	ADD QTY LIMIT: 15 PODS PER 30 DAYS
SUCRAID SOL 8500/ML	ADD QTY LIMIT: 4 BOTTLES PER 30 DAYS
VANCOCIN CAP 250MG VANCOCIN HCL CAP 125MG	ADD QTY LIMIT: 240 CAPSULES PER 30 DAYS
FIRVANQ SOL 25MG/ML FIRVANQ SOL 50MG/ML	ADD QTY LIMIT: 1200 ML PER 30 DAYS
FAMOTIDINE SUS 40MG/5ML	ADD QTY LIMIT: 5 MLS PER DAY
CIMETIDINE TAB 200MG	ADD QTY LIMIT: 2 TABLETS PER DAY
CIMETIDINE TAB 300MG CIMETIDINE TAB 400MG	ADD QTY LIMIT: 4 TABLETS PER DAY
NIZATIDINE CAP 150MG	ADD QTY LIMIT: 2 CAPSULES PER DAY
NIZATIDINE CAP 300MG	ADD QTY LIMIT: 1 CAPSULE PER DAY
NIZATIDINE SOL 15MG/ML	ADD QTY LIMIT: 20 MLS PER DAY
ZYCLARA PUMP CRE 2.5% ZYCLARA PUMP CRE 3.75%	UPDATE QTY LIMIT: 1 BOX (28 PACKETS) PER 28 DAYS; 56 DAYS OF TREATMENT PER YEAR
LUPKYNIS CAP 7.9MG	ADD PA AND QTY LIMIT: 6 CAPSULES PER DAY
TRULICITY INJ 0.75/0.5 TRULICITY INJ 1.5/0.5 TRULICITY INJ 3/0.5 TRULICITY INJ 4.5/0.5	ADD QTY LIMIT: QL: 3 MG/DOSE, 4.5 MG/DOSE SINGLE PEN - 4 SINGLE DOSE PENS (1 CARTON) PER 28 DAYS
FIBERCON TAB 625MG	UPDATE QTY LIMIT: 8 TABLETS PER DAY
NULIBRY INJ 9.5MG	ADD PA
TYSABRI INJ 300/15ML	ADD QTY LIMIT: 1 VIAL PER 28 DAYS
ERYTHROMYCIN OIN 5MG/GM	ADD QTY LIMIT: 3.5 GM PER 30 DAYS
EYSUVIS DRO 0.25%	ADD PA AND QTY LIMIT: 2 BOTTLES PER FILL; 1 FILL PER 30 DAYS

ORLADEYO CAP 150MG ORLADEYO CAP 110MG	ADD PA AND QTY LIMIT: 1 CAPSULE PER DAY
TAKHZYRO INJ 300/2ML	UPDATE QTY LIMIT: DECREASE FROM 2 SYRINGES PER 28 DAYS TO 1 SYRINGE PER 28 DAYS GF EXISTING PA W/ QL FOR 2 PER 28 DAYS
ZOKINVY CAP 50MG ZOKINVY CAP 75MG	ADD PA AND QTY LIMIT: QL: 4 CAPSULES PER DAY
CABERGOLINE TAB 0.5MG	UPDATE QTY LIMIT: 16 TABLETS PER 28 DAYS
HETLIOZ LQ SUS 4MG/ML	ADD NEW PA AND QTY LIMIT: 5 ML PER DAY
DESVENLAFAXINE TAB 25MG ER	ADD QTY LIMIT: 1 PER DAY
SYMBICORT AER 160-4.5 SYMBICORT AER 80-4.5	UPDATE QTY LIMIT: 3 INHALERS PER 30 DAYS
TARGADOX TAB 50MG	ADD QTY LIMIT: 2 TABLETS PER DAY
DOXYCYCLINE SUS 25MG/5ML	ADD QTY LIMIT: 600 ML PER 30 DAYS
ACTICLATE TAB 150MG	ADD QTY LIMIT: 1 TABLET PER DAY
ACTICLATE TAB 75MG	ADD QTY LIMIT: 2 TABLETS PER DAY
AMOXAPINE TAB 25MG AMOXAPINE TAB 50MG AMOXAPINE TAB 100MG AMOXAPINE TAB 150MG	ADD QTY LIMIT: 25, 50 MG: 1 PER DAY 100 MG: 4 PER DAY 150 MG: 2 PER DAY
DIVALPROEX TAB 500MG DR	ADD QTY LIMIT: 2 TABLETS PER DAY
DIVALPROEX TAB 500MG ER	UPDATE QTY LIMIT: 5 TABLETS PER DAY
THEOPHYLLINE SOL 80/15ML	ADD QTY LIMIT: 112.5 ML PER DAY

***DIABETIC SUPPLY CHANGES IMPLEMENTED ON 04/15/2021*

***DIABETIC SUPPLY CHANGES FOR TRUEMETRIX DIABETIC SUPPLIES IMPLEMENTED ON 07/15/2021*

****ORAL ANTIPSYCHOTICS CHANGES IMPLEMENTED ON 06/01/2021*

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