January 2024

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 2/1/2024 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 2/1/2024		
Medication	**Changes**	**Your doctor may change it to one of these preferred drugs:**
YUSIMRY 40MG/0.8ML PEN	PREFERRED WITH PA	N/A
COLCHICINE CAPSULES/TABLETS	PREFERRED	N/A
INFED 50MG/ML INJECTION	PREFERRED WITH PA	N/A
LANTUS VIAL/PEN	PREFERRED	N/A
SEMGLEE VIAL/PEN INSULIN GLARGINE-YFGN VIAL/PEN	NON-PREFERRED	LANTUS
BEYFORTUS 50MG/0.5ML INJECTION BEYFORTUS 100MG/ML INJECTION	PREFERRED (Please note this is medical benefit only)	N/A
BRIXADI WEEKLY/MONTHLY INJECTION	NON-PDL	N/A
Effective for all CHP members on 2/15/2024		
DESCOVY 200/25MG TABLET DESCOVY 120-15MG TABLET	NON-PREFERRED WITH STEP THERAPY	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TABLETS (GENERIC TRUVADA)
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN FEBRUARY 1, 2024 NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY		
KYZATREX 200 MG CAPSULE	UPDATE QL 4 CAPSULES PER DAY	
BREO ELLIPTA 50 MCG/25 MCG	ADD QL 1 INHALER PER 30 DAYS	
NAMZARIC (MEMANTINE EXTENDED RELEASE/DONEPEZIL) TITRATION PACK	ADD 1 PACK PER FILL, ONE TIME FILL	
ZURZUVAE (ZURANOLONE) 20 MG, 25 MG, 30 MG CAPSULE	ADD PA AND QL ZURZUVAE 20MG, 25 MG (28 CAPSULES PER FILL; 1 FILL PER YEAR) 30 MG CAPSULE (14 CAPSULES PER DAY)	

COLUMVI 10 MG/10 ML VIAL COLUMVI 2.5 MG VIAL	ADD PA
VANFLYTA 17.7 MG TABLET VANFLYTA 26.5 MG TABLET	ADD QL 2 TABLETS PER DAY
LUMAKRAS 320 MG TABLET	ADD QL 3 TABLETS PER DAY
TALZENNA 0.1 MG CAPSULE TALZENNA 0.35 MG CAPSULE	ADD QL 1 CAPSULE PER DAY
AKEEGA 50 MG/500MG TABLET AKEEGA 100 MG/500MG TABLET	ADD PA AND QL 1 TABLET PER DAY
ELREXFIO (ELRANATAMAB-BCMM) VIALS	ADD PA
TALVEY (TALQUETAMAB-TGVS) VIALS	ADD PA
CYLTEZO CROHN'S DISEASE, ULCERATIVE COLITIS STARTER PACKAGE 40 MG/0.8 ML PENS CYLTEZO PSORIASIS STARTER PACKAGE 40MG/0.8 ML PENS	ADD QL 1 PACK (28 DAY SUPPLY, ONE TIME FILL)
HADLIMA 40 MG/0.4 ML AUTOINJECTOR HADLIMA 40 MG/0.4 ML PREFILLED SYRINGE	ADD QL 2 AUTOINJECTORS PER 28 DAYS 2 SYRINGES PER 28 DAYS
HYRIMOZ CROHN'S DISEASE STARTER PACKAGE 80 MG/0.8 ML PEN HYRIMOZ CROHN'S DISEASE STARTER PACKAGE 80 MG/0.8 ML AND 40 MG/0.4 ML PENS HYRIMOZ PLAQUE PSORIASIS STARTER PACKAGE 80 MG/0.8 ML AND 40 MG/0.4 ML PENS HYRIMOZ PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8 ML PREFILLED SYRINGE HYRIMOZ PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8 ML AND 40 MG/0.4 ML PREFILLED SYRINGE	ADD QL 1 PACK (28 DAY SUPPLY, ONE TIME FILL)
LODOCO (COLCHICINE) 0.5 MG TABLET	ADD PA AND ST AND QL 1 TABLET PER DAY
LIQREV (SILDENAFIL) 10 MG/ML ORAL SUSPENSION	ADD PA
PREVYMIS (LETERMOVIR) 240 MG, 480 MG TABLETS PREVYMIS (LETERMOVIR) 240 MG/12 ML, 480 MG/24 ML VIALS	UPDATE QL 224 TABLETS PER YEAR UPDATE QL 200 VIALS PER YEAR
VEOPOZ 400 MG/2 ML VIAL	ADD PA AND DOSING LIMIT/QL 10 MG/KG, UP TO A MAXIMUM OF 800 MG (2 VIALS), ONCE WEEKLY; MAXIMUM OF 2 VIALS ONCE WEEKLY
HALOETTE VAGINAL RING	ADD QL 1 RING PER 28 DAYS
AFTERPILL, CURAE, ECONTRA OS, HER STYLE EMERGENCY CONTRACEPTIVES 1.5 MG TABLETS	ADD QL 1 TABLET PER 30 DAYS
INSULIN INFUSION PUMP SUPPLIES	REMOVE QL 15 INFUSION SETS/RESERVOIRS PER 30 DAYS
ALDACTAZIDE (SPIRONOLACTONE/HYDROCHLOROTHIAZIDE 25 MG/25 MG) ALDACTAZIDE (SPIRONOLACTONE/HYDROCHLOROTHIAZIDE 50 MG/50 MG)	REMOVE DO 8 TABLETS PER DAY REMOVE QL 4 TABLETS PER DAY

SOHONOS (PALOVAROTENE) 1 MG, 1.5 MG, 2.5 MG, 5 MG, 10 MG CAPSULES	ADD PA AND QL SOHONOS 1 MG (4 CAPSULES PER DAY) SOHONOS 1.5 MG (2 CAPSULES PER DAY) SOHONOS 2.5 MG, 5 MG (1 CAPSULE PER DAY) 10 MG (APPROVED FOR FLARE UP TREATMENT VIA OVERRIDE CRITERIA)
BYLVAY 200 MCG, 600 MCG, 400 MCG, 1200 MG PELLETS	UPDATE QL BYLVAY 200 MCG (36 PELLETS PER DAY BYLVAY 600 MCG (12 PELLETS PER DAY) BYLVAY 400 MCG (18 PELLETS PER DAY) BYLVAY 1200 MCG (6 PELLETS PER DAY)
NGENLA 24 MG/1.2 ML PREFILLED PEN NGENLA 60 MG/1.2 ML PREFILLED PEN	ADD QL 4 PENS PER 28 DAYS
KALBITOR 10 MG VIAL	UPDATE QL UP TO 6 VIALS (60 MG) PER ATTACK (MAXIMUM 36 VIALS/30 DAYS)
ICATIBANT 30 MG PREFILLED SYRINGE	UPDATE QL UP TO 3 SYRINGES (90 MG) PER ATTACK (MAXIMUM 18 SYRINGES/30 DAYS)
FERAHEME (FERUMOXYTOL) 510 MG/17 ML VIAL	UPDATE QL 1020 MG PER 6 DAYS
FERRLECIT 62.5 MG/5 ML VIAL	UPDATE QL 1000 MG PER 8 WEEKS
INJECTAFER (FERRIC CARBOXYMALTOSE) VIALS	UPDATE QL 1500 MG PER 7 DAYS
MONOFERRIC (FERRIC DERISOMALTOSE) VIALS	UPDATE QL 1000 MG PER DAY
VENOFER (IRON SUCROSE) VIALS	UPDATE QL 1000 MG PER 14 DAYS
MIRCERA 120 MCG/0.3 ML SYRINGE	ADD QL 2 SYRINGES (0.6 ML) PER 28 DAYS
RYSTIGGO 280 MG/2 ML VIAL	ADD PA AND DOSING LIMIT
VYVGART HYTRULO VIAL	ADD PA AND QL 1 VIAL ONCE WEEKLY FOR 4 WEEKS (4 WEEKS=1 CYCLE)
ROWASA (MESALAMINE RECTAL SUSPENSION ENEMA) 4 GRAM/60 ML SFROWASA (MESALAMINE RECTAL SUSPENSION ENEMA) 4 GRAM/60 ML	ADD QL 1680 ML PER 28 DAYS
YCANTH (CANTHARIDIN) 0.7% TOPICAL SOLUTION	ADD PA AND QL 8 APPLICATORS PER 12 WEEKS
SUFLAVE SOLUTION KIT	ADD QL 2 KITS PER 30 DAYS
TYRUKO 300MG/15 ML VIAL	ADD QL 1 VIAL PER 28 DAYS
EYLEA HD 8 MG VIAL	ADD PA AND DOSING LIMIT 8 MG PER EYE EVERY 4 WEEKS FOR THE FIRST THREE DOSES; FOLLOWED BY 8 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 8 WEEKS
XDEMVY (LOTILANER) OPHTHALMIC SOLUTION	ADD PA AND QL 1 BOTTLE PER FILL; 2 FILLS PER YEAR
IZERVAY 20 MG/ML VIAL	ADD PA AND DOSING LIMIT 0.1 ML (OR 2 MG) PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 28 DAYS
VEVYE (CYCLOSPORINE) OPHTHALMIC 0.1% SOLUTION	ADD PA AND QL 6 ML PER 30 DAYS
MIEBO (PERFLUOROHEXYLOCTANE) OPTHALMIC SOLUTION	ADD PA AND QL 12 ML PER 30 DAYS
BUPRENEX 0.3 MG/ML INJECTION	REMOVE QL 3 ML PER DAY
BUTORPHANOL 1 MG/ML INJECTION	REMOVE QL 8 ML PER DAY

BUTORPHANOL 2 MG/ML INJECTION	FREMOVE QL 4 ML PER DAY
DILAUDID (HYDROMORPHONE) INJECTION 0.2 MG/ML, 1 MG/ML AMPULE/SYRINGE, 0.5 MG/0.5 ML SYRINGE (INCLUDING PF), 2 MG/ML INJECTION (AMPULE, SYRINGE, VIAL; INCLUDING PF) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 6 ML PER DAY
DILAUDID (HYDROMORPHONE) 4 MG/ML INJECTION (AMPULE, SYRINGE) (INCLUDING PF) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 2 ML PER DAY
DILAUDID-HP (HYDROMORPHONE) 10 MG/ML INJECTION (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 1 INJECTION PER 30 DAYS
DEMEROL (MEPERIDINE) INJECTION 100 MG/2ML, 100 MG/ML, 25 MG/ML, 75 MG/ML, 10 MG/ML, 50 MG/ML, 75 MG/1.5 ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 4 ML PER DAY
MITIGO/INFUMORPH 200 MG/20 ML MITIGOL/INFUMORPH 500MG/20ML	REMOVE QL 2 VIALS PER MONTH
MORPHINE SULFATE INJECTION 10 MG/0.7 ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 6 INJECTIONS/PENS PER DAY
MORPHINE SULFATE INJECTION 150 MG/30 ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 1 VIAL (30 ML) PER DAY
MORPHINE SULFATE INJECTION 25 MG/ML (100 MG/4 ML, 250 MG/10 ML) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 4 ML PER DAY
MORPHINE SULFATE INJECTION 50 MG/ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 2 ML PER DAY
MORPHINE SULFATE INJECTION (INCLUDING DURAMORPH INJECTION) 0.5 MG/1 ML, 1 MG/ML, 2 MG/ML (10 MG/5 ML), 4 MG/ML, 5 MG/ML, 8 MG/ML, 10 MG/ML (15 MG/1.5 ML) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 6 ML PER DAY
OXYCODONE 10 MG/0.5 ML INJECTION	REMOVE QL 2 ML PER DAY
BRIXADI 8 MG/0.16 ML WEEKLY INJECTION BRIXADI 16 MG/0.32 ML WEEKLY INJECTION BRIXADI 24 MG/0.48 ML WEEKLY INJECTION BRIXADI 32MG/0.64ML WEEKLY INJECTION BRIXADI 64 MG/0.18 ML MONTHLY INJECTION BRIXADI 96MG/0.27ML MONTHLY INJECTION BRIXADI 128MG/0.36ML MONTHLY INJECTION	ADD QL 4 SYRINGES PER 28 DAYS (WEEKLY INJECTION) 1 SYRINGE EVERY 28 DAYS (MONTHLY INJECTION)

SUBOXONE (BUPRENORPHINE/NALOXONE) 2 MG/0.5 MG SUBLINGUAL FILM/TABLET	UPDATE QL 16 FILMS/TABLETS PER DAY
SUBOXONE (BUPRENORPHINE/NALOXONE) 8 MG/2 MG SUBLINGUAL FILM/TABLET	UPDATE QL 4 FILMS/TABLETS PER DAY
SUBOXONE (BUPRENORPHINE/NALOXONE) 4 MG/1 MG SUBLINGUAL FILM	UPDATE QL 8 FILMS PER DAY
AUSTEDO XR (DEUTETRABENAZINE) 6 MG, 12 MG, 24 MG TABLETS AUSTEDO XR (DEUTETRABENAZINE) 6-24 MG TITRATION KIT	ADD PA AND QL 2 TABLETS PER DAY 1 KIT PER FILL, ONE TIME FILL
INGREZZA (VALBENAZINE) 40-60 MG INITIATION PACK	ADD QL 1 PACK (28 DAY SUPPLY), ONE TIME FILL
ZOLPIDEM 7.5 MG CAPSULE	ADD QL 1 CAPSULE PER DAY
NALMEFENE 2 MG/2 ML INJECTION	ADD QL 10 VIALS (1 CARTON) PER 5 MONTHS
NALOXONE 2 MG/ 2ML INJECTION NALOXONE 4 MG/10 ML INJECTION	ADD QL 6 SYRINGES/VIALS PER 3 MONTHS
OPVEE (NALMEFENE) 2.7 MG/0.1 ML NASAL SPRAY	ADD QL 6 NASAL SPRAYS (3 CARTONS) PER 3 MONTHS
SUNLENCA 300MG TABLET SUNLENCA INJECTION	ADD PA *EFFECTIVE 2/15/24

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

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

Enclosures: Get help in another language
Nondiscrimination notice

bcbswny.com/stateplans

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