



April 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 May 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.

| <b>Effective for all CHP members on 5/1/2024</b>                                      |  |  |
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| <b>Medication</b>   | <b>Changes</b>   | <b>Your doctor can change it to one of these preferred drugs:</b>  |
| ADMELOG 100U/ML INJECTION<br>ADMELOG SOLOSTAR 100U/ML INJECTION                       | NON-PREFERRED WITH PA (PRIOR AUTHORIZATION)<br><br>CURRENT UTILIZERS WILL BE GRANDFATHERED | INSULIN LISPRO<br>HUMALOG 50/50<br>HUMALOG 75/25 VIAL<br>INSULIN ASPART 70/30 VIAL<br>HUMULIN N, R AND MIX<br>NOVOLIN N, R AND MIX |
| BIO-DTUSS DMX LIQUID  | PREFERRED  | N/A  |
| DAPAGLIFLOZIN 5MG TABLET<br>DAPAGLIFLOZIN 10MG TABLET                                 | PREFERRED WITH ST (STEP THERAPY)   | N/A  |
| DAPAGLIFLOZIN-METFORMIN 5-1000 MG TABLET<br>DAPAGLIFLOZIN-METFORMIN 10-1000 MG TABLET | PREFERRED WITH ST  | N/A  |
| HUMATROPE 6 MG INJECTION<br>HUMATROPE 12 MG INJECTION                                 | NON-PREFERRED WITH PA  | ZOMACTON (PA REQUIRED)   |

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| HUMATROPE 24MG INJECTION  |                          |   |
| IMIQUIMOD 3.75% CREAM   | PREFERRED WITH PA        | N/A   |
| INSULIN GLARGINE 300/ML INJ<br>INSULIN GLARGINE SOLOSTAR 300/ML INJ<br>(TOUJEO)   | PREFERRED                | N/A   |
| OTC LIDOCAINE SOLUTION/LIQUID   | PREFERRED                | N/A   |
| RX LIDOCAINE 4% SOLUTION  | NON-PREFERRED<br>WITH ST | OTC LIDOCAINE SOLUTION<br>AND LIQUID          |
| LOKELMA 5GM PAK<br>LOKELMA 10GM PAK   | PREFERRED                | N/A   |
| NALMEFENE 1 MG/ML INJECTION   | PREFERRED                | N/A   |
| OPVEE 2.7/0.1 MG NASAL SPRAY  | PREFERRED                | N/A   |
| OXYBUTYNIN 5MG/5ML SOLUTION   | PREFERRED                | N/A   |
| UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN MAY 1, 2024<br>NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY |                          |   |
| ADZYNMA 1500IU KIT<br>ADZYNMA 500IU KIT   |                          | ADD PA  |
| AGAMREE 40MG/ML SUSPENSION  |                          | ADD PA AND QL (QUANTITY LIMIT) 7.5 ML PER DAY |
| AIRSUPRA 90-80MCG INHALER   |                          | ADD ST  |
| ALEVAZOL 1% OINTMENT  |                          | ADD QL 60 GM PER 30 DAYS                      |
| ALVAIZ TABLETS  |                          | ADD PA  |
| ALVAIZ 18 MG TABLET   |                          | ADD QLT 1 TABLET PER DAY                      |
| ALVAIZ 36 MG TABLET   |                          | ADD QL 1 TABLET PER DAY                       |
| ALVAIZ 54 MG TABLET   |                          | ADD QL 1 TABLET PER DAY                       |
| ALVAIZ 9 MG TABLET  |                          | ADD QL 1 TABLET PER DAY                       |

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| AMJEVITA INJ 20/0.2ML                | ADD QL 2 AUTOINJECTORS PER 28 DAYS  |
| AMJEVITA INJ 40/0.4ML                | ADD QL 2 AUTOINJECTORS/SYRINGES PER 28 DAYS   |
| AMJEVITA INJ 80/0.8ML                | ADD QL 2 AUTOINJECTORS/SYRINGES PER 28 DAYS   |
| APHEXDA 62MG INEJECTION              | ADD PA  |
| AUGTYRO 40MG CAPSULE                 | ADD QL 8 CAPSULES PER DAY   |
| BIMZELX 160MG/ML INEJECTION          | ADD PA ADD QL 1 CARTON EVERY 8 WEEKS  |
| BOSULIF 100MG CAPSULE/TABLET         | ADD QL 4 TABLETS/CAPSULES PER DAY   |
| BOSULIF 50MG CAPSULE                 | ADD QL 1 CAPSULE PER DAY  |
| COSENTYX 125/5ML INEJECTION          | ADD QL 3 VIALS EVERY 4 WEEKS  |
| COSENTYX UNOREADY 300/2ML INEJECTION | ADD QL 1 PEN/SYRINGE PER 28 DAYS  |
| DAXXIFY 100U INEJECTION              | ADD DOSING LIMIT CERVICAL DYSTONIA: 125 TO 250 UNITS AS A DIVIDED DOSE AMONG AFFECTED MUSCLES AS FREQUENTLY AS EVERY 3 MONTHS |
| EMPAVELI 1080MG INEJECTION           | ADD QL 10 INJECTORS PER 30 DAYS   |
| ENTYVIO 108/0.68 INEJECTION          | ADD QL 1 SYRINGE/PEN EVERY 2 WEEKS  |
| ESTRING 2MG MIS                      | ADD QL 1 RING EVERY 90 DAYS   |
| ESTRING 7.5/24HR MIS                 | ADD QL 1 RING EVERY 90 DAYS   |
| EXXUA TABLETS                        | ADD ST  |
| EXXUA 18.2 MG TABLET                 | ADD QL 1 TABLET PER DAY   |
| EXXUA 36.3 MG TABLET                 | ADD QL 1 TABLET PER DAY   |
| EXXUA 54.5 MG TABLET                 | ADD QL 1 TABLET PER DAY   |
| EXXUA 72.6 MG TABLET                 | ADD QL 1 TABLET PER DAY   |
| FIASP PMPCRT U-100 INEJECTION        | ADD QL 30ML PER 30 DAYS   |
| FOCINVEZ 150 MG/50 ML INJECTION      | ADD QL 5 VIALS PER 30 DAYS  |
| FREESTY LIBRE MIS 3 READER           | ADD QL 1 READER PER YEAR  |

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| FRUZAQLA CAPSULES                   | ADD PA  |
| FRUZAQLA 1MG CAPSULE                | ADD QL 84 CAPSULES PER 28 DAYS                    |
| FRUZAQLA 5MG CAPSULE                | ADD QL 21 CAPSULES PER 28 DAYS                    |
| GLARGIN YFGN 100U/ML INJECTION      | ADD QL 30ML PER 30 DAYS                           |
| GUARDIAN 4 MIS SENSOR               | ADD QL 5 SENSORS PER 30 DAYS                      |
| GUARDIAN 4 MIS TRANSMITTER          | ADD QL 1 TRANSMITTER PER YEAR                     |
| HUMATIN 250MG CAPSULE               | ADD PA  |
| IMIQUIMOD 3.75% CREAM               | REMOVE PA (GENERIC ONLY)                          |
| IMIQUIMOD 5% CREAM                  | REMOVE PA (GENERIC ONLY)                          |
| INPEFA TABLETS                      | ADD ST  |
| INSULIN GLARGINE MAX SOLOSTAR U-300 | ADD QL 12ML PER 30 DAYS                           |
| INSULIN GLARGINE SOLOSTAR U-300     | ADD QL 13.5ML PER 30 DAYS                         |
| IYUZEH 0.005% DROPS                 | UPDATE QL 2.5 ML PER 30 DAYS 30 UNITS PER 30 DAYS |
| KERENDIA TABLETS                    | ADD ST  |
| LAGEVRIO 200MG CAPSULES             | ADD QL 40 CAPSULES PER FILL; 1 FILL PER 90 DAYS   |
| LEVEMIR FLEXPEN INJ                 | ADD QL 30ML PER 30 DAYS                           |
| LIDO/PRILOCN 2.5-2.5% CREAM         | ADD QL 30 GRAMS PER 30 DAYS                       |
| LIKMEZ 500/5ML SUSPENSION           | ADD PA  |
| LOQTORZI 240/6ML INEJECTION         | ADD PA  |
| LOTRIMIN AF 2% AEROSAL              | ADD QL 150 GM PER 30 DAYS                         |
| MICONAZOLE 2% SOLUTION              | ADD QL 30 ML PER 30 DAYS                          |
| MOTPOLY XR CAPSULES                 | ADD PA  |
| MOTPOLY XR 100MG CAPSULE            | ADD DOSE OPT 1 CAPSULE PER DAY                    |
| MOTPOLY XR 150MG CAPSULE            | ADD QL 2 CAPSULES PER DAY                         |

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| MOTPOLY XR 200MG CAPSULE  | ADD QL 2 CAPSULES PER DAY                                |
| MYALEPT 11.3MG INEJECTION CAPSULE                               | ADD QL 1 VIAL PER DAY                                    |
| OGSIVEO TABLETS   | ADD PA   |
| OGSIVEO 50MG TABLET   | ADD QL 6 TABLETS PER DAY                                 |
| OJJAARA TABLETS   | ADD PA   |
| OJJAARA 100MG TABLET  | ADD QL 1 TABLET PER DAY                                  |
| OJJAARA 150MG TABLET  | ADD QL 1 TABLET PER DAY                                  |
| OJJAARA 200MG TABLET  | ADD QL 1 TABLET PER DAY                                  |
| OMEPRAZOLE 20MG ODT TABLET                                      | REMOVE QL 2 TABLETS PER DAY                              |
| OMVOH INJECTIONS  | ADD PA   |
| OMVOH 100MG/ML INJECTION  | ADD QL 2 PENS PER 28 DAYS                                |
| OMVOH 300/15ML INJECTION  | ADD QL 3 VIALS FOR A ONE TIME FILL                       |
| OPFOLDA 65MG CAPSULE  | ADD PA AND QL 8 CAPSULES PER 28 DAYS                     |
| POMBILITI SOL 105MG   | ADD PA AND DOSING LIMIT 20 MG/KG EVERY 2 WEEKS           |
| RIVFLOZA INJECTIONS   | ADD PA   |
| RIVFLOZA 128/0.8ML INJECTION                                    | ADD QL 1 SYRINGE PER MONTH                               |
| RIVFLOZA 160MG/ML INJECTION                                     | ADD QL 1 SYRINGE PER MONTH                               |
| RIVFLOZA 80/0.5ML INJECTION                                     | ADD QL 2 VIALS PER MONTH                                 |
| ROZLYTREK 50MG PAK  | ADD QL 8 PACKETS PER DAY                                 |
| RYZNEUTA 20 MG/ML INJECTION                                     | ADD PA AND QL 2 SYRINGES PER 28 DAYS                     |
| TOFIDENCE 80 MG, 200 MG, & 400 MG VIAL FOR INTRAVENOUS INFUSION | ADD DOSING LIMIT 8 MG/KG* AS FREQUENTLY AS EVERY 4 WEEKS |
| TRIENTINE 500MG CAPSULE   | ADD QL 4 CAPSULES PER DAY                                |
| TRUQAP TABLET   | ADD PA   |

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|---|--|
| TRUQAP 160MG TABLET                               | ADD QL 64 CAPSULES PER 28 DAYS   |
| TRUQAP 200MG TABLET                               | ADD QL 64 CAPSULES PER 28 DAYS   |
| VABYSMO 6/0.05ML INEJECTION                       | ADD DOSING LIMIT 6 MG PER EYE; EACH EYE CAN BE TREATED EVERY 4 WEEKS FOR 6 MONTHS  |
| VELSIPITY 2MG TABLET                              | ADD PA ADD QL 1 TABLET PER DAY   |
| VOQUEZNA TRIP PAK                                 | ADD PA   |
| VOQUEZNA 10MG TABLET                              | ADD QL 1 TABLET PER DAY  |
| WEZLANA 130 MG/26 ML (5 MG/ML) VIAL               | ADD DOSING LIMIT<br>BODY WEIGHT 55 KG OR LESS: 2 VIALS<br>(8 WEEK SUPPLY, ONE TIME FILL)<br>BODY WEIGHT MORE THAN 55KG TO 85 KG: 3 VIALS<br>(8 WEEK SUPPLY, ONE TIME FILL)<br>BODY WEIGHT MORE THAN 85 KG [MAX LIMIT]: 4 VIALS<br>(8 WEEK SUPPLY, ONE TIME FILL) |
| WEZLANA 45 MG/0.5 ML SINGLE-USE PREFILLED SYRINGE | 1 SYRINGE PER 84 DAYS (12 WEEKS)   |
| WEZLANA 45 MG/0.5 ML VIAL                         | 1 VIAL PER 84 DAYS (12 WEEKS)  |
| WEZLANA 90 MG/1 ML SINGLE-USE PREFILLED SYRINGE   | ADD QL 1 SYRINGE EVERY 84 DAYS   |
| XALKORI CAP 150MG                                 | ADD QL 3 CAPSULES PER DAY  |
| XALKORI CAP 200MG                                 | ADD QL 4 CAPSULES PER DAY  |
| XALKORI CAP 20MG                                  | ADD QL 4 CAPSULES PER DAY  |
| XALKORI CAP 250MG                                 | ADD QL 4 CAPSULES PER DAY  |
| XALKORI CAP 50MG                                  | ADD QL 2 CAPSULES PER DAY  |
| XPHOZAH TABLET                                    | ADD PA   |
| XPHOZAH 10MG TABLET                               | ADD QL 2 TABLETS PER DAY   |
| XPHOZAH 20MG TABLET                               | ADD QL 2 TABLETS PER DAY   |
| XPHOZAH 30MG TABLET                               | ADD QL 2 TABLETS PER DAY   |

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| YUFLYMA PSORIASIS STARTER PACK 80 MG/0.8 ML + 40 MG/0.4 ML PREFILLED AUTOINJECTOR   | ADD QL 1 PACK (28 DAY SUPPLY); ONE TIME FILL  |
| YUFLYMA PSORIASIS STARTER PACK 40 MG/0.4 ML PREFILLED AUTOINJECTOR  | ADD QL 1 PACK (28 DAY SUPPLY); ONE TIME FILL  |
| YUFLYMA CROHN'S DISEASE, PEDIATRIC CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACK 40 MG/0.4 ML PREFILLED AUTOINJECTOR | ADD QL 1 PACK (28 DAY SUPPLY); ONE TIME FILL  |
| YUFLYMA CROHN'S DISEASE, ULCERATIVE COLITIS OR HIDRADENITIS SUPPURATIVA STARTER PACK 80 MG/0.8 ML PREFILLED AUTOINJECTOR                            | ADD QL 1 PACK (28 DAY SUPPLY); ONE TIME FILL  |
| YUFLYMA PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8 ML + 40 MG/0.4 ML PREFILLED AUTOINJECTOR   | ADD QL 1 PACK (28 DAY SUPPLY); ONE TIME FILL  |
| YUFLYMA PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8 ML PREFILLED AUTOINJECTOR  | ADD QL 1 PACK (28 DAY SUPPLY); ONE TIME FILL  |
| YUFLYMA 80/0.8ML INJECTION  | ADD QL 2 AUTOINJECTORS/SYRINGES PER 28 DAYS   |
| ZENPEP 60000 UNIT CAPSULES  | ADD QL 25 CAPSULES PER DAY                    |
| ZILBRYSQ INJECTION  | ADD PA  |
| ZILBRYSQ 16.6MG INJECTION   | ADD QL 1 SYRINGE PER DAY                      |
| ZILBRYSQ 23MG INJECTION   | ADD QL 1 SYRINGE PER DAY                      |
| ZILBRYSQ 32.4MG INJECTION   | ADD QL 1 SYRINGE PER DAY                      |
| ZYMFENTRA (INFLIXIMAB-DYYB) 120 MG/ML PREFILLED SYRINGE/PEN   | ADD PA AND ADD QL 1 SYRINGE/PEN EVERY 2 WEEKS |

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

AL = AGE LIMIT

PA = PRIOR AUTHORIZATION

QL = QUANTITY LIMIT

ST = STEP THERAPY

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

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, 8:30 a.m. to 6 p.m. Eastern time.

**[bcbswny.com/stateplans](https://www.bcbswny.com/stateplans)**

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