BLUE SHIELD OF CALIFORNIA
AUGUST 2024 PLUS DRUG FORMULARY CHANGES

Blue Shield is committed to covering safe, effective and affordable medications, so we regularly review and update our drug formularies. Our Pharmacy and Therapeutics (P&T) Committee is made up of a group of practicing physicians and pharmacists who meet quarterly to recommend changes to our formulary based on the latest medical literature, new clinical guidelines, new information from key physician experts, and new information from the Food and Drug Administration.

Changes to the Plus Drug Formulary from the August 2024 P&T Committee meeting are outlined below. To view a copy of the Plus Drug Formulary, please download a copy.

The drugs listed below are to be used for FDA-approved indications but may also be used for other conditions.

1. DRUGS ADDED TO FORMULARY

The following drugs were added to the formulary:

Drug	FDA Indication(s)	Coverage Restriction(s)
Entresto sprinkle	Heart failure	Quantity limit
estradiol 0.06% gel (Estrogel)	Vasomotor symptoms, Vaginal atrophy	Quantity limit

2. FORMULARY DRUGS WITH CHANGES TO TIER AND/OR COVERAGE RESTRICTION

The following drugs have coverage restriction(s) added or removed, and/or change of tier status as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)	New Tier Status
Humalog 100 unit/ml Kwikpen, Humalog 100 unit/ml Jr Kwikpen	Diabetes		Tier 2
bexagliflozin (Brenzavvy)	Type 2 diabetes	Remove Prior authorization, Add Step therapy	Remain Tier 3
Brenzavvy			
Invokamet, Invokamet XR			
Segluromet			
Steglatro			
alogliptin benzoate (Nesina)			
Nesina			
alogliptin-metformin (Kazano)			
Kazano			
alogliptin-pioglitazone (Oseni)			
Oseni			

Drug	FDA Indication(s)	Coverage Restriction(s)	New Tier Status
Tradjenta	Type 2 diabetes	Remove Prior authorization, Add Step therapy	Remain Tier 3
Jentadueto, Jentadueto XR			
Onglyza			
Kombiglyze XR			
saxagliptin (Onglyza)			Remain Tier 1[1], Remain Tier 3[2]
saxagliptin-metformin (Kombiglyze XR)			
Invokana	Type 2 diabetes, Cardiovascular events, End-stage kidney disease	Remove Prior authorization, Add Step therapy	Remain Tier 3
Victoza[3]	Type 2 diabetes, Cardiovascular events	Prior authorization	Tier 3
dexmethylphenidate er capsule (Focalin XR)	ADHD	Age-limit, Quantity limit, Remove Step therapy	Remain Tier 1
Focalin XR			Remain Tier 3
methylphenidate 10mg er tablet			Remain Tier 1[1], Tier 1[2]
methylphenidate 20mg er tablet			Remain Tier 1
methylphenidate er capsule (Aptensio XR)			Remain Tier 1[1], Tier 1[2]
Aptensio XR			Remain Tier 3
dimethyl fumarate (Tecfidera)[2,3]	Multiple sclerosis	Quantity limit	Tier 1
Avonex[3]	Multiple sclerosis	Quantity limit, Add Prior authorization	Remain Tier 4
Betaseron[3]			
Copaxone[3]			
Tecfidera[3]			
Gilenya 0.5mg capsule[3]			
Extavia[3]			Tier 4
Gilenya 0.25mg capsule[3]			Tier 4
Asmanex HFA, Asmanex Twisthaler	Asthma	Quantity limit, Remove Step therapy	Tier 2
Ryvent[1]	Allergic rhinitis, Vasomotor rhinitis, Allergic conjunctivitis, Allergic skin manifestations	Prior authorization, Quantity limit	Tier 1

1. Applies to Grandfathered plans; 2. Does not apply to Grandfathered plans; 3. Effective 1/2025

3. DRUGS ADDED TO THE SPECIALTY TIER

The following drugs were added to the Blue Shield specialty tier (Tier 4):

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
adalimumab-aaty (Yuflyma)	RA, pJIA, Psoriatic arthritis, AS, Psoriasis, CD, UC, Hidradenitis suppurativa	Prior authorization, Quantity limit
adalimumab-ryvk (Simlandi)	RA, pJIA, Psoriatic arthritis, AS, Psoriasis, CD, UC, Hidradenitis suppurativa, Uveitis	
Rinvoq LQ	pJIA, Psoriatic arthritis	
Tyenne 162mg/0.9ml auto-injector, and prefilled syringe	RA, pJIA, sJIA, Giant cell arteritis	
Zymfentra	Crohn's disease, Ulcerative colitis	
Duvyzat	Duchenne muscular dystrophy	
Ingrezza sprinkle	Huntington's disease, Tardive dyskinesia	
Igirvo	Primary biliary cholangitis	
Libervant[2]	Seizure clusters	
Ohtuvayre	COPD	
Ojemda	Pediatric low-grade glioma	
Opsynvi	PAH	
Prenatol-M[2]	Dietary supplement	
sajazir	Hereditary angioedema	
Sofdra[2]	Primary axillary hyperhidrosis	
Vijoice granules	PIK3CA-related overgrowth spectrum	
Xolremdi	WHIM syndrome	
yargesa	Type 1 Gaucher disease	

2. Does not apply to Grandfathered plans

4. DRUGS REMOVED FROM COVERAGE

The following drugs were excluded from coverage because it is available without a prescription, effective January 1, 2025:

Drug	
hydrocortisone 1% cream	Proctocort 1% cream