BLUE SHIELD OF CALIFORNIA
SECOND QUARTER 2024 FORMULARY AND MEDICATION POLICY UPDATES

EFFECTIVE JUNE 5, 2024
for Large Group, Small Group, and Individual & Family Plans

The Blue Shield of California (BSC) Pharmacy and Therapeutics (P&T) Committee, consisting of network physicians and pharmacists, regularly evaluates drugs for formulary inclusion and medication policy coverage criteria. The second quarter 2024 P&T Committee decisions on formulary changes and medication policy changes, which apply to Commercial members with an outpatient drug benefit, are summarized below:

PHARMACY BENEFIT FORMULARY UPDATE:

Please refer to the appropriate drug formulary posted on our website for the following information:

- *Quantity limits, if applicable, for specific drugs*
- *Formulary status of newly available strengths of existing drugs. Note: The formulary status of newly available strengths of existing drugs will have the same formulary status as the existing strengths unless otherwise noted.*
- *Non-formulary and non-preferred drugs that require prior authorization or step therapy.*
- *Brand-name medications that are now non-formulary or non-preferred because these medications have newly available generic equivalents covered on the formulary.*

Formularies are available at blueshieldca.com/pharmacy. Select the appropriate drug formulary – "Standard Drug Formulary", "Value Drug Formulary", or "Plus Drug Formulary".

Summary of changes to the Medicare formularies are available at blueshieldca.com/pharmacy. Select "Medicare Drug Formulary", then select the appropriate plan, and the corresponding "Summary of Changes" PDF.

NEW GENERICS with RESTRICTIONS

The following drugs are newly available GENERIC drugs that were ADDED to the Plus Drug Formulary with coverage restrictions:

Drug	FDA Indication(s)	Coverage Restriction(s)
bromfenac 0.075% ophthalmic (Bromsite)	Cataract surgery	Prior authorization
bromfenac 0.07% ophthalmic (Prolensa)		
gabapentin (Gralise)	Postherpetic neuralgia	Prior authorization
Kiprofen[1]	RA, OA, Pain, Dysmenorrhea	Prior authorization
nitroglycerin 0.4% ointment (Rectiv)	Chronic anal fissures	Prior authorization

1. Applies to Grandfathered plans

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) to the Plus and Standard/Value Drug Formularies:

- *Refer to member benefit summary for applicable member share of cost.*

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
tiopronin dr tablet (Thiola EC)	Cystinuria	Prior authorization

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) to the Standard/Value Drug Formularies:

- *Refer to member benefit summary for applicable member share of cost.*

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Sotyktu[2]	Plaque psoriasis	Prior authorization

2. Effective 7/3/2024

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) only for the Plus Drug Formulary:

- *Refer to member benefit summary for applicable member share of cost.*

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
Agamree	Duchenne muscular dystrophy	Prior authorization
deflazacort (Emflaza)		
Alvaiz	Aplastic anemia, Immune thrombocytopenia, Chronic hepatitis C infection-associated thrombocytopenia	Prior authorization
Eohilia[3]	Eosinophilic esophagitis	
Filsuvez	Dystrophic and junctional epidermolysis bullosa	
Kiprofen[3]	RA, OA, Pain, Dysmenorrhea	
mifepristone (Korlym)	Cushing's syndrome	
Rezdiffra	Noncirrhotic nonalcoholic steatohepatitis (NASH)	
Rivfloza	Primary hyperoxaluria type 1	
Simlandi	RA, pJIA, Psoriatic arthritis, AS, Psoriasis, CD, UC, Hidradenitis suppurativa, Uveitis	
Sovuna[3]	Malaria, RA, SLE, Discoid lupus erythematosus	
Spevigo	Generalized pustular psoriasis	
Voydeya	Paroxysmal nocturnal hemoglobinuria	
Winrevair	Pulmonary arterial hypertension	

3. Does not apply to Grandfathered plans

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus Drug Formulary:

Drug	FDA Indication(s)	Coverage Restriction(s)
Avonex	Multiple sclerosis	
Betaseron		
clindamycin-benzoyl peroxide 1%-5% gel (jar)	Acne vulgaris	
efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla)	HIV infection	

DRUGS MOVED to a DIFFERENT TIER

The following drugs were moved to a higher or lower tier for the Plus and Value Drug Formularies as noted:

Drug	FDA Indication(s)	New Tier Status
Qsymia[4]	Chronic weight management	Tier 3 with Prior authorization

4. Effective 7/31/2024

The following drugs were moved to a higher or lower tier for the Standard/Value Drug Formulary as noted:

Drug	FDA Indication(s)	New Tier Status
azelaic acid 15% gel (Finacea)	Acne rosacea	Tier 1
efavirenz-lamivudine-tenofovir disoproxil fumarate (Symfi, Symfi Lo)	HIV infection	Tier 1

The following drugs were moved to a higher or lower tier for the Plus Drug Formulary as noted:

Drug	FDA Indication(s)	New Tier Status
Adthyza	Hypothyroidism, Pituitary TSH suppressant	Tier 2
flurandrenolide 0.5% cream[1]	Corticosteroid-responsive dermatoses	Tier 3 with Prior authorization
Lyvispah[3]	Spasticity	Tier 3 with Prior authorization
metformin er tablet (Glumetza)[3,4]	Type 2 diabetes	Tier 3 with Prior authorization
Mounjaro		Tier 2 with Prior authorization
Saxenda[4]	Chronic weight management	Tier 3 with Prior authorization
Wegovy[4]		
Zepbound[4]		

1. Applies to Grandfathered plans; 3. Does not apply to Grandfathered plans; 4. Effective 7/31/2024

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Standard/Value Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
clindamycin-benzoyl peroxide 1%-5% gel (jar)	Acne vulgaris	
efavirenz-emtricitabine-tenofovir disoproxil fumarate (Atripla)	HIV infection	
Genotropin, Genotropin Miniquick	GHD, Prader-Willi syndrome, Small for gestational age, Turner syndrome, Idiopathic short stature	Prior authorization

The following drugs were ADDED to the Value Drug Formulary as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
Mounjaro	Type 2 diabetes	Prior authorization
Saxenda[4]	Chronic weight management	Prior authorization
Wegovy[4]		
Zepbound[4]		

4. Effective 7/31/2024

The following drugs were ADDED to the Plus Drug Formulary as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
loteprednol 0.2% ophthalmic (Alrex)	Seasonal allergic conjunctivitis	

MEDICAL BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on June 5, 2024, and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → Guidelines & standards → Policy and standards → Medication Policies → Medication Policy List → Medical drug policies for Commercial plans.

Refer to medication policy for complete details. For description of change, refer to top of medication policy.

For additional information, please call 1-800-535-9481

New Policies
• Amtagvi (lifleucel) • Cosentyx (secukinumab)* • Lenmeldy (atidarsagene autotemcel) • Pemrydi RTU (pemetrexed disodium) • Rivfloza (nedosiran, subcutaneous vial) • Spevigo (spesolimab-sbzo, subcutaneous loading dose) • Winrevair (sotatercept)*
Updated Policies

• Abraxane (paclitaxel protein-bound)
• Adcetris (brentuximab)
• bendamustine
• bortezomib, subcutaneous and intravenous
• Breyanzi (lisocabtagene maraleucel)
• Casgevy (exagamglogene autotemcel)
• Cimzia (certolizumab pegol)
• Cinqair (reslizumab)
• Clolar (clofarabine)
• Cosela (trilaciclib)
• Darzalex (daratumumab)
• Darzalex Faspro (daratumumab and hyaluronidase-fihj)
• Elahere (mirvetuximab soravtansine-gynx)
• Enhertu (fam-trastuzumab-deruxtecan-nxki)
• Erbitux (cetuximab)
• Fasenra (benralizumab, subcutaneous prefilled syringe)
• Gazyva (obinutuzumab)
• IVIG (immune globulin, IV)
  ○ Asceniv™
  ○ Bivigam®
  ○ Cytogam®
  ○ Flebogamma DIF®
  ○ Gammagard® liquid
  ○ Gammagard S/D®
  ○ Gamunex-C®
  ○ Gammaked®
  ○ Gammaplex®
  ○ Octagam®
  ○ Panzyga®
  ○ Privigen®

- Jemperli (dostarlimab-gxly)
- Keytruda (pembrolizumab)
- Kyprolis (carfilzomib)
- Leukine (sargramostim)
- Mylotarg (gemtuzumab ozogamicin)
- Nucala (mepolizumab, subcutaneous prefilled syringe)
- Onivyde (irinotecan liposome injection)
- Opdivo (nivolumab)
- Opdualag (nivolumab and relatlimab-rmbw)
- Pemfexy (pemetrexed)
- Prevymis (letermovir)
- Reblozyl (luspatercept-aamt)
- trastuzumab
- Ultomiris (ravulizumab-cwvz)
- Unituxin (dinutuximab)
- Xolair (omalizumab)
- Yervoy (ipilimumab)
- Zynyz (retifanlimab-dlwr)

Retired Policies

- Lumoxiti (moxetumoma pasudotox)
- Zevalin (ibritumomab)

**Added to site of care program*

PHARMACY BENEFIT MEDICATION POLICIES:

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Refer to medication policy for complete details.

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New Policies

- Agamree (vamorolone)
- Alvaiz (eltrombopag)
- Balversa (erdafitinib)
- Bosulif (bosutinib)
- Cosentyx (secukinumab)
- Eohilia (budesonide, oral suspension)
- Filsuvez (birch triterpenes, topical gel)
- Hadlima (adalimumab-bwwd)
- Iclusig (ponatinib)
- Rezdiffra (resmetirom)
- Rivfloza (nedosiran, subcutaneous syringe)
- Sovuna (hydroxychloroquine sulfate)
- Spevigo (spesolimab-sbzo)

- Tasigna (nilotinib)
- Voydeya (danicopan)
- Winrevair (sotatercept)

Updated Policies

- Adbry (tralokinumab)
- Arakoda (tafenoquine)
- Cibinqo (abrocitinib)
- Dupixent (dupilumab)
- Fanapt (iloperidone)
- Fasenra (benralizumab, subcutaneous autoinjector)
- Flovent HFA (fluticasone propionate inhalation aerosol)
- Human growth hormones (somatropin)
    - Genotropin (somatropin)
    - Humatrope (somatropin)
    - Ngenla (somatropin-ghla)
    - Norditropin (somatropin)
    - Saizen (somatropin)
    - Skytrofa (lonapegsomatropin-tcgd)
    - Sogroya (somatropin-beco)
    - Zomacton (somatropin)
- Insulin, delivery devices
    - Humalog Inpen device
    - Fiasp Inpen device
    - Novolog Inpen device
    - Novopen Echo device
- Insulin, intermediate
    - Novolin N Flexpen
- Insulin, mixed
    - Novolin 70/30 FlexPen
    - Novolin 70/30 FlexPen ReLion
    - Novolin 70/30 ReLion vial
    - Novolin 70/30 vial
- Mounjaro (tirzepatide)
- Nexletol (bempedoic acid)
- Nexlizet (bempedoic acid/ezetimibe)
- Nucala (mepolizumab, subcutaneous autoinjector and prefilled syringe)
- Phosphodiesterase type 5 inhibitor agents
    - sildenafil (Viagra)
    - Stendra (avanafil)
    - tadalafil (Cialis)
    - vardenafil (Levitra)
    - vardenafil ODT (Staxyn)
- Rinvoq (upadacitinib)
- Sotyktu (deucravacitinib)
- Wegovy (semaglutide)
- Xhance (fluticasone, nasal spray)
- Xolair (omalizumab)

Retired Policies
• Avonex (interferon beta-1a) • Betaseron (interferon beta-1b) • clindamycin phosphate/benzoyl peroxide 1%-5% jar • Nutropin AQ (somatropin) • Ortikos (budesonide) • Relyvrio (sodium phenylbutyrate/ursodoxicoltaurine)

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DRUGS REMOVED from FORMULARY

The following drug(s) were removed from the Standard/Value Drug Formularies.

- *These drugs require a formulary exception based on medical necessity for coverage at Tier 3 unless noted otherwise.*

Drug	FDA Indication(s)	Alternative(s)
Armour Thyroid	Hypothyroidism, Pituitary TSH suppressant	levothyroxine, Synthroid
Niva Thyroid		
NP Thyroid		
Thyroid		
Ibrance[1]	Breast cancer	Kisqali, Verzenio
methylphenidate hcl 72mg er tablet (Relexxii)	ADHD	methylphenidate hcl cap er 24hr (la), methylphenidate hcl er tab
Relexxii 72mg er tablet		
Nutropin AQ Nuspin[1]	Growth failure due to GHD, Idiopathic short stature, Turner syndrome, CKD; GHD	Genotropin, Omnitrope

1. Non-formulary drugs that meet the Tier 4 description require a medical necessity exception to be covered at the Tier 4 share of cost

DRUGS ADDED to the BLUE SHIELD SPECIALTY TIER

The following drugs were ADDED to the Blue Shield Specialty Tier (Tier 4) to the Standard Drug Formulary:

- *Refer to member benefit summary for applicable member share of cost.*

Specialty Drug	FDA Indication(s)	Coverage Restriction(s)
dalfampridine (Ampyra)	Multiple sclerosis	Prior authorization

EXISTING DRUGS with CHANGES TO RESTRICTIONS

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus and Standard/Value Drug Formularies:

Drug	FDA Indication(s)	Coverage Restriction(s)
Phospholine iodide	Increased intraocular pressure, Strabismus	Prior authorization

The following drugs have no change in formulary status, but have modification to restrictions as noted for the Plus Drug Formulary:

Drug	FDA Indication(s)	Coverage Restriction(s)
Crotan[2]	Scabies, Pruritus	Prior authorization
Humatin	Intestinal amebiasis, Hepatic coma	Prior authorization
Indocin 25mg/5ml oral suspension[2]	RA, AS, OA, Acute bursitis and/or tendonitis, Acute gouty arthritis	Prior authorization
indomethacin 25mg/ml oral suspension (Indocin)[2]		

2 Applies to Grandfathered plans

DRUGS MOVED to a DIFFERENT TIER

The following drugs were moved to a higher or lower tier for the Plus and Standard/Value Drug Formularies as noted:

Drug	FDA Indication(s)	New Tier Status
alendronate 70mg/75ml oral solution[3]	Osteoporosis	Tier 2
nizatidine capsule[3]	Duodenal ulcer, Esophagitis, Gastric ulcer	Tier 2
methadone 5mg & 10mg tablet, oral solution, oral concentrate[3]	Pain, Opioid addiction	Tier 1 with Prior authorization
timolol maleate 0.25%, 0.5% ophthalmic gel forming solution (Timoptic-XE)[3]	Ocular hypertension, Glaucoma	Tier 2

3. Does not apply to Grandfathered plans

The following drugs were moved to a higher or lower tier for the Plus Drug Formulary as noted:

Drug	FDA Indication(s)	New Tier Status
Auryxia[3]	Hyperphosphatemia in CKD, Iron deficiency anemia in CKD	Tier 4 with Prior authorization
calcitriol (Vectical)	Plaque psoriasis	Tier 3[3] Tier 2[2]
Vectical[3]		Tier 4
Velphoro[3]	Hyperphosphatemia in CKD	Tier 4 with Prior authorization
Crotan[3]	Scabies, Pruritus	Tier 4 with Prior authorization
Ergomar[3]	Vascular headache	Tier 4
Extavia	Multiple sclerosis	Tier 4 with Prior authorization
Indocin 25mg/5ml oral suspension[3]	RA, OA, AS, Acute bursitis and/or	Tier 4 with Prior authorization

Drug	FDA Indication(s)	New Tier Status
indomethacin 25mg/ml oral suspension (Indocin)[3]	tendonitis, Acute gouty arthritis	
Naprosyn 125mg/5ml oral suspension[3]	RA, OA, AS, pJIA, Tendonitis, Bursitis, Gout, Pain, Dysmenorrhea	Tier 3 with Prior authorization
naproxen 125mg/5ml oral suspension[3]		
megestrol acetate 625mg/5ml oral suspension (Megace ES)[3]	Anorexia, Cachexia	Tier 2
methylphenidate hcl 72mg er tablet (Relexxii)	ADHD	Tier 3 with Prior authorization, Age-limit
Relexxii 72mg er tablet		
Onexton[3]	Acne vulgaris	Tier 4 with Step-therapy
tadalafil tablet (Cialis)[3]	ED, BPH	Tier 2 with Prior authorization
vancomycin powder for oral solution (Firvanq)[3]	Clostridium difficile-associated diarrhea	Tier 2 with Prior authorization

2 Applies to Grandfathered plans; 3. Does not apply to Grandfathered plans

DRUGS ADDED to FORMULARY

The following drugs were ADDED to the Standard/Value Formularies as noted:

Drug	FDA Indication(s)	Coverage Restriction(s)
quinidine gluconate er tablet	Atrial fibrillation/flutter, Ventricular arrhythmias	

PHARMACY BENEFIT MEDICATION POLICIES:

The following coverage policies were updated (or created if specified "NEW") and changes are effective on January 1, 2025, and available on the BSC Internet site, and Provider Portal: blueshieldca.com → drop down "Providers" → select "Guidelines and Resources" under Public Links → Guidelines & standards → Policy and standards → Medication Policies → Medication Policy List → Outpatient drug policies for Commercial plans.

Refer to medication policy for complete details.

For additional information, please call 1-800-535-9481

New Policies
• Crotan (crotamiton, topical lotion) • Extavia (interferon beta-1b) • Humatin (paromomycin sulfate) • Indocin (indomethacin) 25 mg/5 mL oral suspension • phospholine iodide 0.125% powder for solution, ophthalmic drops