Capital Blue Cross CHIP Formulary Update

(2nd & 3rd Quarter 2024) Effective January 1, 2025

This document lists changes to the CHIP formulary (list of drugs eligible for coverage through your prescription drug benefit). It includes these updates:

- **Drugs that need prior authorization (PA)**—Some prescriptions require prior authorization to make sure they are medically appropriate and cost-effective. Prior authorization changes are effective January 1, 2025.
- **Drugs with a quantity level limit (QLL)**—Certain drugs have a QLL to support safety. Examples of a QLL include limits to the quantity of a drug per prescription or limits to the quantity of a drug in a given period of time. The QLL changes listed here are effective January 1, 2025.
- **Drugs that need step therapy (ST)**—Your prescriptions drug plan may include step therapy for certain drugs. This means you may need to try another proven, cost-effective drug before coverage may be available for the drug included in the program. Step therapy changes are effective January 1, 2025.

Prior Authorization (PAR) Utilization Management Program changes or updates

Effective: January 1, 2025

Drug class / Drug	Indication
adapalene 0.1% pads and 0.1% solution	Retinoids
AIMOVIG	Antimigraine
AJOVY	Antimigraine
CARAFATE	Antiulcer
DIFFERIN	Retinoids
EMGALITY	Antimigraine
EPIDUO	Retinoids
EPIDUO FORTE	Retinoids
INDOMETHACIN	Nonsteroidal Anti-inflammatory Agents (NSAID)
INSULIN ASPART	Antidiabetic
INSULIN ASPART FLEXPEN	Antidiabetic

Prior Authorization (PAR) Utilization Management Program changes or updates—continued

Effective: January 1, 2025

Drug class / Drug	Indication
INSULIN ASPART PENFILL	Antidiabetic
INSULIN ASPART PROTAMINE / ASPART 70/30 MIX	Antidiabetic
JYLAMVO	Anticancer; Antarthritic; Antipsoriatic
NUEDEXTA	Pseudobulbar Affect
NURTEC	Antimigraine
NYMALIZE	Calcium Channel Blocker
PEGASYS [1]	Hepatitis C, Hepatitis B
QULIPTA	Antimigraine
REZUROCK	Chronic Graft-Versus-Host Disease (cGvHD)
TAZORAC	Retinoids
TRETINOIN LOTION	Retinoids

Prior Authorization (PAR) Utilization Management Program changes or updates—continued

Effective: January 1, 2025

Drug class / Drug	Indication
UBRELVY	Antimigraine
VICTOZA	Antidiabetic
XATMEP	Anticancer, Antiarthritic
ZAVZPRET	Antimigraine

Quantity Level Limit (QLL) Program[2]

Effective: January 1, 2025

Drug class / Drug	Dosage	Quantity Limit
ABILIFY	2 mg tablet, 5 mg tablet, 10 mg tablet, 15 mg tablet, 20 mg tablet, 30 mg tablet	30 tablets/30 days
ABILIFY MYCITE	Starter kit: 2 mg tablet with sensor, strips and pod	30 tablets/30 days
	Starter kit: 5 mg tablet with sensor, strips and pod	30 tablets/30 days
	Starter kit: 10 mg tablet with sensor, strips and pod	30 tablets/30 days
	Starter kit: 15 mg tablet with sensor, strips and pod	30 tablets/30 days
	Starter kit: 20 mg tablet with sensor, strips and pod	30 tablets/30 days
	Starter kit: 30 mg tablet with sensor, strips and pod	30 tablets/30 days
ABILIFY MYCITE	Maintenance Kit: 2 mg tablet with sensor and strips	30 tablets/30 days
	Maintenance Kit: 5 mg tablet with sensor and strips	30 tablets/30 days
	Maintenance Kit: 10 mg tablet with sensor and strips	30 tablets/30 days
	Maintenance Kit: 15 mg tablet with sensor and strips	30 tablets/30 days
	Maintenance Kit: 20 mg tablet with sensor and strips	30 tablets/30 days
ABILIFY MYCITE	Maintenance Kit: 30 mg tablet with sensor and strips	30 tablets/30 days
aripiprazole	1 mg/mL oral solution	900 mLs/30 days
	10 mg orally disintegrating tablet	60 tablets/30 days
	15 mg orally disintegrating tablet	60 tablets/30 days
CARAFATE	1 gm/10mL	1,200 mL/30 days
clozapine	12.5 mg orally disintegrating tablet	90 tablets/30 days
	25 mg orally disintegrating tablet	270 tablets/30 days
	100 mg orally disintegrating tablet	90 tablets/30 days
	150 mg orally disintegrating tablet	180 tablets/30 days
	200 mg orally disintegrating tablet	120 tablets/30 days

[2]Impacted members will be notified prior to the change.

Quantity Level Limit (QLL) Program[2]—continued

Effective: January 1, 2025

Drug class / Drug	Dosage	Quantity Limit
CLOZARIL	25 mg tablet	90 tablets/30 days
	50 mg tablet	90 tablets/30 days
	100 mg tablet	270 tablets/30 days
	200 mg tablet	120 tablets/30 days
FANAPT	1 mg tablet, 2 mg tablet, 4 mg tablet, 6 mg tablet, 8 mg tablet, 10 mg tablet, 12 mg tablet	60 tablets/30 days
	Titration pak	1 pack/180 days
GEODON	20 mg capsule, 40 mg capsule, 60 mg capsule, 80 mg capsule	60 capsules/30 days
INDOMETHACIN	100 mg	60 suppositories/30 days
INVEGA	1.5 mg tablet, 3 mg tablet, 9 mg tablet	30 tablets/30 days
JYLAMVO	2 mg/mL	180 mL/28 days
KISQALI	200 mg Daily Dose	21 tablets/28 days
	400 mg Daily Dose	42 tablets/28 days
KISQALI FEMARA	200 mg Dose	49 tablets/28 days
	400 mg Dose	70 tablets/28 days
MEKINIST	2mg tablet	30 tablets/30 days
MIEBO	1.338 gm/mL	1 bottle/30 days
MOUNJARO	2.5 mg/0.5 mL pen	4 pens/180 days
NUEDEXTA	20-10 mg capsule	60 capsules/30 days
NYMALIZE	6 mg/mL	1,260 mL/21 days
QUETIAPINE	150 mg tablet	30 tablets/30 days
REXULTI	0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet, 4 mg tablet	30 tablets/30 days
REZUROCK	200 mg tablet	30 tablets/30 days

[2]Impacted members will be notified prior to the change.

Quantity Level Limit (QLL) Program[2]—continued

Effective: January 1, 2025

Drug class / Drug	Dosage	Quantity Limit
RISPERDAL	0.25 mg tablet, 0.5 mg tablet, 1 mg tablet, 2 mg tablet, 3 mg tablet	60 tablets/30 days
	4 mg tablet	120 tablets/30 days
	1 mg/mL oral solution	480 mLs/30 days
risperidone	0.25 mg orally disintegrating tablet, 0.5 mg orally disintegrating tablet, 1 mg orally disintegrating tablet, 2 mg orally disintegrating tablet, 3 mg orally disintegrating tablet	60 tablets/30 days
	4 mg orally disintegrating tablet	120 tablets/30 days
SAPHRIS	2.5 mg sublingual tablet, 5 mg sublingual tablet, 10 mg sublingual tablet	60 tablets/30 days
SECUADO	3.8 mg/ 24hr transdermal patch, 5.7 mg/ 24hr transdermal patch, 7.6 mg/ 24hr transdermal patch	30 patches/30 days
SEROQUEL	25 mg tablet, 50 mg tablet, 100 mg tablet, 200 mg tablet	90 tablets/30 days
	300 mg tablet, 400 mg tablet	60 tablets/30 days
SEROQUEL XR	150 mg extended-release tablet, 200 mg extended-release tablet	30 tablets/30 days
VERSACLOZ	50 mg/mL oral suspension	540 mls/30 days

[2]Impacted members will be notified prior to the change.

Step Therapy (ST) Program changes or updates

Effective: January 1, 2025

Drug class / Drug	Indication
ADVAIR DISKUS	Asthma; Chronic Obstructive Pulmonary Disease (COPD)
ALVESCO	Asthma

Important notice for CHIP managed care plans in Pennsylvania: Advertised managed care plans or programs may not cover all your healthcare expenses. Read your member handbook carefully to determine which healthcare services are covered. Please call 800.KIDS.101 or the number on the back of your ID card (TTY: 711).