Capital BlueCross Open/Closed Formulary Update

(1st Quarter 2018)

The Capital BlueCross formulary is a reference list of prescription drugs that contains a wide range of generic and brand drugs that have been approved by the U.S. Food and Drug Administration (FDA). The formulary is updated on a quarterly basis or when new generic or brand-name medications become available and as discontinued drugs are removed from the marketplace.

Several new drugs have come to market and are now included in our formulary.

Capital BlueCross Formulary Update KEY: **lowercase bold print = generic**; UPPERCASE PRINT = BRAND; (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply			
Newly Marketed Drugs[#] Effective Immediately			
Brand Name	**Tier Status**	**Indication**	**Preferred Alternatives**
CALQUENCE* (PAR)	BNP	Lymphoma	IMBRUVICA* (PAR), REVLIMID* (PAR)
ENDARI* (PAR)	BP	Sicle Cell Disease	N/A
HEMLIBRA* (PAR)	BP	Bleeding episodes associated with Hemophilia	FEIBA*, NOVOSEVEN*
OZEMPIC (PAR)	BNP	Diabetes Mellitus Type 2	TRULICITY, VICTOZA
PREVYMIS	BP	Cytomegalovirus	N/A
VERZENIO* (PAR)	BNP	Breast Cancer	KISQALI* (PAR), IBRANCE* (PAR)
VYZULTA (PAR)	BNP	Glaucoma	**latanoprost**

KEY: Generic Preferred (GP), Generic Non-Preferred (GNP), Brand Preferred (BP), Brand Non-Preferred (BNP)
* Specialty Medication
[#]Impacted members will be notified

The Capital BlueCross formulary serves as a reference for all prescription drug benefit designs ranging from an *open* formulary to a *closed* formulary.

- An *open* formulary provides access to generic preferred, generic non-preferred, brand preferred brand and brand non-preferred medications.
- A *closed* formulary provides access to generic preferred, generic non-preferred and brand preferred medications. Brand non-preferred medications are not covered under a closed formulary. You or your physician may request coverage for medically necessary brand non-preferred drugs through the Non-formulary Consideration Process.

The following medications have been **added** to the Prior Authorization (PAR) program.

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND	
Prior Authorization (PAR) Program **Effective Immediately**	
Drug Class/Drug	
CALQUENCE* (PAR)	ENDARI* (PAR)
HEMLIBRA* (PAR)	OZEMPIC (PAR)
VERZENIO* (PAR)	VYZULTA (PAR)

*Specialty Medication

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND			
Prior Authorization (PAR) Program# **Effective August 1, 2018**			
Drug Class/Drug			
ADVATE*	ADYNOVATE*	AFSTYLA*	ALPHANATE*
ALPHANINE SD*	ALPROLIX*	AMBIEN	AMBIEN CR
BEBULIN*	BENEFIX*	CAVERJECT	COAGADEX*
CUVITRU*	DAYTRANA	DORAL	DUZALLO
EDEX	EDLUAR	ELOCTATE*	ENBREL MINI*
FEIBA*	FLOLIPID	GRANIX*	HALCION
HELIXATE FS*	HEMOFIL M*	HIZENTRA*	HUMATE-P*
HYQVIA*	IDELVION*	INTERMEZZO	IXINITY*
KOATE*	KOGENATE FS*	KOVALTRY*	LEUKINE*
LEVITRA	LUMIGAN	LUNESTA	MONOCLATE-P*
MONONINE*	MUSE	NEULASTA*	NEUPOGEN*
NOVOEIGHT*	NOVOSEVEN RT*	NUWIQ*	OBIZUR*
ORFADIN*	PROFILNINE*	QTERN	REBINYN*
RECOMBINATE*	RESTORIL	RIXUBIS*	SABRIL*
SILENOR	SONATA	STAXYN	STENDRA
TRAVATAN Z	VIAGRA	WILATE*	XHANCE
XYNTHA*	ZARXIO*	ZOLPIMIST	

Impacted members will be notified prior to change
* Specialty Medication

The following medication has a tier status change:

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND			
Products Changing Tier Status# Effective August 1, 2018			
Brand Name	**Current Tier**	**New Tier**	**Preferred Alternative**
CIALIS 2.5mg (EPA, QLL), 5mg (EPA,QLL), 10mg, 20mg	Brand Non-Preferred	Brand Preferred	N/A
LEVITRA (PAR, QLL)	Brand Preferred	Brand Non-Preferred	**sildenafil**
LUMIGAN (PAR), TRAVATAN Z (PAR)	Brand Preferred	Brand Non-Preferred	**latanoprost**

Impacted Members will be notified prior to change.

Certain medications are subject to *Enhanced Prior Authorization* (EPA) due to health care concerns and/or safety reasons. In order to have these medications covered under your prescription drug benefit, you may be required to try a formulary alternative first or to complete the Prior Authorization process.

To obtain Prior Authorization, your physician or pharmacist should call or fax a request with supporting clinical information to the CVS/caremark™ Prior Authorization Department at 800.294.5979 (Fax: 888.836.0730). Members may initiate a Prior Authorization request by calling CVS/caremark at 800.585.5794 or by visiting the website at capbluecross.com.

The following medications have been **added** to the Enhanced Prior Authorization (EPA) program.

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND	
Enhanced Prior Authorization (EPA) Program Effective August 1, 2018	
Drug Class/Drug	**Purpose/Guidelines**
CIALIS (2.5MG/5MG) EPA, QLL	NOTE: For **symptomatic benign prostatic hyperplasia (BPH) with or without erectile dysfunction (ED) (≥ age 18):** a 30 day prescription of **one alpha-blocker** *(i.e., alfuzosin, doxazosin, silodosin, tamsulosin, or terazosin*), **5 alpha-reductase inhibitor (5-ARI)** (*e.g., dutasteride, finasteride 5 mg)*, **OR combination alpha-blocker and 5-ARI** [e*.g., Jalyn (dutasteride/tamsulosin)]* must be utilized before receiving prior authorization for the medications in this program **For erectile dysfunction (≥ age 18): Prior authorization is required**

Impacted members will be notified prior to change

***** Indicates specialty medication

Certain medications are also subject to *Quantity Level Limit* (QLL) to help promote appropriate use of medications and enhance patient safety. Prescriptions written for more than the allowed quantity will only be filled up to the allowed amount. Your physician can direct quantity override requests to CVS/caremark by calling or faxing the request with supporting clinical information to 800.294.5979 (Fax: 888.836.0730).

The following medications have been **added** to the Quantity Level Limit (QLL) program.

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND	
Quantity Level Limit (QLL) Program[#] Effective August 1, 2018	
Drug Class/Drug	**Quantity Limits**
ARMONAIR (QLL)	1 inhaler/30 days
DUEXIS (PAR, QLL)	90 tablets\30 days
ENBREL MINI (PAR, QLL)	8 injections/28 days
INSOMNIA AGENTS (QLL): (AMBIEN/CR (PAR), BELSOMRA (PAR), DORAL (PAR), EDLUAR (PAR), **estazolam, eszopiclone, flurazepam,** HALCION (PAR), INTERMEZZO (PAR), LUNESTA (PAR), RESTORIL (PAR), ROZEREM (PAR), SILENOR (PAR), SONATA (PAR), **temazepam, triazolam**, **zaleplon, zolpidem/-er,** ZOLPIMIST (PAR)	15 units/25 days for all products [except HALCION and **triazolam** (10 units/25 days)
VIMOVO (PAR, QLL)	60 tablets/30 days

[#] Impacted members will be notified prior to change

The following medications have been designated as a **Specialty drug** and added to the Specialy Program.

Pharmacy Management Program Update KEY: (PAR) = Prior Authorization Required; (EPA) = Enhanced Prior Authorization Required; (QLL) = Quantity Level Limits Apply **lowercase bold print = generic**; UPPERCASE PRINT = BRAND	
Specialty Drug Program[#] Effective August 1, 2018	
Drug Class/Drug	**Purpose/Guidelines**
XYREM*[+] (PAR)	

[#] Impacted members will be notified prior to change
* Specialty Medication
+Limited Distribution