Healthy Blue℠
BlueChoice® HealthPlan of SC

Healthy Connections

Quarterly pharmacy formulary change notice
Posted 1/1/2024

The formulary changes listed in the table below were reviewed and approved at the third quarter Pharmacy and Therapeutics Committee meeting held on August 18, 2023.

What this means to me:

- Effective 2/1/2024, preferred formulary changes will apply.
- Effective 2/1/2024, nonpreferred and prior authorization requirements will apply.
- This notice applies to Healthy Blue.

Effective for all patients on February 1, 2024			
Therapeutic class	**Medication**	**Formulary status change**	**Potential alternatives (preferred products)**
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	YUSIMRY 40MG/0.8ML PEN	NON-PREFERRED TO PREFERRED	N/A
GOUT AGENTS	COLCHICINE CAPSULES/TABLETS	NON-PREFERRED TO PREFERRED	N/A
MONOCLONAL ANTIBODIES	BEYFORTUS 50MG/0.5ML INJECTION BEYFORTUS 100MG/ML INJECTION	NON-PREFERRED TO PREFERRED	N/A
OPIOID DEPENDENCE AGENTS	BRIXADI WEEKLY/MONTHLY INJECTION	NON-PREFERRED TO NON-PDL	N/A
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN February 1, 2024 *No changes in Preferred/Non-Preferred status revision or addition to UM edit only*			
ANDROGENS	KYZATREX 200 MG CAPSULE	UPDATE QL 4 CAPSULES PER DAY	
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	BREO ELLIPTA 50 MCG/25 MCG	ADD QL 1 INHALER PER 30 DAYS	
ANTIDEMENTIA AGENTS	NAMZARIC (MEMANTINE EXTENDED RELEASE/DONEPEZIL) TITRATION PACK	ADD 1 PACK PER FILL, ONE TIME FILL	
ANTIDEPRESSANTS	ZURZUVAE (ZURANOLONE) 20 MG, 25 MG, 30 MG CAPSULE	ADD PA AND QL ZURZUVAE 20MG, 25 MG (28 CAPSULES PER FILL; 1 FILL PER YEAR) 30 MG CAPSULE (14 CAPSULES PER 1 FILL, 1 FILL PER YEAR)	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	COLUMVI 10 MG/10 ML VIAL COLUMVI 2.5 MG VIAL	ADD PA	

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BSCPEC-1173-19 February 2019

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	VANFLYTA 17.7 MG TABLET VANFLYTA 26.5 MG TABLET	ADD QL 2 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	LUMAKRAS 320 MG TABLET	ADD QL 3 TABLETS PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	TALZENNA 0.1 MG CAPSULE TALZENNA 0.35 MG CAPSULE	ADD QL 1 CAPSULE PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	AKEEGA 50 MG/500MG TABLET AKEEGA 100 MG/500MG TABLET	ADD PA AND QL 1 TABLET PER DAY
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ELREXFIO (ELRANATAMAB-BCMM) VIALS	ADD PA
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	TALVEY (TALQUETAMAB-TGVS) VIALS	ADD PA
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	CYLTEZO CROHN'S DISEASE, ULCERATIVE COLITIS STARTER PACKAGE 40 MG/0.8 ML PENS CYLTEZO PSORIASIS STARTER PACKAGE 40MG/0.8 ML PENS	ADD QL 1 PACK (28 DAY SUPPLY, ONE TIME FILL)
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HADLIMA 40 MG/0.4 ML AUTOINJECTOR HADLIMA 40 MG/0.4 ML PREFILLED SYRINGE	ADD QL 2 AUTOINJECTORS PER 28 DAYS 2 SYRINGES PER 28 DAYS
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HYRIMOZ CROHN'S DISEASE STARTER PACKAGE 80 MG/0.8 ML PEN HYRIMOZ CROHN'S DISEASE STARTER PACKAGE 80 MG/0.8 ML AND 40 MG/0.4 ML PENS HYRIMOZ PLAQUE PSORIASIS STARTER PACKAGE 80 MG/0.8 ML AND 40 MG/0.4 ML PENS HYRIMOZ PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8 ML PREFILLED SYRINGE HYRIMOZ PEDIATRIC CROHN'S DISEASE STARTER PACK 80 MG/0.8 ML AND 40 MG/0.4 ML PREFILLED SYRINGE	ADD QL 1 PACK (28 DAY SUPPLY, ONE TIME FILL)
CARDIOVASCULAR AGENTS MISC	LODOCO (COLCHICINE) 0.5 MG TABLET	ADD PA AND ST AND QL 1 TABLET PER DAY
CARDIOVASCULAR AGENTS MISC	LIQREV (SILDENAFIL) 10 MG/ML ORAL SUSPENSION	ADD PA

CMV AGENTS	PREVYMIS (LETERMOVIR) 240 MG, 480 MG TABLETS	UPDATE QL 224 TABLETS PER YEAR
COMPLEMENT INHIBITORS	VEOPOZ 400 MG/2 ML VIAL	ADD PA AND DOSING LIMIT/QL 10 MG/KG, UP TO A MAXIMUM OF 800 MG (2 VIALS), ONCE WEEKLY; MAXIMUM OF 2 VIALS ONCE WEEKLY
CONTRACEPTIVES	HALOETTE VAGINAL RING	ADD QL 1 RING PER 28 DAYS
CONTRACEPTIVES	AFTERPILL, CURAE, ECONTRA OS, HER STYLE EMERGENCY CONTRACEPTIVES 1.5 MG TABLETS	ADD QL 1 TABLET PER 30 DAYS
DIABETIC SUPPLIES	INSULIN INFUSION PUMP SUPPLIES	REMOVE QL 15 INFUSION SETS/RESERVOIRS PER 30 DAYS
DIURETICS	ALDACTAZIDE (SPIRONOLACTONE/HYDROCHLOROTHIAZIDE 25 MG/25 MG) ALDACTAZIDE (SPIRONOLACTONE/HYDROCHLOROTHIAZIDE 50 MG/50 MG)	REMOVE DO 8 TABLETS PER DAY REMOVE QL 4 TABLETS PER DAY
FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS	SOHONOS (PALOVAROTENE) 1 MG, 1.5 MG, 2.5 MG, 5 MG, 10 MG CAPSULES	ADD PA AND QL SOHONOS 1 MG (4 CAPSULES PER DAY) SOHONOS 1.5 MG (2 CAPSULES PER DAY) SOHONOS 2.5 MG, 5 MG (1 CAPSULE PER DAY) 10 MG (APPROVED FOR FLARE UP TREATMENT VIA OVERRIDE CRITERIA)
GASTROINTESTINAL AGENTS MISC	BYLVAY 200 MCG, 600 MCG, 400 MCG, 1200 MG PELLETS	UPDATE QL BYLVAY 200 MCG (36 PELLETS PER DAY BYLVAY 600 MCG (12 PELLETS PER DAY) BYLVAY 400 MCG (18 PELLETS PER DAY) BYLVAY 1200 MCG (6 PELLETS PER DAY)
GROWTH HORMONES	NGENLA 24 MG/1.2 ML PREFILLED PEN NGENLA 60 MG/1.2 ML PREFILLED PEN	ADD QL 4 PENS PER 28 DAYS
HAIR GROWTH AGENTS	LITFULO 50 MG CAPSULE	ADD PA AND QL 1 CAPSULE PER DAY
HEMATOLOGICAL AGENTS MISC	KALBITOR 10 MG VIAL	UPDATE QL UP TO 6 VIALS (60 MG) PER ATTACK (MAXIMUM 36 VIALS/30 DAYS)
HEMATOLOGICAL AGENTS MISC	ICATIBANT 30 MG PREFILLED SYRINGE	UPDATE QL UP TO 3 SYRINGES (90 MG) PER ATTACK (MAXIMUM 18 SYRINGES/30 DAYS)
HEMATOPOIETIC AGENTS	MIRCERA 120 MCG/0.3 ML SYRINGE	ADD QL 2 SYRINGES (0.6 ML) PER 28 DAYS
IMMUNOMODULATORS	RYSTIGGO 280 MG/2 ML VIAL	ADD PA AND DOSING LIMIT
IMMUNOMODULATORS	VYVGART HYTRULO VIAL	ADD PA AND QL 1 VIAL ONCE WEEKLY FOR 4 WEEKS (4 WEEKS=1 CYCLE)

INFLAMMATORY BOWEL AGENTS	ROWASA (MESALAMINE RECTAL SUSPENSION ENEMA) 4 GRAM/60 ML SFROWASA (MESALAMINE RECTAL SUSPENSION ENEMA) 4 GRAM/60 ML	ADD QL 1680 ML PER 28 DAYS
KERATOLYTIC AGENTS	YCANTH (CANTHARIDIN) 0.7% TOPICAL SOLUTION	ADD PA AND QL 8 APPLICATORS PER 12 WEEKS
LAXATIVES	SUFLAVE SOLUTION KIT	ADD QL 2 KITS PER 30 DAYS
MULTIPLE SCLEROSIS AGENTS*	TYRUKO 300MG/15 ML VIAL	ADD QL 1 VIAL PER 28 DAYS
OPHTHALMIC AGENTS	EYLEA HD 8 MG VIAL	ADD PA AND DOSING LIMIT 8 MG PER EYE EVERY 4 WEEKS FOR THE FIRST THREE DOSES; FOLLOWED BY 8 MG PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 8 WEEKS
OPHTHALMIC ANTI-INFECTIVES	XDEMVY (LOTILANER) OPHTHALMIC SOLUTION	ADD PA AND QL 1 BOTTLE PER FILL; 2 FILLS PER YEAR
OPHTHALMIC COMPLEMENT INHIBITORS	IZERVAY 20 MG/ML VIAL	ADD PA AND DOSING LIMIT 0.1 ML (OR 2 MG) PER EYE; EACH EYE MAY BE TREATED AS FREQUENTLY AS EVERY 28 DAYS
OPHTHALMIC DRY EYE AGENTS*	VEVYE (CYCLOSPORINE) OPHTHALMIC 0.1% SOLUTION	ADD PA AND QL 6 ML PER 30 DAYS
OPHTHALMIC DRY EYE AGENTS	MIEBO (PERFLUOROHEXYLOCTANE) OPTHALMIC SOLUTION	ADD PA AND QL 12 ML PER 30 DAYS
OPIOID ANALGESICS	BUPRENEX 0.3 MG/ML INJECTION	REMOVE QL 3 ML PER DAY
OPIOID ANALGESICS	BUTORPHANOL 1 MG/ML INJECTION BUTORPHANOL 2 MG/ML INJECTION	REMOVE QL 8 ML PER DAY FREMOVE QL 4 ML PER DAY
OPIOID ANALGESICS	DILAUDID (HYDROMORPHONE) INJECTION 0.2 MG/ML, 1 MG/ML AMPULE/SYRINGE, 0.5 MG/0.5 ML SYRINGE (INCLUDING PF), 2 MG/ML INJECTION (AMPULE, SYRINGE, VIAL; INCLUDING PF) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 6 ML PER DAY
OPIOID ANALGESICS	DILAUDID (HYDROMORPHONE) 4 MG/ML INJECTION (AMPULE, SYRINGE) (INCLUDING PF) (INCLUDES ALL INJECTABLE	REMOVE QL 2 ML PER DAY

	FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	
OPIOID ANALGESICS	DILAUDID-HP (HYDROMORPHONE) 10 MG/ML INJECTION (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 1 INJECTION PER 30 DAYS
OPIOID ANALGESICS	DEMEROL (MEPERIDINE) INJECTION 100 MG/2ML, 100 MG/ML, 25 MG/ML, 75 MG/ML, 10 MG/ML, 50 MG/ML, 75 MG/1.5 ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 4 ML PER DAY
OPIOID ANALGESICS	MITIGO/INFUMORPH 200 MG/20 ML MITIGOL/INFUMORPH 500MG/20ML	REMOVE QL 2 VIALS PER MONTH
OPIOID ANALGESICS	MORPHINE SULFATE INJECTION 10 MG/0.7 ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 6 INJECTIONS/PENS PER DAY
OPIOID ANALGESICS	MORPHINE SULFATE INJECTION 150 MG/30 ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 1 VIAL (30 ML) PER DAY
OPIOID ANALGESICS	MORPHINE SULFATE INJECTION 25 MG/ML (100 MG/4 ML, 250 MG/10 ML) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 4 ML PER DAY
OPIOID ANALGESICS	MORPHINE SULFATE INJECTION 50 MG/ML (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	REMOVE QL 2 ML PER DAY
OPIOID ANALGESICS	MORPHINE SULFATE INJECTION (INCLUDING DURAMORPH INJECTION) 0.5 MG/1 ML, 1 MG/ML, 2 MG/ML (10 MG/5 ML), 4 MG/ML, 5 MG/ML, 8 MG/ML, 10 MG/ML (15 MG/1.5	REMOVE QL 6 ML PER DAY

	ML) (INCLUDES ALL INJECTABLE FORMULATIONS INCLUDING VIALS, SYRINGES AND AMPULES)	
OPIOID ANALGESICS	OXYCODONE 100MG/0.5 ML ORAL CONCENTRATE	REMOVE QL 2 ML PER DAY
OPIOID DEPENDENCE AGENTS	BRIXADI 8 MG/0.16 ML WEEKLY INJECTION BRIXADI 16 MG/0.32 ML WEEKLY INJECTION BRIXADI 24 MG/0.48 ML WEEKLY INJECTION BRIXADI 32MG/0.64ML WEEKLY INJECTION BRIXADI 64 MG/0.18 ML MONTHLY INJECTION BRIXADI 96MG/0.27ML MONTHLY INJECTION BRIXADI 128MG/0.36ML MONTHLY INJECTION	ADD QL 4 SYRINGES PER 28 DAYS (WEEKLY INJECTION) 1 SYRINGE EVERY 28 DAYS (MONTHLY INJECTION)
OPIOID DEPENDENCE AGENTS	SUBOXONE (BUPRENORPHINE/NALOXONE) 2 MG/0.5 MG SUBLINGUAL FILM/TABLET	UPDATE QL 16 FILMS/TABLETS PER DAY
OPIOID DEPENDENCE AGENTS	SUBOXONE (BUPRENORPHINE/NALOXONE) 8 MG/2 MG SUBLINGUAL FILM/TABLET	UPDATE QL 4 FILMS/TABLETS PER DAY
OPIOID DEPENDENCE AGENTS	SUBOXONE (BUPRENORPHINE/NALOXONE) 4 MG/1 MG SUBLINGUAL FILM	UPDATE QL 8 FILMS PER DAY
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS MISC	AUSTEDO XR (DEUTETRABENAZINE) 6 MG, 12 MG, 24 MG TABLETS AUSTEDO XR (DEUTETRABENAZINE) 6-24 MG TITRATION KIT	ADD PA AND QL 2 TABLETS PER DAY 1 KIT PER FILL, ONE TIME FILL
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS MISC*	INGREZZA (VALBENAZINE) 40-60 MG INITIATION PACK	ADD QL 1 PACK (28 DAY SUPPLY), ONE TIME FILL
SEDATIVE HYPNOTIC AGENTS	ZOLPIDEM 7.5 MG CAPSULE	ADD QL 1 CAPSULE PER DAY
SELECT NALOXONE AGENTS	NALMEFENE 2 MG/2 ML INJECTION	ADD QL 10 VIALS (1 CARTON) PER 5 MONTHS
SELECT NALOXONE AGENTS	NALOXONE 2 MG/ 2ML INJECTION	6 SYRINGES/VIALS PER 3 MONTHS

	NALOXONE 4 MG/10 ML INJECTION	
SELECT NALOXONE AGENTS	OPVEE (NALMEFENE) 2.7 MG/0.1 ML NASAL SPRAY	6 NASAL SPRAYS (3 CARTONS) PER 3 MONTHS

**UM UPDATES WILL APPLY WHEN THE MEDICATION BECOMES AVAILABLE ON THE MARKET*

What action do I need to take?

Please review these changes and work with your Healthy Blue patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

What if I need assistance?

We recognize the unique aspects of patients' cases. If for medical reasons your Healthy Blue patient cannot be converted to a formulary alternative, call our Pharmacy department at **866-757-8286** and follow the voice prompts for pharmacy prior authorization.

You can find the *Preferred Drug List* on our website by visiting **www.HealthyBlueSC.com** and selecting **Providers**. If you need assistance with any other item, contact Provider Services at **866-757-8286**.