[07/01/2025]

Pharmacy Comprehensive Drug List Change Notice

[Posted 06/01/2025]

We want to tell you about some upcoming changes to the Comprehensive Drug List. The Comprehensive Drug List is a list of drugs covered by Healthy Blue. Please see the table below:

EFFECTIVE FOR ALL MEMBERS NO LATER THAN JULY 1, 2025			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
ANALGESICS – NON-NARCOTIC	JOURNAVX TAB 50MG	Covered (18 years and older)	N/A
ANALGESICS - OPIOID	NUCYNTA TAB 50MG NUCYNTA TAB 75MG NUCYNTA TAB 100MG	Benefit exclusion	Refer to Comprehensive Drug List
ANALGESICS - OPIOID	NUCYNTA ER TAB 50MG NUCYNTA ER TAB 100MG NUCYNTA ER TAB 150MG NUCYNTA ER TAB 200MG NUCYNTA ER TAB 250MG	Benefit exclusion	Refer to Comprehensive Drug List
ANALGESICS - OPIOID	OXYCONTIN TAB 10MG ER OXYCONTIN TAB 15MG ER OXYCONTIN TAB 20MG ER OXYCONTIN TAB 30MG ER OXYCONTIN TAB 40MG ER OXYCONTIN TAB 60MG ER OXYCONTIN TAB 80MG ER	Covered	N/A
ANALGESICS - OPIOID	XTAMPZA ER CAP 9MG XTAMPZA ER CAP 13.5MG XTAMPZA ER CAP 18MG XTAMPZA ER CAP 27MG XTAMPZA ER CAP 36MG	Benefit exclusion	Refer to Comprehensive Drug List
ANTICONVULSANTS	BANZEL SUS 40MG/ML	Non-covered / PA required	Refer to Comprehensive Drug List
ANTICONVULSANTS	RUFINAMIDE SUS 40MG/ML	Covered with PA	N/A
ANTICONVULSANTS	SABRIL TAB 500MG	Non-covered / PA required	Refer to Comprehensive Drug List
ANTICONVULSANTS	VIGABATRIN TAB 500MG	Covered with PA	N/A
ANTIEMETICS	SCOPOLAMINE DIS 1MG/3DAY	Covered	N/A

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ANTIHYPERTENSIVES	BENICAR HCT TAB 20-12.5 BENICAR HCT TAB 40-12.5 BENICAR HCT TAB 40-25MG	Non-covered / PA required	Refer to Comprehensive Drug List
ANTIHYPERTENSIVES	OLMESARTAN MEDOXOMIL / HCTZ TAB 20-12.5 OLMESARTAN MEDOXOMIL / HCTZ TAB 40-12.5 OLMESARTAN MEDOXOMIL / HCTZ TAB 40-25	Covered	N/A
ANTIPSYCHOTICS / ANTIMANIC AGENTS	ASENAPINE SUB 2.5MG ASENAPINE SUB 5MG ASENAPINE SUB 10MG	Covered	N/A
ANTIPSYCHOTICS / ANTIMANIC AGENTS	SAPHRIS SUB 2.5MG SAPHRIS SUB 5MG SAPHRIS SUB 10MG	Non-covered / PA required	Refer to Comprehensive Drug List
ANTIVIRALS	VEMLIDY TAB 25MG	Covered	N/A
CEPHALOSPORINS	CEFACLOR CAP 250MG CEFACLOR CAP 500MG	Covered	N/A
CEPHALOSPORINS	CEFACLOR SUS 250/5ML	Covered	N/A
CEPHALOSPORINS	CEFADROXIL CAP 500MG	Covered	N/A
CEPHALOSPORINS	CEFADROXIL SUS 250/5ML CEFADROXIL SUS 500/5ML	Covered	N/A
CEPHALOSPORINS	CEFIXIME CAP 400MG	Covered	N/A
CEPHALOSPORINS	CEFIXIME SUS 100/5ML CEFIXIME SUS 200/5ML	Covered	N/A
CEPHALOSPORINS	CEFPODOXIME TAB 100MG CEFPODOXIME TAB 200MG	Covered	N/A
CEPHALOSPORINS	CEFPODOXIME PROXETIL SUS 50MG/5ML CEFPODOXIME PROXETIL SUS 100MG/5ML	Covered	N/A
DERMATOLOGICALS	AZELAIC ACID GEL 15%	Covered	N/A
DIAGNOSTIC PRODUCTS	ONETOUCH TES ULT BLUE	Non-covered / PA required	Refer to Comprehensive Drug List
DIAGNOSTIC PRODUCTS	ONETOUCH TES ULTRA	Non-covered / PA required	Refer to Comprehensive Drug List
DIAGNOSTIC PRODUCTS	ONETOUCH TES VERIO	Non-covered / PA required	Refer to Comprehensive Drug List
MEDICAL DEVICES AND SUPPLIES	ONETOUCH KIT VERIO FL	Non-covered / PA required	Refer to Comprehensive Drug List
MEDICAL DEVICES AND SUPPLIES	ONETOUCH KIT ULTRA 2	Non-covered / PA required	Refer to Comprehensive Drug List
MEDICAL DEVICES AND SUPPLIES	ONETOUCH DEL MIS PLUS 33G	Non-covered / PA required	Refer to Comprehensive Drug List
MEDICAL DEVICES AND SUPPLIES	ONETOUCH DEL MIS PLUS 30G	Non-covered / PA required	Refer to Comprehensive Drug List
MEDICAL DEVICES AND SUPPLIES	ONETOUCH DEL MIS LANC DEV	Non-covered / PA required	Refer to Comprehensive Drug List

MEDICAL DEVICES AND SUPPLIES	ONETOUCH US MIS 2 30G	Non-covered / PA required	Refer to Comprehensive Drug List
MEDICAL DEVICES AND SUPPLIES	ONETOUCH US MIS LANCETS	Non-covered / PA required	Refer to Comprehensive Drug List
MISCELLANEOUS THERAPEUTIC CLASSES	RAPAMUNE TAB 0.5MG RAPAMUNE TAB 1MG RAPAMUNE TAB 2MG	Non-covered / PA required	Refer to Comprehensive Drug List
MISCELLANEOUS THERAPEUTIC CLASSES	RAPAMUNE SOL 1MG/ML	Non-covered / PA required	Refer to Comprehensive Drug List
MISCELLANEOUS THERAPEUTIC CLASSES	SANDIMMUNE CAP 25MG SANDIMMUNE CAP 100MG	Non-covered / PA required	Refer to Comprehensive Drug List
MISCELLANEOUS THERAPEUTIC CLASSES	SANDIMMUNE SOL 100MG/ML	Non-covered / PA required	Refer to Comprehensive Drug List
OPHTHALMIC AGENTS	DUREZOL EMU 0.05%	Covered	N/A
OPHTHALMIC AGENTS	FLAREX SUS 0.1% OP	Covered	N/A
OPHTHALMIC AGENTS	MAXIDEX SUS 0.1% OP	Covered	N/A
OPHTHALMIC AGENTS	PRED MILD SUS 0.12% OP	Covered	N/A
OPHTHALMIC AGENTS	PREDNISOLONE SODIUM PHOSPHATE SOL 1% OP	Non-covered / PA required	Refer to Comprehensive Drug List
PENICILLINS	AUGMENTIN SUS 125/5ML	Non-covered / PA required	Refer to Comprehensive Drug List
ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS	ESOMEPRAZOLE GRA 5MG DR ESOMEPRAZOLE GRA 10MG DR ESOMEPRAZOLE GRA 20MG DR ESOMEPRAZOLE GRA 40MG DR	Covered	N/A
ULCER DRUGS / ANTISPASMODICS / ANTICHOLINERGICS	NEXIUM GRA 5MG DR NEXIUM GRA 10MG DR NEXIUM GRA 20MG DR NEXIUM GRA 40MG DR	Non-covered / PA required	Refer to Comprehensive Drug List

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN JULY 1, 2025 *NO CHANGES IN PREFERRED/NON-PREFERRED STATUS REVISION OR ADDITION TO UM EDIT ONLY*		
ANALGESICS – NON-NARCOTIC	JOURNAVX TAB 50MG	Update QL: 14 days' supply per 60 days

What action do I need to take?

Some drugs may no longer be covered. Determine if a change to a covered drug can be done. If so, a new prescription needs to be sent to the pharmacy.

If the non-covered drug cannot be changed, a prior authorization may be needed.

What if I have questions?

For members, call Pharmacy Customer Service at **866-781-5094 (TTY 1-866-773-9634)**, 24 hours a day, seven days a week.

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