Blue Cross Blue Shield of Rhode Island
500 Exchange St, Providence, Rhode Island 02903-2699
(401) 459-1000 | bcbsri.com

BCBSRI Pharmacy Program
October 1, 2024 Formulary Changes

The information below is effective as of October 1, 2024 and applies to all commercial BCBSRI products, including all Large Group and Small Group markets. These changes do not apply to the Blue CHiP for Medicare programs. Any changes to this list are the result of a comprehensive review of relevant clinical information by the BCBSRI Pharmacy and Therapeutics Committee.

Large Group and Small Group Markets Formulary

Brand Name Drugs available with generic equivalents (Excluded from coverage)

For application across all commercial formularies the following Brand-name drugs are now **available with generic equivalents**, as a result the Brand name will be **excluded** from coverage, effective October 1, 2024. The generic equivalent will continue to be covered.

ALREX	**KORLYM**	**RECTIV**
BANZEL	**LAMICTAL**	**SABRIL**
BROMSITE	**MIFEPREX**	**SOMATULINE DEPOT**
CORLANOR	**MYRBETRIQ**	**THIOLA EC**
DEPAKOTE	**NARCAN**	**TOPAMAX**
DUREZOL	**ONFI**	**TRILEPTAL**
ESTROGEL	**ORFADIN**	**TROKENDI XR**
FELBATOL	**PRADAXA**	**VIMPAT**
GABITRIL	**PROLENSA**	**ZONEGRAN**
INDOCIN	**QUDEXY XR**	
KEPPRA		

Brand Name and generic Drugs with available alternatives (Excluded from coverage)

The following generic and Brand-name drugs with preferred alternatives will be **excluded** from coverage, effective October 1, 2024. Request for coverage will require documented medical necessity.

METRONIDAZOLE 375MG CAP	**BROMFENAC SODIUM**
NITISINONE	**VICTOZA**

Generic drug with brand alternative (Excluded from coverage)

Thee following generic drug will be excluded from coverage, effective October 1, 2024. The brand product will be covered effective October 1, 2024.

Excluded from coverage	**Covered brand product**
CYCLOSPORINE OPHTHALMIC EMULSION	**RESTASIS SINGLE DOSE VIALS**

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Prior Authorization

The following drug will now require prior authorization for coverage, effective October 1, 2024.

SCEMBLIX **TYENNE** **ADBRY**

Tier changes

The following products will be moved to a **higher** co-pay tier, effective October 1, 2024. This product will move from Tier 2 to Tier 3 or Tier 3 to Tier 4 on the applicable formulary.

METHYLTESTOSTERONE CAPSULES

Quantity Limits

The following product(s) will now have new or updated quantity limits per prescription based upon standard dosing recommendations effective October 1, 2024.

REXTOVY
FREE LIBRE3 KIT PLUS/SEN
DEXLANSOPRAZOLE CAP DELAYED RELEASE 30 MG