

Effective Date: 04/01/2025

Pharmacy Comprehensive Drug List Change Notice

[Posted 03/01/2025]

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 APRIL 1, 2025			
Therapeutic class	Drug	Revised status	Potential alternatives
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	IPRATROPIUM SOL 0.02%INH	Covered	N/A
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	IPRATROPIUM/ALBUTEROL SOL	Covered	N/A
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	FASENRA INJ 10MG/0.5ML FASENRA INJ 30MG/ML FASENRA PEN INJ 30MG/ML	Covered with PA	N/A
ANTICONSULSANTS	LACOSAMIDE TAB 50MG LACOSAMIDE TAB 100MG LACOSAMIDE TAB 150MG LACOSAMIDE TAB 200MG LACOSAMIDE SOL 10MG/ML	Covered	N/A
ANTICONSULSANTS	VIMPAT TAB 50MG VIMPAT TAB 100MG VIMPAT TAB 150MG VIMPAT TAB 200MG VIMPAT SOL 10MG/ML	Non-Covered / PA Required	Refer to State PDL
ANTIDIABETICS	TRESIBA INJ 100UNIT TRESIBA FLEX INJ 100UNIT TRESIBA FLEX INJ 200UNIT	Covered	N/A
ANTIEMETICS	APREPITANT CAP 40MG APREPITANT CAP 80MG APREPITANT CAP 125MG APREPITANT PAK 125 & 80 MG	Covered	N/A
ANTIEMETICS	EMEND CAP 80MG EMEND SUS 125MG EMEND TRIPAC PAK 125 & 80	Non-Covered / PA Required	Refer to State PDL

www.HealthyBlueSC.com

Healthy Blue is offered by BlueChoice HealthPlan, an independent licensee of the Blue Cross Blue Shield Association.

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ANTI-INFECTIVE AGENTS - MISC.	FIRVANQ SOL 25MG/ML FIRVANQ SOL 50MG/ML	Non-Covered / PA Required	Refer to State PDL
ANTI-INFECTIVE AGENTS - MISC.	VANCOMYCIN SOL 25MG/ML VANCOMYCIN SOL 50MG/ML	Covered	N/A
CARDIOVASCULAR AGENTS - MISC.	ADCIRCA TAB 20MG	Non-Covered / PA Required	Refer to State PDL
CARDIOVASCULAR AGENTS - MISC.	TADALAFIL TAB 20MG	Covered	N/A
GASTROINTESTINAL AGENTS - MISC.	AMITIZA CAP 8MCG AMITIZA CAP 24MCG	Non-Covered / PA Required	Refer to State PDL
GASTROINTESTINAL AGENTS - MISC.	LUBIPROSTONE CAP 8MCG LUBIPROSTONE CAP 24MCG	Covered	N/A
HEMATOPOIETIC AGENTS	ENDARI POW 5GM	Covered with PA	N/A
HEMATOPOIETIC AGENTS	L-GLUTAMINE POW 5GM	Covered with PA	N/A
HEMATOPOIETIC AGENTS	SIKLOS TAB 100MG SIKLOS TAB 1000MG	Covered	N/A
MACROLIDES	DIFICID SUS DIFICID TAB 200MG	Covered	N/A
MEDICAL DEVICES AND SUPPLIES	FREE LIBRE2 KIT PLUS/SENSOR	Covered with PA	N/A
MISCELLANEOUS THERAPEUTIC CLASSES	KIONEX SUS 15GM/60	Covered	N/A
MISCELLANEOUS THERAPEUTIC CLASSES	SPS SUS 15GM/60	Covered	N/A
MISCELLANEOUS THERAPEUTIC CLASSES	VELTASSA POW 1GM VELTASSA POW 8.4GM VELTASSA POW 16.8GM VELTASSA POW 25.2GM	Covered	N/A
OPHTHALMIC AGENTS	LEVOFLOXACIN SOL 1.5%	Non-Covered / PA Required	Refer to State PDL
OPHTHALMIC AGENTS	MOXIFLOXACIN SOL HCL 0.5%	Covered	N/A
OPHTHALMIC AGENTS	OFLOXACIN DRO 0.3% OP	Covered	N/A
OPHTHALMIC AGENTS	VIGAMOX DRO 0.5%	Non-Covered / PA Required	Refer to State PDL

UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN APRIL 1, 2025		
NO CHANGES IN COVERED/NON-COVERED STATUS. REVISION OR ADDITION TO UM EDIT ONLY		
ANTICONVULSANTS	CLOBAZAM TAB 10MG CLOBAZAM TAB 20MG CLOBAZAM SUS 2.5MG/ML	Remove PA

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**.