



Blue Cross Blue Shield of Michigan and Blue Care Network Drug List Updates

Blue Cross and BCN update our drug lists monthly. This document includes recent changes or updates that may not yet be reflected on our drug lists.

Some drugs have letters next to them to indicate which ones may have coverage requirements or limits.

PA	Prior authorization – Your doctor is required to give more information to determine coverage.
ST	Step therapy – Requires you try one or more preferred drugs before a higher-cost medication can be covered.
QL	Quantity limit – The quantity of medication dispensed at one time is limited.
15DS	15-day supply – Limits the amount of certain specialty drugs to a 15-day supply to help reduce out-of-pocket costs and waste.
ABA	Approved brand medication marketed by either the brand company or another company without the brand name on its label. Authorized brand alternatives are drugs that are considered brand-name drugs and don't have generic equivalents. These drugs are the same as the brand-name drugs but are not true generic drugs. The respective brand out-of-pocket cost will apply for these medications. Some authorized brand alternatives may not be covered.

This list is intended as a reference guide. Your drug plan determines how these drugs may be covered. For coverage information specific to your drug benefit, check your plan documents.

For a complete list of drugs and coverage requirements, go to bcbsm.com/pharmacy.

Product Name (Brand Name)	Generic Name	Drug List Status			
		Clinical Drug List	Custom Drug List	Custom Select Drug List	Preferred Drug List
DEXTROAMPHETAMINE SULFATE (Generic ZENZEDI)	DEXTROAMPHETAMINE SULFATE	Generic QL (Brand Zenzedi covered nonpreferred)	Nonpreferred generic QL (Brand Zenzedi covered nonpreferred)	Nonpreferred generic QL (Brand Zenzedi not covered)	Generic QL (Brand Zenzedi not covered)
FILSUVEZ	BIRCH TRITERPENES GEL 10%	Preferred specialty PA; QL	Preferred specialty PA; QL	Preferred specialty PA; QL	Preferred specialty PA; QL
HUMIRA (CORDAVIS manufacturer ONLY)	ADALIMUMAB	Not covered	Not covered	Not covered	Not covered
NITROGLYCERIN OINTMENT 0.4% (Generic RECTIV)	NITROGLYCERIN OINT 0.4%	Generic QL (Brand Rectiv covered nonpreferred)	Nonpreferred generic QL (Brand Rectiv covered nonpreferred)	Nonpreferred generic QL (Brand Rectiv not covered)	Generic QL (Brand Rectiv not covered)
RIVIVE	NALOXONE HCL NASAL SPRAY 3 MG/0.1ML	Preferred brand QL	Preferred brand QL	Preferred brand QL	Preferred brand QL
SOVUNA	HYDROXYCHLOROQUINE SULFATE TAB	Not covered	Not covered	Not covered	Not covered
TIOPRONIN DR (Generic THIOLA EC)	TIOPRONIN TAB DELAYED RELEAS	Generic PA (Brand Thiola EC covered nonpreferred)	Nonpreferred generic PA (Brand Thiola EC covered nonpreferred)	Nonpreferred generic PA (Brand Thiola EC not covered)	Generic PA (Brand Thiola EC not covered)
TRUQAP	CAPIVASERTIB TAB	Preferred specialty PA; QL	Preferred specialty PA; QL	Preferred specialty PA; QL	Preferred specialty PA; QL
ZYMFENTRA	INFLIXIMAB-DYYB SOLN AUTO- INJECTOR KIT	Not covered	Not covered	Not covered	Not covered