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
BUTAL/APAP TAB 25-325MG	BUTALBITAL-ACETAMINOPHEN TAB 25-325 MG	Not covered (Brand Allzital also not covered)	Not covered (Brand Allzital also not covered)	Not covered (Brand Allzital also not covered)	Not covered (Brand Allzital also not covered)
DEXCOM G7 MIS RECEIVER	CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER	Covered $0 PA; QL	Covered $0 PA; QL	Covered $0 PA; QL	Covered $0 PA; QL
DEXCOM G7 MIS SENSOR	CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR	Preferred brand PA; QL	Preferred brand PA; QL	Preferred brand PA; QL	Preferred brand PA; QL
DICHLORPHENA TAB 50MG	DICHLORPHENAMIDE TAB 50 MG	Generic specialty PA; QL	Generic specialty PA; QL	Generic specialty PA; QL	Generic specialty PA; QL
EZETIMIBE-ATORVASTATIN TAB	EZETIMIBE-ATORVASTATIN TAB 10-10 MG, 10-20 MG, 10-40 MG, 10-80MG	Not covered	Not covered	Not covered	Not covered
FENOPROFEN CAP 200MG	FENOPROFEN CALCIUM	Not covered	Not covered	No change (Not covered)	No change (Not covered)
GLOPERBA	COLCHICINE ORAL SOLN	Not covered	Not covered	Not covered	Not covered
IVERMECTIN CREAM 1%	IVERMECTIN	No change	No change	No change	Generic not covered (Brand Soolantra covered at generic copayment)
LUBIPROSTONE CAP	LUBIPROSTONE CAP	Generic (Brand Amitiza covered nonpreferred) QL	Nonpreferred generic (Brand Amitiza covered nonpreferred) QL	Nonpreferred generic (Brand Amitiza not covered) QL	Generic (Brand Amitiza not covered) QL
SOD OXYBATE SOL 500MG/ML (ABA for XYREM)	SODIUM OXYBATE ORAL SOLUTION 500 MG/ML	Nonpreferred specialty PA; QL	Nonpreferred specialty PA; QL	Nonpreferred specialty PA; QL	Not covered
STIMUFEND	PEGFILGRASTIM-FPGK SOLN PREFILLED SYRINGE	Nonpreferred specialty ST; QL	Nonpreferred specialty ST; QL	Nonpreferred specialty ST; QL	Nonpreferred specialty ST; QL

TOPIRAMATE CAP ER 25MG, 50MG, 100MG	TOPIRAMATE CAP ER 24HR	Generic PA; QL	Nonpreferred generic PA; QL	Not covered	Generic PA; QL
XACIATO GEL 2%	CLINDAMYCIN PHOSPHATE VAGINAL GEL 2%	Not covered	Not covered	Not covered	Not covered