PREMERA HMO

An Independent Licensee of the Blue Cross Blue Shield Association

Essentials E4 HMO Formulary Drug Changes

UPCOMING CHANGES Effective 01-01-2027

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, we may make changes to the formulary. For example, we may:

- Add or remove drugs from the formulary
- Move a drug to a higher or lower cost-sharing tier
- Add or remove a restriction on coverage for a drug
- Replace a brand name drug with a generic drug

HMO Drug List Changes

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., JANUVIA) and generic drugs are listed in lower-case italics (e.g., metformin oral tablet).

The following drugs will be removed from the Premera Blue Cross Essentials E4-HMO Formulary.

Name of Affected Drug	Reason for Change	Alternative Drug
ADALIMUMAB-ADBM(CF)	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
ADALIMUMAB-ADBM(CF)PEN	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
ADALIMUMAB-RYVK(CF)	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
ADALIMUMAB-RYVK(CF) AUTOINJECT	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
AURYXIA TABLETS	No longer covered	ferric citrate
BOSULIF TABLETS	No longer covered	bosutinib

cyclosporine capsules	Moving to Non-Preferred	Talk with your prescriber about alternatives
diltiazem 24hr er (la) er tablets	Moving to Non-Preferred	diltiazem ER capsule
GLEOSTINE CAPSULES	No longer covered	lomustine capsule
JANUMET XR TABLETS	No longer covered	sitagliptin-metformin ER, saxagliptin-metformin ER
JARDIANCE	No longer covered	dapagliflozin
JENTADUETO	No longer covered	sitagliptin/metformin, sitagliptin, saxagliptin, metformin
JENTADUETO XR	No longer covered	sitagliptin/metformin ER, saxagliptin/metformin ER
kiprofen capsules	No longer covered	ketoprofen 50 mg capsule, naproxen, sulindac
matzim la er tablets	Moving to Non-Preferred	diltiazem ER capsule
methscopolamine bromide tablets	Moving to Non-Preferred	glycopyrrolate tablet, hyoscyamine sulfate tablet
olopatadine hcl drops	Moving to Non-Preferred	azelastine ophthalmic drops
ondansetron hcl vial	No longer covered	ondansetron oral tablet, ondansetron ODT
ribavirin vial	No longer covered	Talk with your prescriber about alternatives
SIMLANDI(CF)	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
SIMLANDI(CF) AUTOINJECTOR	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
sirolimus tablets	Moving to Non-Preferred	Talk with your prescriber about alternatives
SITAGLIPTIN	No longer covered	sitagliptin, saxagliptin
SITAGLIPTIN-METFORMIN	No longer covered	sitagliptin/metformin, sitagliptin, saxagliptin, metformin
SITAGLIPTIN-METFORMIN ER	No longer covered	sitagliptin/metformin ER, saxagliptin/metformin ER
SPRITAM TABLETS FOR SUSPENSION	No longer covered	levetiracetam oral solution, levetiracetam tablet
SYNJARDY	No longer covered	dapagliflozin, metformin
SYNJARDY XR	No longer covered	dapagliflozin/metformin ER
TRADJENTA	No longer covered	sitagliptin, saxagliptin
travoprost drops	Moving to Non-Preferred	latanoprost 0.005% eye drops, bimatoprost 0.03% eye drops

verapamil er pm er capsules	Moving to Non-Preferred	verapamil ER
XIGDUO XR	No longer covered	dapagliflozin/metformin ER
YUFLYMA(CF)	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
YUFLYMA(CF) AI CROHN'S-UC-HS	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
YUFLYMA(CF) AUTOINJECTOR	No longer covered	adalimumab-aaty (CF), adalimumab-adaz (CF), adalimumab-adbm (CF)
ZITUVIMET	No longer covered	sitagliptin/metformin, sitagliptin, saxagliptin, metformin
ZITUVIMET XR	No longer covered	sitagliptin/metformin ER, saxagliptin/metformin ER
ZITUVIO	No longer covered	sitagliptin, saxagliptin

If your prescriber believes that the alternative drugs listed above are not right for you due to your medical condition, you may request an exception to our formulary. To file a request, you may contact us by telephone at 844-261-1756 or fax your request to 888-260-9836. You may also make your request via mail by sending your request to: Premera Blue Cross HMO, P.O. Box 327, Seattle, WA 98111. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception.

If you disagree with our decision to make the above formulary changes, you may file a grievance by calling customer service or notifying us in writing. See Chapter 9 of your Evidence of Coverage for instructions.

This information is not a complete description of benefits. Call Customer Service at 844-722-4661 (TTY/TDD: 711) for more information. Limitations, copayments, and restrictions may apply. Copayments and/or co-insurance may change on January 1 of each year. This is not a complete list of drugs covered by our plan. For a complete listing, please call customer service or visit premera.com. The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary.