PREMERA HMO

An Independent Licensee of the Blue Cross Blue Shield Association

Essentials E4 HMO Formulary Drug Changes

UPCOMING CHANGES Effective 10-01-2026

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
ATROVENT HFA	No longer covered	ipratropium bromide hfa inhaler
ASTAGRAF XL CAPSULES	No longer covered	tacrolimus capsules
bimatoprost 0.01% eye drops	Moved to Tier 4 (non-preferred)	bimatoprost 0.03% eye drops
BRIVIACT SOLUTION	No longer covered	brivaracetam solution
BRIVIACT VIALS	No longer covered	brivaracetam vials
BRIVIACT TABLETS	No longer covered	brivaracetam tablets
EDURANT TABLETS	No longer covered	rilpivirine tablets
FANAPT TABLETS	No longer covered	aripiprazole tablet, olanzapine tablet, paliperidone tablet

FARXIGA TABLETS	No longer covered	dapagliflozin capsules
Hydrocortisone AC Suppositories	Moved to Tier 4 (non-preferred)	hydrocortisone AC 25 mg suppositories
JANUMET TABLETS	No longer covered	sitagliptin phosphate/ metformin tablets
JANUVIA TABLETS	No longer covered	sitagliptin phosphate tablets
OFEV CAPSULES	No longer covered	nintedanib esylate capsules
OPSUMIT TABLETS	No longer covered	bosentan tablet, ambrisentan tablet
phytonadione vials	No longer covered	phytonadione tablet
phytonadione ampules	No longer covered	phytonadione tablet
POMALYST CAPSULES	No longer covered	pomalidomide capsules
QTERN TABLETS	No longer covered	dapagliflozin/saxagliptin tablets
SAVELLA TABLETS	No longer covered	milnacipran tablets
STEQEYMA VIALS	Covered under the medical benefit only	STEQEYMA VIALS
vitamin K ampules	No longer covered	phytonadione tablet
XELJANZ TABLETS	No longer covered	tofacitinib citrate tablets
XELJANZ SOLUTION	No longer covered	tofacitinib citrate solution
XELJANZ XR TABLETS	No longer covered	tofacitinib citrate ER tablets
XIGDUO XR TABLETS	No longer covered	dapagliflozin/metformin ER tablets
XYREM SOLUTION	No longer covered	sodium oxybate solution
YESINTEK VIALS	Covered under the medical benefit only	
ZEPBOUND VIALS	No longer covered	ZEPBOUND PENS

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.