BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Health Choice

2026 Formulary Changes – Year to Date

Blue Cross Blue Shield Arizona Health Choice may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, and/or move a drug at a higher cost-sharing tier, we will notify you of the change at least 30 days before the date that the change becomes effective. However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary.

This table shows drugs that have been removed from the 2026 Blue Cross Blue Shield Arizona Health Choice Arizona Formulary.

Name of Drug	Description of Change	Alternative Drug	Effective Date
BRAND ENTRESTO TABLETS	Remove from formulary	SACUBITRIL-VALSARTAN TABLETS (Generic Entresto)	1/1/2026
BRAND PROTONIX PACKETS	Remove from formulary	PANTOPRAZOLE PACKETS (Generic Protonix)	1/1/2026
CALCIUM ACETATE 667MG (Rx)	Remove from formulary	CALCIUM ACETATE 667MG (OTC)	1/1/2026
PERAMPANEL TABLETS (generic FYCOMPA)	Remove from formulary	BRAND FYCOMPA TABLETS	1/1/2026
BRAND CARBATROL CAPSULES	Remove from formulary	CARBAMAZEPINE ER CAPSULES (generic Carbatrol)	1/1/2026
BRAND BANZEL TABLETS	Remove from formulary	RUFINAMIDE TABLETS (generic Banzel)	1/1/2026
CODEINE SULFATE TABLETS	Remove from formulary	OXYCODONE TABLETS, MORPHINE SULFATE TABLETS	1/1/2026
OXYCODONE CAPSULES	Remove from formulary	OXYCODONE TABLETS	1/1/2026
HYDROCOD/IBUPROFEN TABLET 10-200MG	Remove from formulary	HYDROCOD/IBUPROFEN TABLET 7.5-200MG	1/1/2026

OXYMORPHONE TABLETS	Remove from formulary	OXYCODONE TABLETS, MORPHINE SULFATE TABLETS	1/1/2026
ASPIRIN/CODEINE CAPSULES	Remove from formulary	ACETAMINOPHEN/CODEINE TABLETS	1/1/2026
HYDROMORPHONE LIQUID	Remove from formulary	MORPHINE LIQUID	1/1/2026
ZOMIG NASAL SPRAY	Remove from formulary	SUMATRIPTAN NASAL SPRAY	1/1/2026
TOPIRAMATE SPRINKLE CAPSULES	Remove from formulary	TOPIRAMATE TABLETS	1/1/2026
TOLNAFTATE SOLN 1%	Remove from formulary	CLOTRIMAZOLE SOLN 1%	1/1/2026
ZIOPTAN DROPS	Remove from formulary	BIMATOPROST 0.03% EYE DROPS, LATANOPROST 0.005% EYE DROPS, TRAVOPROST 0.004% EYE DROP	1/1/2026
TAFLUPROST SOLUTION	Remove from formulary	BIMATOPROST 0.03% EYE DROPS, LATANOPROST 0.005% EYE DROPS, TRAVOPROST 0.004% EYE DROP	1/1/2026
BRAND ALPHAGAN P SOLUTION	Remove from formulary	BRIMONIDINE SOLUTION (Generic Alphagan P)	1/1/2026
PILOCARPINE OPTH SOLUTION	Remove from formulary		1/1/2026
AFTERA TABLET	Remove from formulary	MY CHOICE TABLET, NEW DAY OTC TABLET, OPTION 2 TABLET	1/1/2026
CURAE TABLET	Remove from formulary	MY CHOICE TABLET, NEW DAY OTC TABLET, OPTION 2 TABLET	1/1/2026
HER STYLE TABLET	Remove from formulary	MY CHOICE TABLET, NEW DAY OTC TABLET, OPTION 2 TABLET	1/1/2026
ECONTRA OS TABLET	Remove from formulary	MY CHOICE TABLET, NEW DAY OTC TABLET, OPTION 2 TABLET	1/1/2026
LEVONORGESTR TAB 1.5MG	Remove from formulary	MY CHOICE TABLET, NEW DAY OTC TABLET, OPTION 2 TABLET	1/1/2026

FEMLYV TABLET 1/0.02MG	Remove from formulary	ALYACEN, AUROVELA, BALZIVA, BRIELLYN, DASETTA, HAILEY, JUNEL, LARIN, MICROGESTIN, NECON, NORETHINDRON-ETHINYL ESTRADIOL, NORTREL, NYLIA, PHILITH, WERA	1/1/2026
GEMMILY CAPSULE	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026
MERZEE CAPSULE	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026
NORE/ETH/FER CAP 1/20	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026
TAYSOFY CAPSULE	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026

CHARLOTTE 24 CHEWABLE TABLET	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026
FINZALA CHEWABLE TABLET	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026
MIBELAS CHEWABLE TABLET	Remove from formulary	AUROVELA 24 FE, AUROVELA FE, BLISOVI 24 FE, BLISOVI FE, HAILEY 24 FE, HAILEY FE, JUNEL FE, JUNEL FE 24, KAITLIB FE, LARIN 24 FE, LARIN FE, MICROGESTIN FE, NORETHINDRONE/ETHINYL ESTRADIOL FE MONOPHASIC (GENERESS FE), TARINA 24 FE, TARINA FE 1-20 EQ, TILIA FE	1/1/2026
ARANELLE TABLET	Remove from formulary	ALYACEN, AUROVELA, BALZIVA, BRIELLYN, DASETTA, HAILEY, JUNEL, LARIN, MICROGESTIN, NECON, NORETHINDRON-ETHINYL ESTRADIOL, NORTREL, NYLIA, PHILITH, WERA	1/1/2026
LEENA TABLET	Remove from formulary	ALYACEN, AUROVELA, BALZIVA, BRIELLYN, DASETTA, HAILEY, JUNEL, LARIN, MICROGESTIN, NECON, NORETHINDRON-ETHINYL ESTRADIOL, NORTREL, NYLIA, PHILITH, WERA	1/1/2026
BRAND DETROL, DETROL LA	Remove from formulary	Generic TOLTERODINE, TOLTERODINE ER	4/1/2026

BRAND TOVIAZ	Remove from formulary	Generic FESOTERODINE ER	4/1/2026
PROLIA	Remove from preferred list	BILDYOS	4/1/2026
XGEVA	Remove from preferred list	BILDYOS	4/1/2026
GLYBYRIDE-METFORMIN TABLETS (combination product)	Remove from formulary	Separate GLYBURIDE, METFORMIN tablets	4/1/2026
LENALIDOMIDE	Remove from formulary	BRAND REVLIMID	4/1/2026
IMBRUVICA TABLET	Remove from formulary	IMBRUVICA CAPSULE, SUSPENSION	4/1/2026
CIPRO HC OTIC	Remove from formulary	CIPROFLOXACIN/DEXAMETHASONE OTIC, NEOMYCIN/POLYMYXIN/HC SOLN/SUSP OTIC	4/1/2026
BRAND PROMACTA TABLET	Remove from formulary	Generic ELTROMBOPAG tablet	4/1/2026
LUPRON DEPOT 6-MONTH; LUPRON DEPOT PEDIATRIC 3-MONTH/6-MONTH	Remove from formulary	FENSOLVI	4/1/2026
BRAND COPAXONE	Remove from formulary	Generic Glatiramer	5/1/2026
BRAND SYMFI	Remove from formulary	Generic Efavir/Lamiv/Tenofivir	5/1/2026
BRAND TRACLEER	Remove from formulary	Generic Bosentan	5/1/2026
AIRDUO RESPICLICK	Remove from formulary	Generic Fluticasone/Salmeterol	5/1/2026
BRAND ROZEREM	Remove from formulary	Generic Ramelteon	5/1/2026
METHYLIN SOLUTION	Remove from formulary	Generic Methylphenidate	5/1/2026
BRAND BRILINTA	Remove from formulary	Generic Tigacrelor	8/1/2026
EXENATIDE	Remove from formulary	Brand Byetta, Trulicity, Victoza, Liraglutide, Mounjaro	10/1/2026

PERSERIS	Remove from formulary	UZEDY, RISPERDAL CONSTA, INVEGA, ARISTADA, ABILIFY	10/1/2026
TUDORZA	Remove from formulary	INCRUSE ELLIPTA	10/1/2026
YESINTEK (biosimilar Stelara)	Remove from formulary	STARJEZMA (biosimilar Stelara)	10/1/2026
OCREVUS	Remove from formulary	AVONEX, BRIUMVI, DALFAMPRIDINE, DIMETHYL FUMARATE, FINGOLIMOD, KESIMPTA, TYSABRI, TERIFLUNOMIDE, REBIF, GLATIRAMER	10/1/2026
VYVANSE (Brand)	Remove from formulary	Generic LISDEXFETAMINE	10/1/2026

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This table outlines the positive changes to our formulary that may impact you.

Name of Drug	Description of Change	Drug Coverage	Effective Date
POSACONAZOLE TABLETS	Add to Formulary	PA required	1/1/2026
HEMANGEOL SOL	Add to Formulary	PA required	1/1/2026
BENAZEPRIL/HCTZ TABLETS	Add to Formulary		1/1/2026
AMLODIPINE BESYLATE-VALSARTAN TABLETS	Add to Formulary		1/1/2026
AURYXIA TABLETS	Add to Formulary	PA required	1/1/2026
LANTHANUM CHEWABLE TABLETS	Add to Formulary		1/1/2026
BRIVIACT TABLETS/SOLUTION	Add to Formulary	PA required	1/1/2026
ZONISADE SUSPENSION	Add to Formulary	PA required	1/1/2026
PANTOPRAZOLE PACKETS (Generic Protonix)	Add to Formulary		1/1/2026
CALCIUM ACETATE 667MG (OTC)	Add to Formulary		1/1/2026
ZAFEMY PATCH	Add to Formulary		1/1/2026
ELURYNG	Add to Formulary		1/1/2026
ENILLORING	Add to Formulary		1/1/2026
HALOETTE	Add to Formulary		1/1/2026
NYLIA TABLET 1/25	Add to Formulary		1/1/2026
DROS/ETH EST LEVOMEFO TABLET	Add to Formulary		1/1/2026

TILIA FE	Add to Formulary		1/1/2026
NORETH/ETHIN FE TABLET	Add to Formulary		1/1/2026
SOLIFENACIN	Add to Formulary		2/15/2026
FESOTERODINE ER	Add to Formulary		2/15/2026
DESVENLAFAXINE ER (generic PRISTIQ)	Add to Formulary	Quantity Limit of 1 per day	2/15/2026
BILDYOS (biosimilar Prolia)	Add to Formulary	PA required; Bill to Medical	4/1/2026
REVLIMID	Add to Formulary	PA required	4/1/2026
YUTREPIA	Add to Formulary	PA required	4/1/2026
ELTROMBOPAG TABLET	Add to Formulary	PA required	4/1/2026
HAEGARDA	Add to Formulary	PA required	4/1/2026
FENSOLVI 6-MONTH KIT	Add to Formulary	PA required	4/1/2026
CUTAQUIG	Add to Formulary	PA required; Bill to Medical	4/1/2026
GAMMAPLEX	Add to Formulary	PA required; Bill to Medical	4/1/2026
DICLOFENAC SOL 1.5%	Add to Formulary	PA required	4/1/2026
VYSCOXA SUS 10MG/ML	Add to Formulary	PA required for age <2 or >10	4/1/2026
GLATIRAMER 40 MG/ML SYRINGE	Add to Formulary	PA required	5/1/2026
EFAVIR-LAMIV-TENOF 600-300-300	Add to Formulary		5/1/2026
BOSENTAN 32 MG TABLET	Add to Formulary	PA required	5/1/2026
FLUTICASONE-SALMETEROL 55-14, 113-14, 232-14	Add to Formulary	No PA required for FDA approved ages	5/1/2026

RAMELTEON 8 MG TABLET	Add to Formulary	PA required	5/1/2026
METHYLPHENIDATE SOLN	Add to Formulary	No PA required for ages greater than 6; Quantity Limit applies	5/1/2026
INSULIN GLARGINE-YFGN (select NDCs)	Add to Formulary		8/1/2026
DEFLAZACORT	Add to Formulary	PA required	8/1/2026
TOFIDENCE	Add to Formulary	PA required	8/1/2026
AVTOZMA	Add to Formulary	PA required	8/1/2026
TICAGRELOR	Add to Formulary		8/1/2026
MOUNJARO	Add to Formulary	PA required	9/1/2026
AJOVY	Add to Formulary	PA required	9/1/2026
PALIPERIDONE ER TABLETS	Add to Formulary	QL of 1 tablet daily	9/1/2026
VRAYLAR	Add to Formulary	PA required	9/1/2026
INCRUSE ELLIPTA	Add to Formulary		9/1/2026
STARJEZMA (biosimilar Stelara)	Add to Formulary	PA required	9/1/2026
PRUCALOPRIDE	Add to Formulary	PA required	9/1/2026
SOGROYA	Add to Formulary	PA required	10/1/2026
MYFEMBREE	Add to Formulary	PA required	10/1/2026
ORIAHNN	Add to Formulary	PA required	10/1/2026
TETRABENAZINE	Add to Formulary	PA required	10/1/2026

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EFFECTIVE 10/1/22, BLUE CROSS BLUE SHIELD ARIZONA HEALTH CHOICE USES AHCCCS FFS PRIOR AUTHORIZATION CRITERIA. PLEASE VISIT https://www.azahcccs.gov/PlansProviders/Pharmacy/ **FOR A COPY OF ALL CURRENT PA CRITERIA.**