

Pharmacy Policy Bulletin

Title: Nonformulary Medication Copay Exception Requests

Policy #: Rx.01.61

Application of pharmacy policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Some medications may be subject to precertification, age, gender or quantity restrictions. Individual member benefits must be verified.

This pharmacy policy document describes the status of pharmaceutical information and/or technology at the time the document was developed. Since that time, new information relating to drug efficacy, interactions, contraindications, dosage, administration routes, safety, or FDA approval may have changed. This Pharmacy Policy will be regularly and updated as scientific and medical literature becomes available. This information may include new FDA-approved indications, withdrawals, or other FDA alerts. This type of information is relevant not only when considering whether this policy should be updated, but also when applying it to current requests for coverage.

Members are advised to use participating pharmacies in order to receive the highest level of benefits.

▶ Intent:

The Select Drug Program® Formulary offers drug coverage through a three-tiered cost-share structure: generic formulary, brand preferred formulary, and brand non-preferred formulary. It is the intent of FutureScripts® to ensure that there are sufficient formulary alternatives for non-preferred agents when possible. Members who participate in the Select Drug Program Formulary may request non-preferred formulary medications be covered at the formulary benefit level. These requests are evaluated to determine if all or an approved list of formulary alternatives from the FutureScripts® Pharmacy and Therapeutics Committee has been tried. Prior authorization is required for the use of non-preferred formulary medications at the formulary benefit level. FutureScripts® is an independent company that provides pharmacy benefit management services.

▶ Description:

N/A

▶ Policy:

Inclusion criteria for the use of non-formulary medications at the formulary benefit level include all of the following:

- Documentation of a trial and failure, allergy or contraindication to at least three (when available) preferred formulary alternative(s) in the same drug class

Authorization requires review by a clinical pharmacist and/or a Medical Director. Approved requests are authorized to pay at the appropriate formulary cost-share.

In the absence of an approved list (see Policy List of Applicable Drugs), all formulary alternatives will be required. Approved formulary alternatives will be added to the Policy List of Applicable Drugs.

▶ Guidelines:

Refer to the specific manufacturer's prescribing information for administration and dosage details and any applicable Black Box warnings.


BENEFIT APPLICATION

Subject to the terms and conditions of the applicable benefit contract, the applicable drug(s) identified in this policy is (are) covered under the pharmacy benefits of the Company's products when the medical necessity criteria listed in this pharmacy policy are met. Any services that are experimental/investigational or cosmetic are benefit contract exclusions for all products of the Company.

▶ References:

N/A

Applicable Drugs:

 Inclusion of a drug in this table does not imply coverage. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and Company policies apply.

DRUG	AGENTS TO BE TRIED
Xyzal®	All of the following:
	A loratadine-containing product
	A cetirizine-containing product
	A fexofenadine-containing product
Clarinex®	For individuals 2 years of age or older, all of the following:
	A loratadine-containing product
	A cetirizine-containing product
	A fexofenadine-containing product
	For individuals less than 2 years of age, all of the following:
	A cetirizine-containing product
A fexofenadine-containing product	
Clarinex® Syrup (For individuals requiring a liquid)	For individuals 2 years of age or older, all of the following:
	Loratadine syrup
	Cetirizine syrup
	For individuals less than 2 years of age:
Cetirizine syrup	
Allegra® (Brand name)	For individuals 2 years of age or older, all of the following:
	A loratadine-containing product
	A cetirizine-containing product
	A generic fexofenadine-containing product
	For individuals less than 2 years of age, all of the following:
	A cetirizine-containing product
A generic fexofenadine-containing product	
Allegra® Syrup	For individuals 2 years of age or older, all of the following:
(For individuals	Loratadine syrup

requiring a liquid)	
	Cetirizine syrup
	For individuals less than 2 years of age:
	Cetirizine syrup
Allegra-D® or Clarinex-D®	All of the following:
	A loratadine-containing product
	A cetirizine-containing product

CRITERIA FOR NONFORMULARY MEDICATION COPAY EXCEPTION REQUESTS FOR EFFEXOR XR®

DRUG	AGENTS TO BE TRIED:
Effexor XR	Use of all of the following: Bupropion SR/XL AND
	Any two of the following agents: Sertraline Fluoxetine Citalopram Paroxetine Escitalopram/(Lexapro®)

CRITERIA FOR NONFORMULARY COPAY EXCEPTION REQUESTS FOR NON-PREFERRED DIABETIC TEST STRIPS

PRODUCT	AGENTS TO BE TRIED
Non-preferred diabetic test strips	Trial/failure/contraindication with all of the following:
	Ascensia® Autodisc™ Test Strips
	Ascensia® Breeze® 2 Test Strips
	Ascensia® Contour® Test Strips
	Freestyle® Lite™ Test Strips
	Freestyle® Test Strips
	Precision Xtra® Test Strips

CRITERIA FOR NONFORMULARY COPAY EXCEPTION REQUESTS FOR NON-PREFERRED INSULINS

PRODUCT	AGENTS TO BE TRIED
Non-Preferred Insulins	Trial/failure/contraindication with one of the following:
	Novolin N
	Novolin R
	Novolin 70/30
	Novolog
	Novolog Mix 70/30

This is not an all inclusive list. All applicable drugs are not listed.

▸ Cross References:

Age Edits for Pharmaceuticals Covered Under the Pharmacy Benefit

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