

Policies Repository



Policy Title Nonformulary Medication Copay Exception Requests

Policy Number FS.CLIN.4

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 edits. 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. If the Medical/Pharmacy Reviewer is aware of any new information on the subject of this document, please provide it promptly to the Medical/Pharmacy Policy Department. 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.

Policy The Select Drug Program® Formulary offers drug coverage through a three-tiered copay 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.

Policy Description N/A

Policy Guideline Inclusion Inclusion criteria for the use of nonformulary medications at the formulary benefit level include one of the following:

- An allergy or contraindication to all current or approved formulary alternative(s)
- A trial and failure or inappropriate clinical response to all current or approved formulary alternative(s)

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

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.

Policy Guideline Exclusion

Exclusion criteria for the use of nonformulary medications at the formulary benefit level include one of the following:

- No documentation of an allergy or contraindication to all current or approved formulary alternative(s)
- No documentation of a trial and failure or an inappropriate clinical response to all current or approved formulary alternative(s)

If the request is denied, the member will still be able to receive the medication at the non-formulary copay.

Policy List of Applicable Drugs

CRITERIA FOR NONFORMULARY MEDICATION COPAY EXCEPTION REQUESTS FOR NONSEDATING ANTIHISTAMINES FEXOFENADINE (ALLEGRA®), (ALLEGRA D®); LEVOCETIRIZINE (XYZAL®); AND DESLORATADINE (CLARINEX®), (CLARINEX-D®)

DRUG	AGENTS TO BE TRIED
Xyzal®	All of the following:
	A loratadine-containing product
	A cetirizine-containing product
Clarinex®	A fexofenadine-containing product
	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	
Clarinex® Syrup (For individuals requiring a liquid)	A fexofenadine-containing product
	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	
	For individuals 2 years of age or older, all of the following:
	A loratadine-containing

Allegra® (Brand name)	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
Allegra® Syrup	A generic fexofenadine-containing product
	For individuals 2 years of age or older, all of the following:
(For individuals requiring a liquid)	Loratadine syrup
	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
	Trial/failure/contraindication with all of the following:

Non-preferred diabetic test strips	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

Dosing and Administration Refer to the specific manufacturer's prescribing information for administration and dosage details for each specific agent.

Policy References N/A

Policy Link to Related Policies

Printed 09/07/2010 16:28:01

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