

BCBSNM Drug List 2008

Limitations, Exclusions, and Prior Authorization Criteria



Blue Cross and Blue Shield
of New Mexico

The BCBSNM Pharmacy Benefit provides coverage of most drugs for our members. Effective communication about specific drug limitations is important for consistent benefit administration and customer satisfaction. The following information includes the drug limitations, exclusions, and prior authorization criteria for most BCBSNM pharmacy plans.

I. Drug Limitations

- A1. BCBSNM 3-Tier and 4-Tier Prescription Drug Plans:** 30-day supply or 120 units, whichever is less per copay at retail pharmacies; or 90-day supply or 360 units, whichever is less per two or two-and-a-half retail copays at mail-order (depending on plan).
- A2. 25/50 Percent Prescription Drug Plan:** 30-day supply or up to 180 units, whichever is less per copay at retail pharmacies; or 90-day supply or up to 540 units, whichever is less per two retail copays at mail-order.
- B. Specialty Pharmacy Program:** Specialty medications are used to treat serious or chronic conditions such as multiple sclerosis, pulmonary hypertension, hepatitis, rheumatoid arthritis and some oral cancer therapies. Most medications are injectable and can be administered by a patient or family member. Specialty medications are dispensed by a specialty pharmacy provider and limited to a 30-day supply. For plans participating in the Specialty Pharmacy Program, specialty medications may be covered under a 4th tier benefit. Please see your Prescription Drug Plan Rider or Benefit Summary for details, including which copayment or coinsurance applies for these medications. All Specialty Pharmacy drugs require prior authorization. See the [Specialty Pharmacy Program](#) brochure for a listing of specialty drugs.
- C. Step Therapy:** Requires a generic drug within the same drug class be tried and failed before a branded product may be utilized:
- Generic cholesterol lowering drugs (simvastatin, lovastatin, pravastatin) before the branded drug products (Lipitor[®], Lescol[®], Crestor[®])
 - Generic antidepressants (bupropion, paroxetine, fluoxetine, citalopram) before the branded drug products (Cymbalta[®], Effexor XR[®], Lexapro[®])
- D. Drug-specific quantity limits** are identified on the Dispensing Limit (DL) list below. Requests for larger quantities are referred to the BCBSNM Health Services Department for review.

Legend

- F Tier 2 copay applies
 NF Tier 3 copay applies
 * Not available through mail-order

Drug	DL	Notes
Abilify	30/30 days	NF
Aldara	12 (1 box)/21 days for 16 weeks	F*
Alinia	60 ml/30 days	NF
Ambien	30/30 days	NF
Ambien CR	30/30 days	NF
Amerge 1mg, 2.5mg	9/30 days	NF
Axert 6.25mg, 12.5mg	12/30 days	NF
Anzement	6/30 days	NF
Boniva	1/30 days	NF
Celebrex	60/30 days	NF
Cipro XR 500mg & 1g	3/30 days	NF*
Crestor	30/30 days	F
Diflucan (fluconazole) (all strengths)	14/30 days	F
DHE-45 150mg	10/30 days	NF
Duragesic	10/30 days	NF
Emend	12/30 days	NF*
EMLA	30gm tube/60 days	F
Exubera	270 units/30 days	NF
Fragmin	30/90 days	NF*
Frova	18/30 days	NF
Imitrex Inj Kits	3/30 days	NF
Imitrex Inj Vials	6/30 days	NF
Imitrex Nasal 5mg	1 x 1 pack of 6/30 days	NF
Imitrex Nasal 20mg	1 x 1 pack of 6/30 days	NF
Imitrex Tabs	18/30 days	NF
Kytril	15/30 days	F
Lovenox	30/90 days	F*
Lunesta	30/30 days	NF
Maxalt, Maxalt MLT	12/30 days	F
Migranal NS	2 x 1 pack of 4/30 days	NF
Namenda 5 mg	30/30 days	NF
Namenda 10 mg	60/30 days	NF
Namenda Titration Pak	49 (1 Pak) 365 days	NF
Plan B	4/year	NF
Prilosec (omeprazole)10 mg	30/30 days	F
Provigil	30/30 days	NF
Regranex	15/30 days	F*
Relenza	2 treatments (40 disks)/year	NF*
Relpax	12/30 days	NF
Revia	180/360 days	F
Rozerem	30/30 days	NF
Sonata	30/30 days	NF
Stadol NS	6ml (2 bottles)/30 days	F
Tamiflu	2 treatments (20 caps)/year	NF*
Toradol 10mg Tabs	20/30 days	NF
Ultram	240/30 days	NF
Ultram ER	30/30 days	NF
Xanax XR	60/30 days	NF

Drug	DL	Notes
Xopenex HFA	30 units/30 days	NF
Zithromax 250mg	12/30 days	F
Zofran	15/30 days	F
Zomig, Zomig ZMT 2.5mg	12/30 days	F
Zomig, Zomig ZMT 5mg	6/30 days	F
Zyvox Susp	150 ml/180 days	NF
Zyvox tabs	20/180 days	NF

II. Drug Exclusions

Certain classes of medications may be excluded from the benefit and therefore are not covered. Examples of common exclusions are:

A. Drugs used for smoking cessation (Note: Prior authorization is required for plans covering smoking cessation programs)

1. Zyban
2. Bantron
3. Nicorette and Nicorette DS gum
4. Habitrol patch
5. Nicoderm patch
6. Nicotrol patch, inhaler, and spray
7. Prostep
8. Wellbutrin (Also used for depression – see Step Therapy Criteria, III.A.44)
9. Chantix

B. Drugs used for weight loss

1. Meridia (sibutramine)
2. Pondimin (fenfluramine)
3. Ionamin, Adipex-P, or Fastin (phentermine)
4. Mazanor or Sanorex (mazindol)
5. Didrex (benzphetamine)
6. Adipost (phendimetrazine)
7. Tenuate (diethylpropion)
8. Xenical (orlistat)

C. Drugs used to treat erectile dysfunction

1. Viagra
2. Caverject
3. MUSE
4. EDEX
5. Levitra
6. Cialis

D. Drugs used to treat infertility

1. Antagon (ganirelix)
2. Lutrepulse (gonadorelin)
3. Profasi or Pregnyl (HCG)
4. Follistim (follitropin beta)
5. Gonal-F (follitropin alfa)

6. Fertinex (urofollitropin)
7. Pergonal or Humegon (menotropins)
8. Clomid or Serophene (clomiphene)

E. Drugs used to treat hair loss

1. Propecia
2. Rogaine

F. Drugs considered cosmetic

1. Renova (tretinoin)
2. Vaniqa (eflornithine)
3. Hydroquinone

G. Drugs considered investigational

H. Drugs for international travel

I. Compounded Medications (coverage varies by plan)

III. Drug Prior Authorization

Contact the BCBSNM Health Services Department for drug prior authorization. Changes to the prior authorization list are published in the *BLUE Review* newsletter, and posted on the website.

BCBSNM allows for certain off-label uses of drugs when the off-label use has reputable medical literature supporting its safe and effective use. BCBSNM uses the following criteria in evaluating off-label medication use:

- Drug must be approved by the FDA for at least one indication
- Drug must be prescribed by a participating licensed health care provider within scope of practice
- With most benefits, drugs in clinical phase 1 or 2 trials are considered experimental and therefore not a covered benefit

Note: Not all medication requiring prior authorization may appear on this list. Many plans have “global” restrictions on such things as injectable products. Refer these types of requests to Health Services.

Note: For all medications on the preauthorization list:

- Hypersensitivity to any of the medications is a contraindication for use
- Inclusion in the list by itself does not imply that the drug listed will be approved
- Uses other than those defined in the criteria must meet the BCBSNM criteria for approval of new technologies and off-label use

A. Medications Requiring Prior Authorization

1. Actiq (fentanyl citrate)

- a. Pain control for oncology patients **ONLY**

Duration: 6 months (quantity limited to 120 units per month)

2. Byetta (exenatide)

- a. Type 2 Diabetes and
- b. Adjunct therapy with TZD and/or metformin and/or sulfonylureas (Not insulin)
- c. A1C >7

Duration: 1 year

3. Celebrex (celecoxib) Step Therapy Criteria

- a. Age 50 years old or greater or
- b. 30-day trial of one generic NSAID in the last 180 days or
- c. Currently on GI, steroid, or anticoagulant therapy

Duration: 12 months

4. Copaxone (glatiramer), Rebif, Avonex (interferon beta-1a), or BetaSeron (Interferon Beta-1b)

- a. Diagnosis of relapsing, remitting multiple sclerosis (RRMS only)

Duration: 6 months initially

5. Enteral Feeding Products (Nutritional Supplements)

- a. Nonprescription enteral nutritional products and special medical foods only when:
 - Delivered by a medically necessary enteral access tube that has been surgically placed (e.g., gastrostomy, jejunostomy) or
 - Meeting the definition of special medical foods used to treat and to compensate for the metabolic abnormality of persons with genetic inborn errors of metabolism in order to maintain their adequate nutritional status
 - Benefits are limited to the purchase of a 30-day supply during any 30-day period and are subject to coinsurance. (Most BCBSNM Plans cover 50%)

Duration: 1 year

6. Enbrel (etanercept)

- a. Documented diagnosis of moderate to severe rheumatoid arthritis, psoriatic arthritis, psoriasis or ankylosing spondylitis.
- b. Therapeutic failure of adequate trial of at least one of the following:
 - Plaquenil (hydroxychloroquine)
 - Solganal or Ridaura (gold)
 - Methotrexate
 - Imuran (azathioprine)
 - Cuprimine (penicillimine)
 - Azulfidine (sulfasalazine)
 - Arava (leflunomide)

Duration: 6 months initial, for a quantity of 8 per month; re-evaluate every 6 months

7. Exjade (deferasirox)

- a. Chronic Iron Overload due to blood transfusions
Duration: 6 months

8. Fentora (fentanyl citrate)

- a. Pain control for oncology patients **ONLY**
Duration: 6 months

9. Forteo (teriparatide)

- a. Verified diagnosis of osteoporosis and
- b. Has failed trial of one other osteoporosis therapy (Fosamax, Actonel, Miacalcin)
Duration: 1 year; maximum therapy of 2 years

10. Gleevec (imatinib mesylate)

- a. Diagnosis of Philadelphia Chromosome positive CML (Chronic Myeloid Leukemia)
- b. GIST (Gastro intestinal stromal tumor) with positive protein tyrosine kinase KIT (C-KIT)
Duration: 6 months

11. Growth Hormone – Protropin (somatren), Humatrope, Genotropin, Norditropin, Nutropin, Nutropin AQ, Nutropin-Depot (somatropin)

Preferred Products: Genotropin, Nutropin, Nutropin AQ, Nutropin-Depot (somatropin)

- a. Diagnosis of neonatal hypopituitarism and hypoglycemia or
- b. Proven growth deficiency in children or
 - Fail two provocative growth hormone stimulation tests (L-dopa, clonidine, glucagon, propranolol, arginine, or insulin – Peak <10ug/L) (24-hour monitoring of IGF or IGFBP are considered experimental) and
 - Have a height >2.5 standard deviations below the median for age or
 - Growth velocity is below the 10th percentile when compared with expected growth velocity for chronological age using standard growth chart with at least 3 data points to indicate velocity and
 - A yearly growth rate of <4.5 cm/yr and a bone age of two standard deviations below chronological age
- c. Growth hormone deficiency in adults or
 - Have no contraindications to therapy; active malignancy, benign intracranial hypertension, proliferative or pre-proliferative diabetic retinopathy and
 - Negative response to standard growth hormone stimulation test (Peak <5ug/L)
 - Growth hormone deficiency syndrome alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, or radiation therapy or
 - Growth hormone deficiency during childhood with growth hormone deficiency syndrome confirmed as an adult before replacement therapy with somatropin is started. Approximate physiologic dose 10mcg/kg/day.
- d. Turner's Syndrome or
- e. Children with chronic renal insufficiency or
- f. AIDS wasting or Cachexia or
- g. Full-thickness skin loss associated with third degree burn NOS or
- h. Prader-Willi syndrome (FDA approved for Genotropin)

Duration: 6 months – Growth hormone approved through Specialty Pharmacy Program providers only

For continuation of therapy every six months:

- Must be compliant with therapy
- have a growth velocity of >2.5cm/yr in the first 6 months and >4.5cm/yr or more thereafter in children. Usually discontinued around 13 to 16 years of age when growth velocity is less than 2cm/yr, when epiphyseal fusion occurs, or when height reaches 5th percentile of expected adult height based upon mean height of parents

12. Hexalen (altretamine)

- a. Ovarian cancer: For use as a single agent in the treatment of patients with persistent or recurrent ovarian cancer following first-line therapy with cisplatin or alkylating agent-based combination.

Duration: 6 months

13. Humira (adalimumab)

- a. Diagnosis of moderate to severe rheumatoid arthritis by rheumatologist
- b. Therapeutic failure of adequate trial of at least one of the following:
 - Plaquenil (hydroxychloroquine)
 - Sologanal or Ridaura (gold)
 - Methotrexate
 - Imuran (azathioprine)
 - Cuprimine (penicillimine)
 - Azulfidine (sulfasalazine)
 - Arava (leflunomide)

Duration: 6 months initial; 12 months thereafter

14. Increlex (mecasermin)

- a. Diagnosis of insulin like growth factor deficiency (IGFD)

Duration: 6 months

15. Infergen (interferon alfacon-1)

- a. 18 years and
- b. Chronic hepatitis non A, non B (C) or
- c. Hairy cell leukemia

Duration: 6 months

16. Intron-A (interferon alfa 2b)

- a. 18 years and
- b. Hairy cell leukemia or
- c. AIDS-related Kaposi's sarcoma or
- d. Chronic hepatitis non A, non B (C) or
- e. Chronic hepatitis B, serum HBe Ag positive or
- f. Condylomata acuminata involving external surfaces of the genital or perianal area or
- g. Chronic myelogenous leukemia, CML (Philadelphia chromosome-positive) or
- h. Multiple myeloma or
- i. Non-Hodgkin's lymphoma, low- or intermediate-grade disease or
- j. Malignant melanoma or

- k. Consult with medical director for the following unlabeled uses:
- Bladder tumors
 - Carcinoid tumors
 - Cytomegaloviruses
 - Essential thrombocythemia
 - Cutaneous T-cell lymphoma
 - Cutaneous warts
 - Herpes keratoconjunctivitis
- Duration: 6 months

17. Kineret (anakinra)

- a. Diagnosis of moderate to severe rheumatoid arthritis by rheumatologist
- b. Not currently on Enbrel or Remicade
- c. Therapeutic failure of adequate trial of at least one of the following:
 - Plaquenil (hydroxychloroquine)
 - Solganal or Ridaura (gold)
 - Methotrexate
 - Imuran (azathioprine)
 - Cuprimine (penicillimine)
 - Azulfidine (sulfasalazine)
 - Arava (leflunomide)

Duration: 6 months initial, for a quantity of 30 100mg injections per month; 12 months thereafter

18. Lamisil (terbinafine)

- a. Fingernail onychomycosis; 6-week course of therapy; one course per lifetime as documented by BCBSNM – includes Sporanox and Diflucan – or
- b. Toenail onychomycosis; 12-week course of therapy; one course per lifetime as documented by BCBSNM – includes Sporanox and Diflucan

19. Lotronex (alosetron hcd)

- a. Irritable bowel syndrome
- Duration: 6 months

20. Lysodren (mitotane)

- a. Adrenal cortical carcinoma

Duration: 3 months (If no clinical benefits are observed after 3 months at the maximum tolerated dose, the case would generally be considered a clinical failure)

21. Neupogen, G-CSF (filgrastim) and Neulasta (pegfilgrastin)

- a. Treatment of chemotherapy-induced neutropenia in non-myeloid malignancies or
- b. Prophylaxis in Cytotoxic chemotherapy of high intensity where neutropenia is expected or
- c. Neutropenia associated with HIV or
- d. Aplastic anemia or
- e. Alloimmune neonatal neutropenia or
- f. Congenital or drug-induced agranulocytosis

Not to be approved for “prime” responses to chemotherapy in patients by administering prior to and/or concurrent with chemotherapy.

Duration: 3 months

22. Nexavar (sorafenib)

- a. Advanced renal cell carcinoma

Duration: 6 months

23. Pegasys (peginterferon alfa-2a) and Peg-Intron (peginterferon alfa-2b)

- a. Diagnosis by gastroenterologist of chronic hepatitis C in patients with compensated liver disease and meets the following criteria:

- Patient seropositive for HCV RNA and
- Elevated serum alanine aminotransferase

Do not approve in patients with decompensated cirrhosis.

Refer to medical director for use during pregnancy.

Duration: 6 months; may be renewed one additional time only

24. Procrit, Epogen (erythropoietin), or Aranesp (darbepoetin alpha)

- a. Anemia of chronic renal failure or
- b. Anemia with HIV infection and retrovir, AZT therapy < 4200mg/w or
- c. Chemotherapy-induced anemia with non-myeloid malignancy or
- d. Reduction of allogeneic blood transfusion in surgery patients

Duration: 3 months

25. Pulmozyme, rhDNase (dornase alfa)

- a. Diagnosis of Cystic Fibrosis
 - Five years of age or older and
 - Baseline forced vital capacity (FVC) >40% of predicted

Duration: 1 year; once daily dosing only

26. Raptiva (efalizumab)

- a. Age 18 yrs or older
- b. Diagnosis of moderate to severe plaque psoriasis
- c. Trial of corticosteroids or dovonex or soriatane or methotrexate

Duration: 6 months only; 4 vials per month

27. Rebetron (ribavirin)

- a. Diagnosis by gastroenterologist of chronic hepatitis C in patients with compensated liver disease and meets the following criteria:

- Patient seropositive for HCV RNA and
- Elevated serum alanine aminotransferase

Do not approve in patients with decompensated cirrhosis.

Refer to medical director for use during pregnancy.

Duration: 6 months; may be renewed one additional time only

28. Retin-A or Avita (tretinoin) (Renova not a covered benefit)

- a. Member age > 40 years and
- b. Acne Vulgaris or
- c. Actinic Keratosis

Duration: 1 year

29. Revatio (sildenafil citrate)

- a. Documented pulmonary hypertension

Duration: 6 months – Limited to a quantity of 90 in 30 days

30. Revlimid (lenalidomide)

- a. Diagnosis of MDS – Myelodysplastic Syndrome
- b. Multiple Myeloma (after at least one prior therapy – thalidomide)

Duration: 6 months

31. Sporanox (itraconazole)

- a. Documented histoplasmosis or blastomycosis infection or
- b. Aspergillosis in patients who are intolerant of or refractory to amphotericin B therapy
- c. Fingernail onychomycosis; 6-week course of therapy; one course per lifetime as documented by BCBSNM – includes Lamisil and Diflucan – or
- d. Toenail onychomycosis; 12-week course of therapy; one course per lifetime as documented by BCBSNM – includes Lamisil and Diflucan

32. Sprycel (dasatinib)

- a. Chronic myeloid leukemia (CML)
- b. Acute lymphoblastic leukemia (ALL)

Duration: 6 months

33. Sutent (sumitinib)

- a. GI stromal tumor (GIST)
- b. Advanced renal cell carcinoma (RCC)

Duration: 6 months

34. Tarceva (erlotinib)

- a. Nonsmall cell lung cancer (NSCLC)
- b. Pancreatic cancer

Duration: 6 months

35. Tazorac (tazarotene topical gel)

- a. Member age >40 years and
- b. Diagnosis of Psoriasis or
- c. Acne Vulgaris or
- d. Actinic Keratosis

Duration: 1 year

36. Temodar (temozolomide)

- a. Anaplastic astrocytoma
- b. Glioblastoma multiforme

Duration: 6 months

37. Testosterone (AndroGel, AndroDerm, or TestoDerm)

- a. Restricted to males with documented low serum testosterone
- Duration: 1 year

38. Thalomid (thalidomide)

Thalidomide is approved for marketing only under a special restricted distribution program approved by the FDA called “System for Thalidomide Education and Prescribing Safety” (STEPS). Only program registered pharmacists and prescribers are allowed to possess and use the product.

- a. Multiple myeloma: In combination with dexamethason, for the treatment of patients with newly diagnosed multiple myeloma
- b. Erythema nodosum leprosum:
 - **Acute treatment:** Acute treatment of the cutaneous manifestations of moderate to severe erythema nodosum leprosum. Not indicated as monotherapy for such erythema nodosum leprosum treatment in the presence of moderate to severe neuritis.
 - **Maintenance therapy:** For prevention and suppression of the cutaneous manifestations of erythema nodosum leprosum recurrence.
- c. Orphan Status: Clinical manifestations of mycobacterial infection caused by mycobacterium tuberculosis and non-tuberculous mycobacteria; Crohn’s disease; HIV-associated wasting syndrome; Kaposi sarcoma; lupus erythematosus; multiple myeloma; myelofibrosis with myeloid metaplasia; primary brain malignancies; treatment and maintenance of reactional lepromatous leprosy; treatment and prevention of GVHD; treatment and recurrent aphthous stomatitis; treatment and prevention of recurrent aphthous ulcer in severely, terminally immunocompromised patients.

Duration: 6 months through STEPS.

39. Tracleer (bosentan)

- a. Documented diagnosis of Pulmonary Hypertension
- b. Concurrent therapy limited to any two agents at a time (Tracleer, Ventavis, Flolan, Revatio/Viagra)

Duration: 6 months

40. Tykerb (lapatinib)

- a. Advanced or metastatic breast cancer
- b. Combination therapy with Capecitabine
- c. Prior therapy including: Anthracycline, Taxane, or Trastuzumab

Duration: 6 months

41. Ventavis (Ioprost)

- a. Documented diagnosis of Pulmonary Hypertension
- b. Concurrent therapy limited to any two agents at a time (Tracleer, Ventavis, Flolan, Revatio/Viagra)

Duration: 6 months

42. Vesanoid (tretinoin)

a. Induction of remission: in patients with APL

Duration/Comments: 90 days (remission induction), 12 months (remission maintenance)

43. Vfend (voriconazole)

a. Restricted to treatment of

- Invasive Aspergillosis or
- Serious infections caused by fusarium species or S. apiospermum

Duration: 30 days

44. Wellbutrin SR, Wellbutrin XL (bupropion)

a. Treatment of depression or ADHD

- Past trials of other medication used in the treatment of depression or ADHD or
- Has documented depression work up or psychiatric referral

Duration: 1 year

45. Xeloda (capecitabine)

a. Colorectal cancer

b. Breast cancer:

Duration: 6 months

46. Xolair (omalizumab)

a. Patient with severe persistent asthma who falls within recommended dosing guidelines with:

- Age \geq 12 years old and
- Allergy testing
- Weight less than 150kg and
- IgE serum levels less than 700iu and
- FEV-1 $<$ 80%

Duration: 6 months

47. Zavesca (miglustat)

a. Gaucher Disease

Duration: 1 year

48. Zolinza (vorinostat)

a. Cutaneous T-cell lymphoma (CTCL)

Duration: 6 months

49. Zyvox (linezolid)

a. Culture and sensitivities verifying:

- Vancomycin resistant Enterococcus faecium or Enterococcus faecalis or
- Methicillin resistant Staphylococcus aureus or
- Methicillin resistant Streptococcus pyogenes or Streptococcus agalactiae

Duration: Maximum duration of therapy is 14 days including inpatient therapy