



Drug List Exclusions for Retail Qualified Health Plans

Drug Name*	Generic Alternatives	Brand Alternatives
RANEXA <i>Antianginal Agents/Other</i>	<ul style="list-style-type: none"> nitroglycerin tablet nitroglycerin transdermal 	N/A
TROKENDI XR <i>Anticonvulsants</i>	<ul style="list-style-type: none"> topiramate ER capsules topiramate tablets 	N/A
REXULTI <i>Antipsychotics</i>	<ul style="list-style-type: none"> aripiprazole risperidone ziprasidone 	N/A
XELJANZ XR <i>Biologics: Rheumatoid & Other Arthritides</i>	N/A	<ul style="list-style-type: none"> ENBREL HUMIRA SIMPONI
SENSIPAR <i>Calcimimetic (Calcium Reducer)</i>	Generic equivalent available	N/A
TRADJENTA <i>Anti-Diabetic</i>	N/A	<ul style="list-style-type: none"> JANUVIA ONGLYZA
MINIVELLE <i>Estrogens, TD</i>	Generic equivalent available	N/A
COLCHICINE <i>Gout</i>	N/A	MITIGARE

Drug Name*	Generic Alternatives	Brand Alternatives
ULORIC <i>Gout</i>	allopurinol	MITIGARE
COLCRYS <i>Gout</i>	N/A	MITIGARE
OMNITROPE <i>Growth Hormones & Somatomedins</i>	N/A	NORDITROPIN
CIALIS <i>Impotence Agents</i>	Generic equivalent available	N/A
COPAXONE <i>Multiple Sclerosis</i>	glatiramer	N/A
METAXALONE <i>Musculoskeletal Therapy Agents</i>	<ul style="list-style-type: none"> • baclofen tablet • cyclobenzaprine hcl tablet • methocarbamol tablet 	N/A
CHLORZOXAZONE <i>Musculoskeletal Therapy Agents</i>	cyclobenzaprine hcl Tablet	N/A
AURYXIA <i>Phosphate Binders</i>	OTC options available	N/A
SOOLANTRA <i>Rosacea Agents</i>	N/A	SKLICE
FINACEA <i>Rosacea Agents</i>	Generic equivalent available	N/A
SUBOXONE <i>Substance Abuse</i>	Generic equivalent available	N/A
MUPIROCIN CREAM <i>Topical Antibiotics</i>	mupirocin ointment	N/A

* May not apply to all strengths/formulations.

Prior Authorization

Designed to promote patient safety and use of the drug as intended by the manufacturer and the FDA.

- Physicians are required to submit a prior authorization request for certain prescriptions before a drug is covered
- Existing prior authorization approvals for current members will be transitioned
- Members who were with other carriers need to go through the prior authorization process
- No coverage if request is denied

Step Therapy

Encourages use of safe, clinically appropriate and most cost-effective drugs.

- Program requires that a member try a prerequisite drug before the targeted agents in the program will be covered
- Members who have a recent fill history of the requested drug may not need to go first try the prerequisite drug
- If member cannot take prerequisite or if prerequisite agent is not appropriate for the patient, the doctor can request authorization for the targeted agent
- No coverage if request is denied

Dispensing Limits

Limits are placed to promote appropriate use and prevent stockpiling.

- Limits are based on FDA-approved dosing, national published guidelines, package size and evidence from peer-reviewed literature
- Limits are approved by a committee of physicians and pharmacists from a variety of specialties
- A dispensing limit list is posted on our member website for reference. If a member requires a quantity beyond the dispensing limit, a dispensing limit request may be submitted

Specialty Pharmacy Program

Specialty medications are used to treat conditions such as multiple sclerosis, rheumatoid arthritis, cancer and cystic fibrosis.

- Medications are limited to a 30-day supply because of high cost and to prevent waste
- Self-administered products are covered under the pharmacy benefit
- Physician-administered products are covered under the medical benefit
- 50% out of network penalty if members do not use an In-Network Specialty Pharmacy Network

Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico,
Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas,
Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association