AmeriHealth Medicare PPO
2024 Utilization Management Criteria: Step Therapy

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN

This document was updated on 4/18/2024. For more recent information or other questions, please contact our Member Help Team at 1-866-569-5190 or, for TTY/TDD users, 711, seven days a week from 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, visit www.amerihealthmedicare.com to use our *Formulary (List of Covered Drugs)* search tool or view a downloadable document.

When this document refers to "we," "us," or "our," it means AmeriHealth Medicare PPO. When it refers to "plan" or "our plan," it means AmeriHealth Medicare Core PPO, AmeriHealth Medicare Enhanced PPO, AmeriHealth Medicare Secure PPO, and AmeriHealth Medicare Ultimate PPO.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2025.

AmeriHealth Medicare coverage issued by AmeriHealth Insurance Company of New Jersey.

AmeriHealth Insurance Company of New Jersey offers PPO plans with a Medicare contract. Enrollment in AmeriHealth PPO plans depends on contract renewal.

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There may be restrictions to your drug coverage

Some covered drugs may have additional requirements or limits on coverage. We call this "utilization management." These requirements and limits may include:

- **Prior Authorization (PA):** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, our plan may not cover the drug. Drugs that require prior authorization are listed in *2024 Utilization Management Criteria: Prior Authorization*.
- **Step Therapy (ST):** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Drugs that require step therapy are listed in this document. Drugs that require step therapy are listed in *2024 Utilization Management Criteria: Step Therapy*.
- **Quantity Limits (QL):** For certain drugs, our plan limits the amount of the drug that our plan will cover. Drugs that have quantity limits are listed in the *AmeriHealth Medicare PPO Formulary (List of Covered Drugs)*.

You can find out if your drug has any additional requirements or limits by looking in your plan *Formulary (List of Covered Drugs)*. You can also get more information about the restrictions applied to specific covered drugs by visiting www.amerihealthmedicare.com.

You can ask our plan to make an exception to these restrictions or limits, or for a list of other similar drugs that may treat your health condition. Your *Formulary (List of Covered Drugs)* and *Evidence of Coverage* will have more information about the exception request process.

How to use this document

This document, along with *2024 Utilization Management Criteria: Prior Authorization*, is intended to be used with your *Formulary (List of Covered Drugs)*. If your prescription drug has the note "ST" in the "Requirements" column of the A*meriHealth Medicare PPO Formulary* (*List of Covered Drugs)*, you can find more information on the restriction(s) in this document.

Locate your drug in the index on page 23. The restriction information includes step therapy criteria.

Be sure to read all the information listed for your affected drug. If you have any questions or need assistance with the information contained in this document, please call our Member Help Team: AmeriHealth Medicare PPO at 1-866-569-5190 or, for TTY/TDD users, 711.

ALBUTEROL 2024

Products Affected

- PROAIR DIGIHALER AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT INHALATION

Details	
Criteria	Trial of Proair Respiclick. Always Applies.

ANTIDEPRESSANTS [SNRIS] 2024

Products Affected

- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 20 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 40 MG ORAL
- FETZIMA CAPSULE EXTENDED RELEASE 24 HOUR 80 MG ORAL
- FETZIMA TITRATION CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL

Details	
Criteria	Trial of two generic formulary serotonin-norepinephrine reuptake Inhibitor (SNRI). Applies to new starts.

BRAND ANTIPSYCHOTICS 2024

Products Affected

- FANAPT TABLET 1 MG ORAL
- FANAPT TABLET 10 MG ORAL
- FANAPT TABLET 12 MG ORAL
- FANAPT TABLET 2 MG ORAL
- FANAPT TABLET 4 MG ORAL
- FANAPT TABLET 6 MG ORAL
- FANAPT TABLET 8 MG ORAL
- FANAPT TITRATION PACK TABLET 1 & 2 & 4 & 6 MG ORAL
- LYBALVI TABLET 10-10 MG ORAL
- LYBALVI TABLET 15-10 MG ORAL
- LYBALVI TABLET 20-10 MG ORAL
- LYBALVI TABLET 5-10 MG ORAL
- REXULTI TABLET 0.25 MG ORAL
- REXULTI TABLET 0.5 MG ORAL
- REXULTI TABLET 1 MG ORAL
- REXULTI TABLET 2 MG ORAL
- REXULTI TABLET 3 MG ORAL
- REXULTI TABLET 4 MG ORAL
- SECUADO PATCH 24 HOUR 3.8 MG/24HR TRANSDERMAL
- SECUADO PATCH 24 HOUR 5.7 MG/24HR TRANSDERMAL
- SECUADO PATCH 24 HOUR 7.6 MG/24HR TRANSDERMAL
- VRAYLAR CAPSULE 1.5 MG ORAL
- VRAYLAR CAPSULE 3 MG ORAL
- VRAYLAR CAPSULE 4.5 MG ORAL
- VRAYLAR CAPSULE 6 MG ORAL
- VRAYLAR CAPSULE THERAPY PACK 1.5 & 3 MG ORAL

Details	
Criteria	Trial of two generic formulary antipsychotic products. Applies to new starts.

CITALOPRAM CAPSULE 2024

Products Affected

- *citalopram hydrobromide capsule 30 mg oral*

Details	
Criteria	Trial of both generic formulary citalopram oral solution and tablet. Applies to new starts.

EPRONTIA 2024

Products Affected

- EPRONTIA SOLUTION 25 MG/ML ORAL

Details	
Criteria	Trial of generic formulary topiramate. Applies to new starts.

GOUT AGENTS 2024

Products Affected

- *febuxostat tablet 40 mg oral*
- *febuxostat tablet 80 mg oral*

Details	
Criteria	Trial of generic formulary allopurinol 100mg or 300mg. Always applies.

INSULIN GLARGINE 2024

Products Affected

- BASAGLAR KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS
- BASAGLAR TEMPO PEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS

Details	
Criteria	Trial of two of the following: Lantus, Levemir, Toujeo, Tresiba. Always applies.

MULTIPLE SCLEROSIS AGENTS 2024

Products Affected

- AUBAGIO TABLET 14 MG ORAL
- AUBAGIO TABLET 7 MG ORAL
- BAFIERTAM CAPSULE DELAYED RELEASE 95 MG ORAL
- COPAXONE SOLUTION PREFILLED SYRINGE 20 MG/ML SUBCUTANEOUS
- COPAXONE SOLUTION PREFILLED SYRINGE 40 MG/ML SUBCUTANEOUS
- KESIMPTA SOLUTION AUTO-INJECTOR 20 MG/0.4ML SUBCUTANEOUS
- MAYZENT STARTER PACK TABLET THERAPY PACK 12 X 0.25 MG ORAL
- MAYZENT STARTER PACK TABLET THERAPY PACK 7 X 0.25 MG ORAL
- MAYZENT TABLET 0.25 MG ORAL
- MAYZENT TABLET 1 MG ORAL
- MAYZENT TABLET 2 MG ORAL
- PONVORY STARTER PACK TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG ORAL
- PONVORY TABLET 20 MG ORAL
- TASCENSO ODT TABLET DISPERSIBLE 0.25 MG ORAL
- TASCENSO ODT TABLET DISPERSIBLE 0.5 MG ORAL
- VUMERITY CAPSULE DELAYED RELEASE 231 MG ORAL

Details	
Criteria	Trial of two of the following formulary products: (1) Avonex (interferon beta-1a), (2) Plegridy (peginterferon beta-1a), (3) Betaseron (interferon beta-1b), (4) Glatopa (glatiramer acetate), (5) Tecfidera (Dimethyl Fumarate), (6) Gilenya (fingolimod), (7) Teriflunomide, or (8) Rebif (interferon beta 1a). Applies to new starts.

OIC AGENTS 2024

Products Affected

- RELISTOR SOLUTION 12 MG/0.6ML SUBCUTANEOUS
- RELISTOR SOLUTION 8 MG/0.4ML SUBCUTANEOUS
- RELISTOR TABLET 150 MG ORAL

Details	
Criteria	Trial of lubiprostone or lactulose. Always Applies.

OPHTHALMIC PROSTAGLANDINS 2024

Products Affected

- RHOPRESSA SOLUTION 0.02 % OPHTHALMIC

Details	
Criteria	Trial of two from the following: generic formulary ophthalmic prostaglandin products, brand Lumigan 0.01%. Always applies.

PEG-FILGRASTIM 2024

Products Affected

- FYLNETRA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS

Details	
Criteria	Trial of Neulasta. Always applies

PREFERRED GLP-1 AGONISTS 2024

Products Affected

- BYDUREON BCISE AUTO-INJECTOR 2 MG/0.85ML SUBCUTANEOUS
- BYETTA 10 MCG PEN SOLUTION PEN-INJECTOR 10 MCG/0.04ML SUBCUTANEOUS
- BYETTA 5 MCG PEN SOLUTION PEN-INJECTOR 5 MCG/0.02ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 10 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 12.5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 15 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 2.5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 5 MG/0.5ML SUBCUTANEOUS
- MOUNJARO SOLUTION PEN-INJECTOR 7.5 MG/0.5ML SUBCUTANEOUS
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SOLUTION PEN-INJECTOR 2 MG/3ML SUBCUTANEOUS
- OZEMPIC (1 MG/DOSE) SOLUTION PEN-INJECTOR 4 MG/3ML SUBCUTANEOUS
- OZEMPIC (2 MG/DOSE) SOLUTION PEN-INJECTOR 8 MG/3ML SUBCUTANEOUS
- RYBELSUS TABLET 14 MG ORAL
- RYBELSUS TABLET 3 MG ORAL
- RYBELSUS TABLET 7 MG ORAL
- TRULICITY SOLUTION PEN-INJECTOR 0.75 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 1.5 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 3 MG/0.5ML SUBCUTANEOUS
- TRULICITY SOLUTION PEN-INJECTOR 4.5 MG/0.5ML SUBCUTANEOUS
- VICTOZA SOLUTION PEN-INJECTOR 18 MG/3ML SUBCUTANEOUS

Details	
Criteria	Trial of a formulary product from one of the following classes: Alpha-Glucosidase Inhibitors, Metformin, Meglitinide Analogues, Dipeptidyl Peptidase-4 (DPP-4) Inhibitors, Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors, DPP-4 Inhibitor - Metformin Combinations, DPP-4 Inhibitor - Thiazolidinedione Combinations, SGLT2 Inhibitor - Metformin Combinations, SGLT2 Inhibitor - DPP-4 Inhibitor Combinations, SGLT2 Inhibitor - DPP-4 Inhibitor - Metformin Combinations, Sulfonylureas, Sulfonylurea - Metformin Combinations, Sulfonylurea - Thiazolidinedione Combinations, Thiazolidinedione - Metformin Combinations. Step requirements do not apply to members with type 2 diabetes and multiple cardiovascular risk factors or established cardiovascular disease.

SANCUSO 2024

Products Affected

- SANCUSO PATCH 3.1 MG/24HR TRANSDERMAL

Details	
Criteria	Trial of (a) ondansetron or granisetron and (b) aprepitant. Always applies.

SAVELLA 2024

Products Affected

- SAVELLA TABLET 100 MG ORAL
- SAVELLA TABLET 12.5 MG ORAL
- SAVELLA TABLET 25 MG ORAL
- SAVELLA TABLET 50 MG ORAL
- SAVELLA TITRATION PACK 12.5 & 25 & 50 MG ORAL

Details	
Criteria	Trial of generic formulary duloxetine. Applies to new starts.

SERTRALINE CAPSULE 2024

Products Affected

- *sertraline hcl capsule 150 mg oral*
- *sertraline hcl capsule 200 mg oral*

Details	
Criteria	Trial of both generic formulary sertraline oral concentrate and tablet. Applies to new starts.

TRULANCE 2024

Products Affected

- TRULANCE TABLET 3 MG ORAL

Details	
Criteria	Trial of both of the following: (1) lactulose and (2) Linzess or lubiprostone. Always applies.

UZEDY 2024

Products Affected

- UZEDY SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML SUBCUTANEOUS
- UZEDY SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML SUBCUTANEOUS
- UZEDY SUSPENSION PREFILLED SYRINGE 150 MG/0.42ML SUBCUTANEOUS
- UZEDY SUSPENSION PREFILLED SYRINGE 200 MG/0.56ML SUBCUTANEOUS
- UZEDY SUSPENSION PREFILLED SYRINGE 250 MG/0.7ML SUBCUTANEOUS
- UZEDY SUSPENSION PREFILLED SYRINGE 50 MG/0.14ML SUBCUTANEOUS
- UZEDY SUSPENSION PREFILLED SYRINGE 75 MG/0.21ML SUBCUTANEOUS

Details	
Criteria	Trial of one of the following: Perseris, formulary generic risperidone ER IM injection or Risperdal Consta. Applies to new starts

VENLAFAXINE BESYLATE TAB ER 2024

Products Affected

- *venlafaxine besylate er tablet extended release 24 hour 112.5 mg oral*

Details	
Criteria	Trial of both generic formulary venlafaxine hydrochloride extended-release tablet and capsule before receiving Venlafaxine Besylate extended-release tablet. Applies to new starts only.

XCOPRI 2024

Products Affected

- XCOPRI (250 MG DAILY DOSE) TABLET THERAPY PACK 100 & 150 MG ORAL
- XCOPRI (350 MG DAILY DOSE) TABLET THERAPY PACK 150 & 200 MG ORAL
- XCOPRI TABLET 100 MG ORAL
- XCOPRI TABLET 150 MG ORAL
- XCOPRI TABLET 200 MG ORAL
- XCOPRI TABLET 50 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 150 MG & 14 X200 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X100 MG ORAL

Details	
Criteria	Trial of two generic formulary anticonvulsants. Applies to new starts.

ZONISADE 2024

Products Affected

- ZONISADE SUSPENSION 100 MG/5ML ORAL

Details	
Criteria	Trial of generic zonisamide capsule. Applies to new starts.

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