Select Option® Rx PDP

(Select Option Value 2025)

2025 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 **08/26/2024.** For more recent information or other questions, please contact our Member Help Team: Select Option Rx at **1-888-678-7009** 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.ibxmedicare.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 Independence Blue Cross. When it refers to "plan" or "our plan," it means Select Option Rx.

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, 2026, and from time to time during the year.

Select Option is a PDP plan with a Medicare contract. Enrollment in Select Option PDP depends on contract renewal.

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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 *2025 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.
- **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 *Select Option Rx 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.ibxmedicare.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 *2025 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 *and Select Option Rx 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 13. 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: Select Option Rx at 1-888-678-7009 or, for TTY/TDD users, 711.

ANTIDEPRESSANTS [SNRIS] 2025

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 2025

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
- 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

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

EPRONTIA 2025

Products Affected

- EPRONTIA SOLUTION 25 MG/ML ORAL

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

INSULIN GLARGINE 2025

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, Toujeo, Tresiba. Always applies.

MULTIPLE SCLEROSIS AGENTS 2025

Products Affected

- REBIF REBIDOSE SOLUTION AUTO-INJECTOR 22 MCG/0.5ML SUBCUTANEOUS
- REBIF REBIDOSE SOLUTION AUTO-INJECTOR 44 MCG/0.5ML SUBCUTANEOUS
- REBIF REBIDOSE TITRATION PACK SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG SUBCUTANEOUS
- REBIF SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML SUBCUTANEOUS
- REBIF SOLUTION PREFILLED SYRINGE 44 MCG/0.5ML SUBCUTANEOUS
- REBIF TITRATION PACK SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG SUBCUTANEOUS

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

OIC AGENTS 2025

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.

SAVELLA 2025

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.

XCOPRI 2025

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 25 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 2025

Products Affected

- ZONISADE SUSPENSION 100 MG/5ML ORAL

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

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