



**Keystone 65 Preferred Rx HMO,  
Keystone 65 Select Rx HMO, and  
Personal Choice 65<sup>SM</sup> Rx PPO**

**2026 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 **3/24/2026**. For more recent information or other questions, please contact our Member Help Team: Keystone 65 Rx at **1-800-645-3965** and Personal Choice 65 Rx at **1-888-718-3333**, 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](http://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 Keystone 65 Rx and Personal Choice 65 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, 2027, and from time to time during the year.

Independence Blue Cross offers PPO, HMO-POS, and HMO Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross PPO, HMO-POS, and HMO Medicare Advantage plans depends on contract renewal.

Independence Blue Cross offers products through its subsidiaries Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — 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 *2026 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 *Keystone 65 Preferred Rx HMO, Keystone 65 Select Rx HMO, and Personal Choice 65 Rx 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.ibxmedicare.com](http://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 *2026 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 *Keystone 65 Preferred Rx HMO, Keystone 65 Select Rx HMO, and Personal Choice 65 Rx 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: Keystone 65 Rx at **1-800-645-3965** or Personal Choice 65 Rx at **1-888-718-3333** or, for TTY/TDD users, **711**.

# ANTIDEPRESSANTS [SNRIS] 2026

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## 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

<b>Criteria</b>	Trial of two of the following generic formulary serotonin-norepinephrine reuptake Inhibitor (SNRI): desvenlafaxine tablet, duloxetine capsules, venlafaxine hydrochloride ER tablets, venlafaxine hydrochloride immediate release tablets, and venlafaxine hydrochloride ER capsules. Applies to new starts.
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# BRAND ANTIPSYCHOTICS 2026

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## 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 A TABLET 1 & 2 & 4
- & 6 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

## Details

<b>Criteria</b>	Trial of two generic formulary antipsychotic products. Applies to new starts.
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# BRAND BUPROPION PRODUCTS 2026

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## Products Affected

- WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 150 MG ORAL
- WELLBUTRIN XL TABLET EXTENDED RELEASE 24 HOUR 300 MG ORAL

## Details

<b>Criteria</b>	Trial of one generic formulary bupropion product. Applies to new starts.
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# CITALOPRAM CAPSULE 2026

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## Products Affected

- *citalopram hydrobromide capsule 30 mg oral*

## Details

<b>Criteria</b>	Trial of both generic formulary citalopram oral solution and tablet. Applies to new starts.
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# DRIZALMA 2026

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## Products Affected

- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 20 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 30 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 40 MG ORAL
- DRIZALMA SPRINKLE CAPSULE DELAYED RELEASE SPRINKLE 60 MG ORAL

## Details

<b>Criteria</b>	Trial of generic formulary duloxetine. Applies to new starts.
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# DYMISTA 2026

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## Products Affected

- *azelastine-fluticasone suspension 137-50 mcg/act nasal*

## Details

<b>Criteria</b>	Trial of both generic formulary fluticasone nasal spray and azelastine nasal spray. Always applies.
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# EPRONTIA 2026

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## Products Affected

- EPRONTIA SOLUTION 25 MG/ML ORAL

## Details

<b>Criteria</b>	Trial of generic formulary immediate release pregabalin or topiramate capsules or solution. Applies to new starts.
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# EXXUA 2026

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## Products Affected

- EXXUA TABLET EXTENDED RELEASE 24 HOUR 18.2 MG ORAL
- EXXUA TABLET EXTENDED RELEASE 24 HOUR 36.3 MG ORAL
- EXXUA TABLET EXTENDED RELEASE 24 HOUR 54.5 MG ORAL
- EXXUA TABLET EXTENDED RELEASE 24 HOUR 72.6 MG ORAL
- EXXUA TITRATION PACK TABLET EXTENDED RELEASE 24 HOUR 18.2 MG ORAL

## Details

<b>Criteria</b>	Trial of two of the following: bupropion, citalopram tablets, desvenlafaxine extended-release (ER), duloxetine capsules, escitalopram tablets, fluoxetine, mirtazapine tablet, paroxetine IR/ER, sertraline tablets, venlafaxine IR/ER. Applies to new starts.
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# GOUT AGENTS 2026

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## Products Affected

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

## Details

<b>Criteria</b>	Trial of generic formulary allopurinol 100mg or 300mg. Always applies.
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# INSULIN GLARGINE 2026

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## Products Affected

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

## Details

<b>Criteria</b>	Trial of two of the following: Lantus, Toujeo, Tresiba. Always applies.
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# MULTIPLE SCLEROSIS AGENTS 2026

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## Products Affected

- 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
- 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
- VUMERITY CAPSULE DELAYED RELEASE 231 MG ORAL

## Details

<b>Criteria</b>	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.
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# OIC AGENTS 2026

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## Products Affected

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

## Details

Criteria	
	Trial of lubiprostone or lactulose. Always Applies.

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# PEG-FILGRASTIM 2026

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## Products Affected

- FULPHILA SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS
- ZIEXTENZO SOLUTION PREFILLED SYRINGE 6 MG/0.6ML SUBCUTANEOUS

## Details

Criteria
Trial of one of the following: Neulasta or Udenyca. Always applies

# PROTON PUMP INHIBITORS (PPIs) 2026

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## Products Affected

- *rabeprazole sodium tablet delayed release 20 mg oral*

## Details

<b>Criteria</b>	Trial of two generic formulary proton pump inhibitors capsules or tablets. Always applies.
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# SANCUSO 2026

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## Products Affected

- SANCUSO PATCH 3.1 MG/24HR TRANSDERMAL

## Details

<b>Criteria</b>	Trial of (a) ondansetron or granisetron and (b) aprepitant. Always applies.
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# SAVELLA 2026

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## 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

<b>Criteria</b>	Trial of generic formulary duloxetine. Applies to new starts.
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# SERTRALINE CAPSULE 2026

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## Products Affected

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

## Details

<b>Criteria</b>	Trial of both generic formulary sertraline oral concentrate and tablet. Applies to new starts.
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# TRULANCE 2026

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## Products Affected

- TRULANCE TABLET 3 MG ORAL

## Details

<b>Criteria</b>	Trial of both of the following: (1) lactulose and (2) Linzess or lubiprostone. Always applies.
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# XCOPRI 2026

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## 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 X 200 MG ORAL
- XCOPRI TABLET THERAPY PACK 14 X 50 MG & 14 X 100 MG ORAL

## Details

Details	
<b>Criteria</b>	Trial of two generic formulary anticonvulsants. Applies to new starts.

# ZONISADE 2026

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## Products Affected

- ZONISADE SUSPENSION 100 MG/5ML ORAL

## Details

<b>Criteria</b>	Trial of generic zonisamide capsule. Applies to new starts.
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