Keystone 65 Rx HMO
Personal Choice 65℠ Rx PPO
Select Option® Rx PDP
2018 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 11/1/18. For more recent information or other questions, please contact our Member Help Team: Keystone 65 at 1-844-352-1699, Personal Choice 65 at 1-888-879-4293, Select Option 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 February 15 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 Keystone 65 Rx, Personal Choice 65 Rx, and 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, 2019, and from time to time during the year.

Independence Blue Cross offers Medicare Advantage plans with a Medicare contract. Enrollment in Independence Medicare Advantage plans depends on contract renewal.

Keystone 65: Benefits underwritten by Keystone Health Plan East, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

Personal Choice 65 & Select Option: 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 *2018 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 Rx, Personal Choice 65 Rx, and 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 *2018 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 Rx, Personal Choice 65 Rx, 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: Keystone 65 at 1-844-352-1699, Personal Choice 65 at 1-888-879-4293, Select Option at 1-888-678-7009.

ANTIDEPRESSANTS [SNRIS] 2018

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
- KHEDEZLA TABLET EXTENDED RELEASE 24 HOUR 100 MG ORAL
- KHEDEZLA TABLET EXTENDED RELEASE 24 HOUR 50 MG ORAL

Details

Criteria	Prior use of one of the following: desvenlafaxine ER, desvenlafaxine succinate ER, duloxetine, venlafaxine, venlafaxine ER prior to filling any of the following: Khedezla, Fetzima. Applies to new starts.

BASAGLAR 2018

Products Affected

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

Details	
Criteria	Prior use of TWO of the following Lantus, Levemir, Toujeo, Tresiba prior to filling Basaglar (always applies)

BRAND BUPROPION PRODUCTS 2018

Products Affected

- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 174 MG ORAL
- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 348 MG ORAL
- APLENZIN TABLET EXTENDED RELEASE 24 HOUR 522 MG ORAL
- FORFIVO XL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL

Details	
Criteria	Prior use of one generic product (bupropion, bupropion SR, bupropion XL) prior to filling either of the following: Aplenzin, Forfivo XL. Applies to new starts.

BRAND ORAL ANTIPSYCHOTICS 2018

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
- LATUDA TABLET 120 MG ORAL
- LATUDA TABLET 20 MG ORAL
- LATUDA TABLET 40 MG ORAL
- LATUDA TABLET 60 MG ORAL
- LATUDA TABLET 80 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
- SAPHRIS TABLET SUBLINGUAL 10 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 2.5 MG SUBLINGUAL
- SAPHRIS TABLET SUBLINGUAL 5 MG SUBLINGUAL
- 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	Prior use of one generic product (aripiprazole, olanzapine, paliperidone, quetiapine [ER], risperidone, ziprasidone) prior to filling any of the following: Fanapt, Latuda, Rexulti, Saphris, Vraylar. Applies to new starts.

CUPRIMINE 2018

Products Affected

- CUPRIMINE CAPSULE 250 MG ORAL

Details	
Criteria	Prior use of penicillamine (Depen) prior to filling Cuprimine. Always applies.

DUZALLO 2018

Products Affected

- DUZALLO TABLET 200-300 MG ORAL

Details

Criteria	Prior use of allopurinol prior to filling Duzallo. Always applies.

LONHALA STEP THERAPY 2018

Products Affected

- LONHALA MAGNAIR STARTER KIT
  SOLUTION 25 MCG/ML INHALATION

Details	
Criteria	Prior use of Spiriva or Spiriva Respimat prior to filling Lonhala Magnair. Always applies.

RELISTOR ORAL 2018

Products Affected

- RELISTOR TABLET 150 MG ORAL
- SYMPROIC TABLET 0.2 MG ORAL

Details

Criteria	Prior use of Amitiza prior to filling Relistor, Symproic oral tablets. Always Applies.

RENIN INHIBITORS 2018

Products Affected

- TEKTURNA HCT TABLET 150-12.5 MG ORAL
- TEKTURNA HCT TABLET 150-25 MG ORAL
- TEKTURNA HCT TABLET 300-12.5 MG ORAL
- TEKTURNA HCT TABLET 300-25 MG ORAL
- TEKTURNA TABLET 150 MG ORAL
- TEKTURNA TABLET 300 MG ORAL

Details

Criteria	Prior use of one generic ACE inhibitor (benazepril, benazepril/HCTZ, captopril, captopril/HCTZ, enalapril, enalapril/HCTZ, fosinopril, fosinopril/HCTZ, lisinopril, lisinopril/HCTZ, moexipril, moexipril/HCTZ, perindopril, quinapril, quinapril/HCTZ, ramipril, trandolapril, trandolapril/verapamil) or one generic ARB (candesartan, candesartan/HCTZ, eprosartan, irbesartan, irbesartan/HCTZ, losartan, losartan/HCTZ, olmesartan, olmesartan/amlodipine/HCTZ, olmesartan/amlodipine, olmesartan/HCTZ, telmisartan, telmisartan/hctz, telmisartan/amlodipine, valsartan, valsartan/amlodipine, valsartan/amlodipine/HCTZ, valsartan/HCTZ) prior to filling either of the following: Tekturna, Tekturna HCT. Always Applies.

TRINTELLIX/VIIBRYD 2018

Products Affected

- TRINTELLIX TABLET 10 MG ORAL
- TRINTELLIX TABLET 20 MG ORAL
- TRINTELLIX TABLET 5 MG ORAL
- VIIBRYD STARTER PACK KIT 10 & 20 MG ORAL
- VIIBRYD TABLET 10 MG ORAL
- VIIBRYD TABLET 20 MG ORAL
- VIIBRYD TABLET 40 MG ORAL

Details

Criteria	Prior use of (1) one generic SSRI (e.g. citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline) OR (2) one generic SNRI (e.g. desvenlafaxine ER, duloxetine, venlafaxine, venlafaxine ER) prior to filling Trintellix OR Viibryd. Applies to new starts.

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