

Coverage Exception Criteria – Health Insurance Marketplace

Coverage Exception Criteria

These criteria apply to any request for medication that is not included on the covered drug list and can be used to treat a medical condition/disease state that is not otherwise excluded from coverage under the pharmacy benefit.

If the request is for a medication and disease state/medical condition that is addressed with current clinical review criteria that criteria set also will be applied.

1. Is the request for a drug/drug class/medical condition that is on the list of drugs/drug classes/medical conditions which are excluded from coverage under the pharmacy benefit?

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| Cosmetic Drugs (i.e., Alopecia/minoxidil, tretinoin) (Third Party Restriction Code C) |
| Weight Loss Agents (Anorexiants non-amphetamine, anti-obesity agents) (Third Party Restriction Code 8) |
| Lifestyle (Prostaglandin impotence agents, PDE-5 Inhibitors, Addyi/flibanserin) |
| Bulk Chemicals (Emollient cream, Emollient foam, Capsaicin & cleansing gel, Miscellaneous dermatological products) |
| Bulk Powders (all NDCs designated by 3 rd party exception code B) |
| Pharmaceutical Adjuvants (GPI: 98*****) |
| Rx Products with OTC Equivalent (does NOT apply to ACA and diabetic supplies) |
| Over-the-counter products not on the covered drug list |
| Schedule 5 OTC products |
| PPI products with an OTC equivalent |
| Medical foods (FID 207; Modifier code BBAIO1) |
| Compound Kits (FID 212) |
| Compounded products from outsourced facilities (Modifier code BBADJI) |
| Scar treatment product (GPI: 9093*****) |
| Institutional/unit dose (Modifier codes AAAD31, AAADQQ, BBAD9A, TTAAJQ, TTAA5V, AAAB9A, AAAD6T) |
| Non-FDA approved products (FID 220) |
| Viscosupplements |
| Repackers |
| Alternative medicines (GPI: 95*****) |
| General anesthetic (GPI: 70*****) |
| Chemicals (GPI: 96*****) |

If yes, deny as a plan exclusion. If no, continue to 2.

2. Is the request for a drug/drug class drug/drug class/medical condition that is restricted to coverage under the Medical Benefit?

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| Horizon Standard Exclusion lists (GPI list - HZ9STDEXC HZ GENERAL STD EXCLUSION SEQ45 and NDC list - HZEX GENERAL STD EXCLUSION_) |
| Intraarticular Steroid combination injections (GPI: 221099*****) |

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| ROA Exclusions (Epidural [EP], Intra-arterial [IA], Implant [IL], Intraocular [IO], Intraperitoneal [IP], Intra-articular [IX], Intravenous [IV], Intrathecal [IT], Hemodialysis [HM], Intralesional [LS], Intratympanic [TP], Intravitreal [IZ]) |
| Medical Supplies/Devices (GPI 97*, unless on the covered drug list or Dexcom G6 sensors, receivers or transmitters), Durable Medical Equipment, and Surgical Supplies (Third Party Restriction Code of 3) |
| IV Immune Globulin and IM Immune Globulin products |
| CYCLOPHOSPHAMIDE SOLR |
| MECHLORETHAMINE HCL SOLR |
| BLEOMYCIN SULFATE SOLR |
| PEGASPARGASE SOLN |
| LORAZEPAM SOLN |
| DESIRUDIN SOLR |
| AFLIBERCEPT |
| RANIBIZUMAB SOLN |
| TUBERCULIN PPD SOLN |
| COLLAGENASE CLOSTRIDIUM HISTOLYTICUM |
| OCRIPLASMIN |

If yes, deny as not covered under the pharmacy benefit. If no, continue to 3.

NOTE; In letter, refer provider/member to the medical benefit.

3. Is the patient's diagnosis an FDA-approved or compendia accepted indication [National Comprehensive Cancer Network (NCCN) Compendium™ level of evidence 1, or 2A; American Hospital Formulary Service (AHFS); Truven Micromedex/DrugDex – Class I or IIa recommendation, Clinical Pharmacology or a phase 3 clinical trial OR the prescriber has submitted a clinical study or additional documentation published in a major peer-reviewed medical journal supporting the requested therapeutic use (approval by the Clinical Review Pharmacist required)] for the requested medication?
If yes, continue to 4. If no, deny.
4. Has the patient tried and failed at least TWO generic (MSC Y) formulary alternatives?
If yes, continue to 6. If no, continue to 5.
5. Has the prescriber provided documentation stating that ALL available generic (MSC Y) alternatives are contraindicated, are likely to be less effective, or will cause an adverse reaction or other harm for the patient?
If yes, continue to 6.
If no, deny.
6. Has the patient tried and failed TWO Brand Name (MSC M or N) formulary (any formulary tier) alternatives (if applicable) for the diagnosis being treated with the requested drug?
If yes, continue to 8.
If no, continue to 7.
7. Has the prescriber provided documentation stating that ALL available Brand Name (MSC M or N) formulary (any formulary tier) alternatives are contraindicated, are likely to be less effective, or will cause an adverse reaction or other harm for the patient?
If yes, continue to 8.
If no, deny.

8. Is the request for a drug/drug class/medical condition that is on the list of drugs/drug classes/medical conditions which have additional clinical review criteria?
If yes, review clinical criteria and continue to 9. If no, continue to 10.
9. Is the additional clinical review criteria met?
If yes, continue to 10. If no, deny.
10. Is the request for an Affordable Care Act Copay Waiver product?
If yes, continue to 11.
If no, approve for 12 months.
11. Does the plan apply the Affordable Care Act Copay Waiver requirements?
If yes, approve for 12 months and refer to Copay Waiver criteria.
If no, approve for 12 months.
 - Apply first tier copay for generics (MSC = Y)
 - Apply third tier copay for brands (MSC = M, N, O)