BlueCross BlueShield of Kansas
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Drug Coverage Exception Program Summary - For Individuals Who Purchased BlueCare/EPO Products

These criteria will apply to the Health Insurance Marketplace for Groups using the BlueCare/EPO Formulary

Coverage Exception Criteria – Program Summary

Objective

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

For any agent which has additional clinical review criteria specific to the agent and/or disease state/medical condition, the additional clinical review criteria will also be applied.

EXCEPTION CRITERIA FOR APPROVAL

A coverage exception will be granted when ALL of the following are met:

1. The request is NOT 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
   AND
2. The request is NOT for a drug/drug class/medical condition that is restricted to coverage under the Medical Benefit
   AND
3. The patient has an FDA labeled indication, or an indication supported in AHFS, DrugDex with 1 or 2a level of evidence, or NCCN with 1 or 2a level of evidence for the requested agent
   AND
4. ONE of the following:
   a. The requested agent has formulary alternatives (any formulary tier) for the diagnosis being treated by the requested agent AND BOTH of the following:
      i. If the requested agent is a brand product with an available formulary generic equivalent ONE of the following:
         1. The patient has tried and had an inadequate response to one or more available formulary generic equivalent to the requested agent
            OR
         2. The prescriber has provided information stating that ALL available formulary (any formulary tier) alternative generic equivalent to the requested agent are contraindicated, are likely to be less effective, or will cause an adverse reaction or other harm for the patient

      AND

      ii. ONE of the following
         1. The patient has tried and had an inadequate response to at least two formulary alternatives (any formulary tier), if available, for the diagnosis being treated with the requested agent
            OR
         2. The prescriber has provided information stating that ALL available formulary (any formulary tier) alternatives are contraindicated, likely to be less effective, or cause an adverse reaction or other harm for the patient

   OR

   b. The requested agent does NOT have formulary (any formulary tier) alternatives for the diagnosis being treated with the requested agent

 Effective: 02/01/2023

OR

c. The prescriber stated that the patient is currently receiving the requested agent and is at risk if the therapy is changed

AND

5. If the request is for a drug/drug class/medical condition that is on the list of drugs/drug classes/medical conditions which have additional clinical review criteria, the patient has met the additional clinical review criteria

Length of Approval: 12 months

