Drug Coverage Exception Criteria - For Individuals Who Purchased BlueCare Products Program Summary

POLICY REVIEW CYCLE

Effective Date **Date of Origin**
01-01-2025

OBJECTIVE

These criteria will apply to the Health Insurance Marketplace for Groups using the BlueCare Formulary
Coverage Exception Criteria Program Summary
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.

CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	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: 1. If the requested agent is a brand product with an available formulary generic equivalent, ONE of the following: A. The patient has tried and had an inadequate response to one or more available formulary generic equivalent to the requested agent **OR** B. There is support that ALL available formulary (any formulary tier) alternative generic equivalents 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** 2. ONE of the following A. 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** B. There is support 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 **OR** C. The prescriber states that the patient is currently receiving the requested agent and is at risk if the therapy is changed **Length of Approval:** 12 month

