

Combination NSAIDs Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
11-01-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Yosprala	aspirin-omeprazole tab delayed release	325-40 MG ; 81-40 MG	M ; N ; O ; Y	M ; N		
Duexis	ibuprofen-famotidine tab	800-26.6 MG	M ; N ; O ; Y	O ; Y		
Vimovo	naproxen-esomeprazole magnesium tab dr	375-20 MG ; 500-20 MG	M ; N ; O ; Y	O ; Y		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Duexis	ibuprofen-famotidine tab	800-26.6 MG	90	Tablets	30	DAYS	QL cumulative across strengths		
Vimovo	naproxen-esomeprazole magnesium tab dr	375-20 MG ; 500-20 MG	60	Tablets	30	DAYS	QL cumulative across strengths		
Yosprala	aspirin-omeprazole tab delayed release	325-40 MG ; 81-40 MG	30	Tablets	30	DAYS			

ADDITIONAL QUANTITY LIMIT INFORMATION

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
661099023203	Duexis	ibuprofen-famotidine tab	800-26.6 MG	QL cumulative across strengths			
6610990244	Vimovo	naproxen-esomeprazole magnesium tab dr	375-20 MG ; 500-20 MG	QL cumulative across strengths			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Duexis	ibuprofen-famotidine tab	800-26.6 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Vimovo	naproxen-esomeprazole magnesium tab dr	375-20 MG ; 500-20 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Yosprala	aspirin-omeprazole tab delayed release	325-40 MG ; 81-40 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Duexis	ibuprofen-famotidine tab	800-26.6 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Vimovo	naproxen-esomeprazole magnesium tab dr	375-20 MG ; 500-20 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Yosprala	aspirin-omeprazole tab delayed release	325-40 MG ; 81-40 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> ONE of the following:

Module	Clinical Criteria for Approval
	<ul style="list-style-type: none"> A. BOTH of the following: <ul style="list-style-type: none"> 1. ONE of the following: <ul style="list-style-type: none"> A. For Duexis or ibuprofen/famotidine requests, the patient has a diagnosis of at least ONE of the following: <ul style="list-style-type: none"> 1. Rheumatoid arthritis OR 2. Osteoarthritis OR B. For Vimovo or naproxen/esomeprazole requests, the patient has a diagnosis of at least ONE of the following: <ul style="list-style-type: none"> 1. Osteoarthritis in adults OR 2. Rheumatoid arthritis in adults OR 3. Ankylosing spondylitis in adults OR 4. Juvenile idiopathic arthritis (JIA) in adolescents weighing greater than or equal to 38 kg AND 2. The patient has at least ONE of the following risk factors for developing NSAID-induced gastrointestinal (GI) ulcers: <ul style="list-style-type: none"> A. Age greater than or equal to 65 years B. Prior history of peptic, gastric, or duodenal ulcer C. History of NSAID-related ulcer D. History of clinically significant GI bleeding E. Untreated or active <i>H. pylori</i> gastritis F. Concurrent use of oral corticosteroids G. Concurrent use of anticoagulants H. Concurrent use of antiplatelets OR B. For Yosprala or aspirin/omeprazole requests, BOTH of the following: <ul style="list-style-type: none"> 1. The patient has an indication of use of at least ONE of the following: <ul style="list-style-type: none"> A. Reducing the combined risk of death and nonfatal stroke in patients who have had ischemic stroke or transient ischemia of the brain due to fibrin platelet emboli OR B. Reducing the combined risk of death and nonfatal myocardial infarction (MI) in patients with previous MI or unstable angina pectoris OR C. Reducing the combined risk of MI and sudden death in patients with chronic stable angina pectoris OR D. Use in patients who have undergone revascularization procedures (coronary artery bypass graft [CABG] or percutaneous transluminal coronary angioplasty [PTCA]) when there is a pre-existing condition for which aspirin is already indicated AND 2. The patient has at least ONE of the following risk factors for developing NSAID-induced gastrointestinal (GI) ulcers: <ul style="list-style-type: none"> A. Age greater than or equal to 55 years B. Prior history of peptic, gastric, or duodenal ulcer C. History of NSAID-related ulcer D. History of clinically significant GI bleeding E. Untreated or active <i>H. pylori</i> gastritis F. Concurrent use of oral corticosteroids G. Concurrent use of anticoagulants H. Concurrent use of antiplatelets AND 2. If the patient has an FDA labeled indication, then ONE of the following: <ul style="list-style-type: none"> A. The patient's age is within FDA labeling for the requested indication for the requested agent OR B. There is support for using the requested agent for the patient's age for the requested indication AND 3. ONE of the following: <ul style="list-style-type: none"> A. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR B. There is support for why the use of the individual ingredients within the target combination agent, as separate dosage forms, is not clinically appropriate for the patient OR C. BOTH of the following: <ul style="list-style-type: none"> 1. ONE of the following:

Module	Clinical Criteria for Approval
	<p>A. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR</p> <p>B. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes required] AND</p> <p>2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration</p> <p>D. The prescriber states the patient is currently being treated with the requested agent AND the patient is currently stable on the requested agent [chart notes required] OR</p> <p>E. The patient has tried and had an inadequate response to the individual ingredients within the target combination agent, as separate dosage forms [chart notes required] OR</p> <p>F. The individual ingredients within the target combination agent, as separate dosage forms, were discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR</p> <p>G. The patient has an intolerance or hypersensitivity to the individual ingredients within the target combination agent, as separate dosage forms [chart notes required] OR</p> <p>H. The patient has an FDA labeled contraindication to the individual ingredients within the target combination agent, as separate dosage forms [chart notes required] OR</p> <p>I. The individual ingredients within the target combination agent, as separate dosage forms, are expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient’s adherence of care; OR worsen a comorbid condition; OR decrease the patient’s ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm [chart notes required] OR</p> <p>J. The individual ingredients within the target combination agent, as separate dosage forms, are not in the best interest of the patient based on medical necessity [chart notes required] OR</p> <p>K. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the individual ingredients within the target combination agent, as separate dosage forms, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] AND</p> <p>4. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when ONE of the following is met:</p> <p>1. The request is for a BCBS NM Fully Insured or NM HIM member and ALL of the following:</p> <p>A. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>B. The requested indication is a rare disease AND</p>

Module	Clinical Criteria for Approval
	<p>C. ONE of the following:</p> <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR <p>2. ALL of the following:</p> <ol style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR C. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND

Module	Clinical Criteria for Approval
	<p data-bbox="469 180 1305 237">2. There is support for therapy with a higher dose for the requested indication</p> <p data-bbox="232 275 634 304">Length of Approval: 12 months</p>