



Rayos Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
12-15-2025

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
Rayos	prednisone tab delayed release	1 MG ; 2 MG ; 5 MG	M ; N ; O ; Y	N		

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
Rayos	Prednisone Tab Delayed Release 1 MG	1 MG	90	Tablets	30	DAYS			
Rayos	Prednisone Tab Delayed Release 2 MG	2 MG	60	Tablets	30	DAYS			
Rayos	Prednisone Tab Delayed Release 5 MG	5 MG	360	Tablets	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Rayos	prednisone tab delayed release	1 MG ; 2 MG ; 5 MG	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 HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Rayos	Prednisone Tab Delayed Release 1 MG	1 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 ; IL HMO Performance Quarterly ; 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
Rayos	Prednisone Tab Delayed Release 2 MG	2 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 ; IL HMO Performance Quarterly ; 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
Rayos	Prednisone Tab Delayed Release 5 MG	5 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 ; IL HMO Performance Quarterly ; 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

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			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"> 1. The patient has an FDA labeled indication for the requested agent AND 2. If the patient has an FDA labeled indication, then ONE of the following: <ol 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: <ol 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. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 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 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 OR C. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes required] OR D. The patient has tried and had an inadequate response to BOTH generic oral prednisone AND another different generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, prednisolone) [chart notes required] OR E. BOTH generic oral prednisone AND another different generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, prednisolone) were discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] OR F. The patient has an intolerance or hypersensitivity to BOTH generic oral prednisone AND another different generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, prednisolone) that is NOT expected to occur with the requested agent [chart notes required] OR G. The patient has an FDA labeled contraindication to ALL generic oral corticosteroids that is NOT be expected to occur with the requested agent [chart notes required] OR H. BOTH generic oral prednisone AND another different generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, prednisolone) 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 I. BOTH generic oral prednisone AND another different generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, prednisolone) are not in the best interest of the patient based on medical necessity [chart notes required] OR

Module	Clinical Criteria for Approval
	<p>J. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as BOTH generic oral prednisone AND another different generic oral corticosteroid (e.g., dexamethasone, methylprednisolone, prednisolone) 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>BCBSIL and BCBSMT: 12 months</p> <p>ALL other plans: 6 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. 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>

Module	Clinical Criteria for Approval
	<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 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval:</p> <p>BCBSIL: 12 months</p> <p>ALL other plans: 6 months</p>