

Supplemental Therapeutic Alternatives Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
02-01-2026

Date of Origin

OBJECTIVE

The intent of the Supplemental Therapeutic Alternatives Prior Authorization with quantity limit is to promote the use of lower cost, clinically appropriate, formulary alternatives over the high cost targets. Targets will be approved when the patient has experienced an inadequate response to optimized therapy of the lower cost alternative(s); the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the lower cost alternatives that is not expected to occur with the requested agent; or the prescriber has provided documentation and the pharmacist has reviewed and approved the patient's needs for the requested agent over the lower cost alternative(s).

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Carbidopa/levodopa er ; Crexont ; Rytary	carbidopa & levodopa cap er	23.75-95 MG ; 35-140 MG ; 36.25-145 MG ; 48.75-195 MG ; 52.5-210 MG ; 61.25-245 MG ; 70-280 MG ; 87.5-350 MG	M ; N ; O ; Y	M ; N		
Daraprim	pyrimethamine tab	25 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
Daraprim	Pyrimethamine Tab 25 MG	25 MG	116	Tablets	180	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Carbidopa/levodopa er ; Crexont ; Rytary	carbidopa & levodopa cap er	23.75-95 MG ; 35-140 MG ; 36.25-145 MG ; 48.75-195 MG ; 52.5-210 MG ; 61.25-245 MG ; 70-280 MG ; 87.5-350 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 ; NM HIM Annual 2024

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026
Daraprim	pyrimethamine tab	25 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 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM 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
Daraprim	Pyrimethamine Tab 25 MG	25 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

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval	
	Target	More cost-effective, clinically appropriate, therapeutic alternative
	Daraprim (pyrimethamine)	No alternatives
	Rytary, Crexont (carbidopa-levodopa ER)	Generic carbidopa-levodopa ER

Module	Clinical Criteria for Approval
	<p>Target Agents will be approved when ALL of the following are met:</p> <p>Initial Evaluation</p> <ol style="list-style-type: none"> 1. The patient has an FDA labeled indication for the requested agent and route of administration 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 optimized therapy of a more cost-effective, clinically appropriate, formulary alternative [chart notes required] OR E. Optimized therapy of a more cost-effective, clinically appropriate, formulary alternative was 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 a more cost-effective, clinically appropriate, formulary alternative that is not expected to occur with the requested agent [chart notes required] OR G. The patient has an FDA labeled contraindication to a more cost-effective, clinically appropriate, formulary alternative that is not expected to occur with the requested agent [chart notes required] OR H. Optimized therapy of a more cost-effective, clinically appropriate, formulary alternative is 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. Optimized therapy of a more cost-effective, clinically appropriate, formulary alternative is not in the best interest of the patient based on medical necessity [chart notes required] OR J. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as optimized therapy of a more cost-effective, clinically appropriate, formulary alternative and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes required] AND 4. The patient does NOT have any FDA labeled contraindications to the requested agent

Module	Clinical Criteria for Approval
	<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> <ol style="list-style-type: none"> 1. The request is for a BCBS NM Fully Insured or NM HIM member and ALL 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. The requested indication is a rare disease AND C. 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 2. ALL of the following: <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> <p>Renewal Evaluation</p>

Module	Clinical Criteria for Approval
	<p>1. The patient was previously approved for the requested agent through the Prime Therapeutics Prior Authorization process in the previous 18 months</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 AND 3. The dosage increase requested is appropriate based on recommended dosage titrations in FDA labeling or Compendia (i.e. dosage increase is not excessive, patient has been on current dose a sufficient length of time to determine efficacy/adverse effects) 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>Compendia Allowed: AHFS, or DrugDex 1, 2a, or 2b level of evidence</p> <p>Length of Approval: 12 months</p>